Ringdane Limited

South Quay Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on the 28 and 29 October 2014 and was unannounced. An inspection undertaken on 3 October 2013 found there was a minor breach of Regulation 21, appertaining to records kept by the home. A further inspection, conducted on 21 January 2014, found this issue had been addressed and there were no further breaches of legal requirements.

South Quay Care Home is registered to provide accommodation for up to 58 people and is divided into two distinct units; one unit supporting older persons, some of whom were living with dementia, which can accommodate up to 45 people, and a smaller unit offering care and respite facilities to a maximum of 13 younger people with a neurological condition. At the time of the inspection there were 25 people living on the older person's unit and 10 people using the neurological conditions service.

The home had a registered manager who had been registered since September 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the home and felt the staff treated them appropriately. There were systems in place to help protect people from harm or abuse and staff had a good understanding of safeguarding issues. They told us they would report any concerns of potential abuse to the registered manager or the regional manager. Staff were also aware of the registered provider's whistle blowing policy and knew how they could raise concerns about care. The premises were effectively maintained and safety checks undertaken on a regular basis. A process was in place to assess people's needs and this information was used to determining appropriate staffing levels. Proper recruitment procedures and checks were in place to ensure staff had the correct skills and experience to support people at the home. Medicines were dealt with safely and effectively.

People told us they had sufficient food and drink. They said the meals at the home were good and they could have alternatives to the planned menu, if they wished. They also told us they felt staff had the right skills to support them. Staff told us they had access to learning, although highlighted this relied heavily on ELearning at the current time. However, we found some staff had not had access to regular supervision, to review their support and training needs and ensure they were working safely. In some cases there had been no supervision for over nine months.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw evidence that assessments and best interest meetings had taken place in relation to people's care and health needs. However, we found the registered provider had not yet instigated a process to assess whether people were being detained in line with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. The local safeguarding adults team confirmed that they had not been approached by the registered manager in relation to managing the implementation of the recent Supreme Court ruling in relation to DoLS.

People told us they were happy with the care provided. We observed staff treated people patiently and appropriately. Staff had a good understanding of people's individual needs. People's wellbeing was monitored and they had access to general practitioners, dentists and opticians, along with a range of other health professionals. Where necessary specialist advice was sought. People said they were treated with dignity and respect and staff were able to demonstrate how people's dignity was maintained during the provision of personal care.

People had care plans that reflected their individual needs and these were reviewed to reflect changes in people's care requirements. There were a range of activities offered for people to participate in. People told us they knew how they could raise a complaint, if they needed to. Complaints and concerns were dealt with by the registered manager, using a full and proper process.

The registered manager carried out regular checks on people's care and the environment of the home. Staff were positive about the leadership of the home and felt well supported. The registered manager held regular meetings with staff groups and people who used the service, to allow them input into the running of the home. However, the registered manager had not notified the Care Quality Commission (CQC) of significant accidents or incidents and important safeguarding issues.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This related to supporting workers. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe whilst living at the home. Staff had undertaken training and had a good knowledge about safeguarding issues and recognising potential abuse. Staff told us they would report any concerns they had to the registered manager or the local safeguarding adults team.

Risk assessments had been undertaken in relations to people's individual care and the wider care home environment. Care plans reflected the issues highlighted in the risk assessments. Medicines were handled appropriately and people received them on time and safely.

Proper recruitment processes were in place to ensure appropriately qualified and experienced staff worked at the home. There was a process in place to ensure correct staffing levels were maintained, based on people's care needs.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People told us they felt staff had the right skills to support them. Staff told us and records confirmed staff had access to training. However, not all staff had received supervision and appraisals in a timely manner. Some staff had received no supervision for over nine months.

There was evidence that assessments had been undertaken in line with the Mental Capacity Act (2005) to determine if care or treatment was being provided in their best interests. No process was in place and no applications had been made to determine if people had their freedom restricted under the Deprivation of Liberty Safeguards.

People told us they had access to sufficient food and drink. Staff were aware of people's special dietary requirements. Advice was sought from specialist practitioners when required.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and were well supported by staff at the home. We observed staff supporting people appropriately and recognising them as individuals.

People's wellbeing was effectively monitored. They had access to a range of health and social care professionals for health assessments and checks. People who were unwell were able to access appointments with their general practitioner.

Summary of findings

Care was provided whilst maintaining people's dignity and respecting their right to privacy.

Is the service responsive?

Good

The service was responsive.

Care plans were in place that reflected people's individual needs. Plans were reviewed and updated as people's needs changed.

There were a range of activities for people to participate in and people had choice to follow their own interest of spend time alone.

People and their relatives told us they felt involved in their care. Complaints were logged and dealt with using a proper complaints process.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

The registered manager undertook a range of audits to ensure people's care and the environment of the home were effectively monitored.

Staff talked positively about the support they received from the registered manager and said teamwork was encouraged in the home. People told us the atmosphere in the home was a happy one and staff were positive in their approach.

The registered manager had not sent CQC notifications of all incidents that he was legally obliged to inform us of within the required timescale.

South Quay Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 and 29 October 2014 and was unannounced.

The inspection team consisted of an adult social care inspector and a specialist clinical advisor who had experience in the area of neurological conditions.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the Local Authority contracts team, the local authority safeguarding adults team, the local Clinical Commissioning Group and the local NHS trust community nursing home matron who works into the home.

We spoke with eight people who used the service to obtain their views on the care and support they received. We also spoke with two relatives and two friends, who were visiting the home on the day of our inspection. We talked with the registered manager, six care workers, four nurses, the assistant cook, two personal assistant liaison workers (activities) and a member of the domestic team. Additionally, we spoke with a pharmacist who was visiting the home during our inspection and conducted telephone interviews with a local general practitioner and a NHS trust care manager.

We observed care and support being delivered in communal areas including lounges and dining rooms, looked in the kitchen areas, the laundry, treatment rooms, sensory room, bath/ shower rooms, toilet areas and checked people's individual accommodation, this was carried out with people's permission. We reviewed a range of documents and records including; nine care records for people who used the service, nine medicine administration records in the older person's unit and a further nine records on the neuro-disability unit; five records of people employed at the home, duty rotas, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings of people who used the service or their relatives and a range of other quality audits and management records.

Is the service safe?

Our findings

We asked people if they felt safe living at the home. They told us staff looked after them well. Comments from people included, "I feel very safe here. There is no shouting or rough treatment; nothing like that"; "They know how to look after me; they certainly don't treat you roughly" and "The carers are all good and all kind; I feel very safe here." A friend of a person who lived on the neurological conditions unit told us, "He is so content it is unbelievable." Staff approached and dealt with people in a caring and understanding way. They dealt with people equally, whether they were aware of their surroundings or not, and spoke to them appropriately. One staff member told us, "It is about treating people as people, treating them fairly and with respect." This indicated staff understood about respecting people's individuality and rights.

We spoke with staff and asked them what they would do if they had concerns about the care being delivered at the home or felt that someone may be being abused. Staff told us they would immediately raise their concerns with the registered manager, deputy manager or regional manager. Some staff also mentioned they would contact the local safeguarding adults' team. We saw there was information and contact numbers for the local safeguarding team on several notice boards throughout the building. All the staff we spoke with said they had completed training in relation to safeguarding adults and the identification of abuse. Central training records and certificates in staff files confirmed training in this area had been completed.

Staff we spoke with were able to tell us about the registered provider's whistle blowing policy. They directed us to information about whistle blowing displayed on several notice boards around the home. The registered manager told us about an incident that had been reported to him by staff members which had resulted in disciplinary action being taken. Staff demonstrated they had the necessary skills and knowledge to ensure the risk of people being abused was minimised.

We saw risks to individuals were assessed and monitored. People's care plans had risk assessments relating to moving and handling, skin integrity and the use of equipment, such as bed rails to protect people from falling. We saw these were reviewed and altered as required. For example, was saw one person who had been ill, required additional support to walk or the use of a wheelchair immediately after their illness. Another person, who had a high risk of choking had been assessed by a speech and language therapist and had a care plan based on the advice provided.

People's care plans indicated the number of staff required to help them move safely. Where people could get about the home alone or with minimum support this was also documented. Wider risk assessments were also in place for the home environment and for areas such as fire safety. This established individual risks relating to people's needs were assessed and monitored and wider risks within the home were reviewed.

We looked at the information system used by the home to record accidents and incidents. We saw that as part of the recording process a review of each incident was undertaken. The registered manager told us he and the regional manager were currently reviewing staffing levels at night to see if they remained safe because of a number of falls during the night shift. We saw one person's mobility care plan had been temporarily changed, following a fall, to increase the support required when walking and to instigate the use of bedrails at night to limit the possibility of a fall. The regional manager also told us information placed on the management system was reviewed as part of a wider company quality process. This meant processes were in place to review incidents in the home and make changes to care or systems in the light of new information.

We saw the premises were well maintained and clean and tidy. We saw the home had a person who dealt with any repairs which required addressing. On the day of our inspection we witnessed him carrying out safety checks on the home's fire system. We saw him conduct the weekly fire systems test to check if alarm systems worked and fire doors closed. We saw one fire door was slightly slow to close. We later saw the person working on the door to ensure it closed effectively. Other checks on the premises such as gas and electrical system checks were also undertaken within prescribed time scales. The registered manager told us he carried out a range of checks and audits on the fabric and environment of the building. We saw he carried out regular checks on safety within the home, such as fire systems and emergency lighting. We also saw equipment was regularly checked to ensure it was safe to use. This meant appropriate systems were followed to ensure the safety of the premises and ensure ongoing

Is the service safe?

repairs and maintenance was up to date. There were some elements of the home environment designed to support people living with dementia, such as the use of signs on bathrooms and toilet areas and plain flooring to aid mobility and avoid confusion over floor levels. However, there was limited other decoration specifically designed to support people living with dementia.

The registered manager told us the home employed 54 staff in total, including eight nursing staff, who all worked full time. He told us the older people's unit was short of one care worker because someone had called in sick that morning. Staff told us that, whilst they would always welcome additional staff, they felt there were enough staff available at the home. They said they worked as a team and this was supported by the registered manager. One member of the domestic team approached us and told us, "We work as a team that is what it is all about. You are here to make it nice for the residents. I'm not just a domestic; I am part of a bigger team." We observed all staff engaged and supported people who lived at the home. We saw domestic staff, kitchen staff and the home's handyman all engage positively with people and support them; reminding them to take drinks or be careful when walking. We spent time observing the lounge area of the older people's unit. We found there were periods, particularly in the early afternoon, when the lounge area was left unobserved for a period of 25 minutes and it was difficult to locate a member of staff nearby. We noted that an absence of staff had been raised in the providers own quality report and the potential danger to people who used the service through lack of observation noted in the report. We raised this with the registered manager who agreed to look into the issue further.

The registered manager showed us the electronic system for determining staffing levels in the home, based on dependency levels. He demonstrated how individual dependency levels were assessed monthly and then added to the staffing tool, which calculated suggested staffing levels. People told us they felt there were enough staff. They said, "I think there are enough staff; I am well looked after. I can have a shower whenever I like" and "When you need help they are there in seconds." Another person told us, "Sometimes they can be a bit short of staff, if someone does not come in; but it's not a regular thing." However, one person on the neurological conditions unit told us, "I can't always get my shower every other day as they don't always have the staff." We noted call bells on both units were answered within a few minutes. One member of staff told us, "There are enough staff. I think the home is well covered. They are looking at an extra care worker on nights, which I think would be good." This meant the registered manager was able to determine effective levels of staff were rostered to be on duty.

Staff personal files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, notes from a formal interview process, references being taken up and Disclosure and Barring Service (DBS) checks being made. Staff told us they were required to wait for checks to be completed prior to starting work at the home. The registered manager showed us he checked the registration of the nursing staff on a monthly basis to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council. This verified the registered provider had appropriate recruitment and vetting processes in place.

We observed the nursing staff dealing with people's medicines. We saw people were given their medicine appropriately; with the reason for their medicines explained, time given for them to take their tablets and a drink given to help them swallow the dose. We examined the Medicine Administration Record (MAR) sheets. We found there were no gaps in the recording of medicines, that handwritten entries were double signed to say they had been checked as being correct and people with "as required" prescriptions had a care plan covering the circumstances when the medicine should be offered. "As required" medicines are those given only when needed, such as for pain relief. We spoke to a pharmacist who was visiting the home on the day of our inspection. She told us she was working with the home to improve the management of medicines and had no major concerns about the use or administering of medicines at the home. She said, "There is nothing that jumps out at me as worrying. Staff are very well informed about patient's needs." Nursing staff confirmed they had their competency for safe handling of medicines assessed by the registered manager. This indicated medicines at the home were handled safety and administered correctly.

Is the service effective?

Our findings

People we spoke with told us they felt staff who supported them had the right skills to provide their care. One person told us, "I think staff have all the right skills to help me. They certainly don't want me to be miserable." Staff told us they had access to training, although three members of staff pointed out that currently this was predominantly through the use of ELearning, rather than face to face training. One staff member told us how the registered manager had recently been ensuring staff training records were up to date and all required ELearning had been completed. Another staff member told us, "It can be a bit difficult if you are not very tech savvy, like me."

Nursing staff on the neurological conditions unit told us it was sometimes difficult to access on-going clinical training for their speciality. They said they would contact local health professionals, such as the multiple sclerosis nurse, if they needed help and support, but there was no on-going programme of updating for them to link into. The clinical lead for the neurological conditions unit told us they would not accept an admission unless they felt confident they had the right skills and training to support the person safely. We saw from staff training files there was a record of up to date training in areas such as first aid, nutritional awareness, dementia and whistleblowing. The registered manager confirmed there was a system in place, through the registered provider's electronic reporting system, to monitor training undertaken and when updating was required. Staff told us they had undertaken an induction process at the start of their employment. We saw evidence of a check list in staff files, indicating each element of the induction had been covered. This meant the registered manager was able to demonstrate staff's skills and knowledge, to deliver effective care to people, were updated and reviewed.

Members of staff answered variably about access to supervision and appraisals. Some staff told us they had recently had supervision or received it on a regular basis. Other staff told us it had been several months since they had last had supervision. Nursing staff on the neurological conditions unit told us they had received no supervision since the previous registered manager left over nine months ago. They also told us that because they tended to work 12 hour shifts, opposite to each other, it was sometimes difficult to find time to meet up and discuss service or clinical issues. We checked the supervision matrix for the home and individual supervision and appraisal records for staff members. We saw some staff had received supervision in September 2014, whist other staff records indicated they had not had a supervision session since March 2014. The nursing staff in the neurological conditions unit had no recorded supervision sessions in 2014. We saw a copy of the registered provider's supervision policy which indicated all staff should receive a minimum of six supervision sessions each year, including one appraisal meeting.

We spoke to the registered manager about this. He told us he was aware of the deficit in supervision and was working to address this. He told us that when he arrived there had been no supervision records beyond June 2013 and he was trying to catch up on the processes and bring things up to date. This meant proper arrangements were not in place to ensure staff had access to regular supervision and ensure their work was reviewed in relation to delivering appropriate care.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 and the action we have asked the provider to take can be found at the back of this report.

Information contained in people's care plans indicated some consideration had been given to people's mental capacity and their right and ability to make their own choices, under the Mental Capacity Act (2005) (MCA). We saw some care plans indicated where people were able to make every day decisions, about the clothes they wore and the food they would like to eat. Care plans indicated major decisions would require a best interest meeting and that relatives, care managers and other key professionals should be involved in reaching a decision about the best course of action to take for the individual concerned.

We found three people had "Do not attempt cardio pulmonary resuscitation" forms in the front of their files. We saw these had been signed by the person's general practitioner. However, in only one case could we find any indication that a best interest decision had been taken with regard to this matter. This meant there was no clear indication that a proper process had been followed to ensure people's best interests were at the centre of these decisions.

Is the service effective?

Staff we spoke with told us they had undertaken training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), although we noted this training had been predominantly based around ELearning. Staff were aware of the concept of best interest decisions, but were unclear when such a decision would be required and who should be involved. Staff told us that best interest decisions and MCA matters were dealt with by the registered manager or the nursing staff.

Nursing staff on the older people's unit were unaware of the recent Supreme Court ruling on DoLS and the implication for people who lived in care homes. They told us no one at the home was currently prevented from leaving and subject to DoLS. When we questioned them further about the implications of the Supreme Court ruling, they identified people in the home who may be required to be registered in line with the safeguards. We spoke to the registered manager about the application of DoLS. He told us no applications had been made to the local supervisory body for DoLS applications. He said he had not made applications because he was aware they were very busy and so had decided to "hang fire", as most of the people in the home were low risk. The local safeguarding adults team confirmed that they had not been approached by the registered manager in relation to managing the implementation of the recent Supreme court ruling in relation to DoLS. This meant people's rights against inappropriate restriction of liberty were not protected because appropriate measures were not in place to make the required assessments and applications, in line with MCA and DoLS legislation.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 and the action we have asked the provider to take can be found at the back of this report.

People told us they enjoyed the food and they had enough to drink and eat. Comments from people included, "You get plenty of cups of tea throughout the day"; You get plenty to eat and plenty of sweet stuff, like puddings" and "The food is very good. It comes around for you to choose on a menu each day. They always say to me they can do me a fried egg or something, if there is nothing I like." One person on the neurological conditions unit told us overall they were satisfied with the food, but stated, "It can be bland at times." People's care plans contained specific information in relations to their nutritional needs. The care plan covered their likes and dislikes and any special dietary requirements; such as if people required a diabetic, soft or pureed diet.

We spoke with the assistant cook about the provision of meals at the home. She showed us records of people's dietary requirements which were kept in the kitchen; detailing their likes and dislikes and any supplements or special diets. Kitchen staff had a good knowledge of special diets, national descriptors on the use of soft diets and people's individual likes. They told us one person often had a baked potato because they really liked these. We saw there was a good range of food and ingredients available at the home.

We observed meal times at the home. We saw the food was hot and appetising. Pureed meals were also well presented with individual items identifiable and the meal contained both meat and vegetables. Where necessary, people were encouraged to eat or were supported when they could not immediately help themselves. Between meals we saw people had regular access to drinks and snacks. One person asked for a cup of tea when they came back from a trip out and was immediately provided with one. One person told us, "You get water if you need it and there is always a jug of juice on the table." We saw people's weight and dietary intake was monitored and reviewed. One general practitioner, who we spoke with after the inspection told us, "They very quickly alert us to people who are losing weight; it is a common call. They are concerned about weight loss, even when it is end of life care."

Is the service caring?

Our findings

People we spoke with told us they were happy with the care provided and were involved in their care, where possible. Comments from people about their care included, "It is very good. They get full marks for the way the conduct the business"; "The staff are very good; I can only speak highly of them"; "It is okay. The staff are smashing. They get you anything you want"; "I love living here; the staff are great" and "Marvellous; it is marvellous." One relative told us" She is happy here. That is the main thing."

We spent time observing how staff interacted and treated people who used the service. We saw people were treated appropriately, patiently and individually. For example, staff asked everyone, irrespective of their ability to communicate, whether they wanted a drink of tea or coffee and whether they also wanted sugar. One staff member described how they supported one person through the use of a booklet which contained pictures. They told us how staff used this to help the person communicate and make choices. Another staff member told us how staff came in on days off to assist people to attend a local church. This suggested people's diverse needs were recognised and addressed.

Staff spoke to everyone by name. Staff took time to have conversations with people, about what they had done or where they were going. For example, three members of staff independently asked one lady, who was going out with a relative, where she was going and what she was going to do. When staff talked to people they crouched to ensure they were at the correct height to engage with people and so they could be seen. One person told us, "Staff listen. If I need to talk or complain about anything they will sit and listen." This indicated people were given choices and were involved in making decisions.

People who were independently mobile were able to move about the home freely. We saw some people chose to sit in a conservatory area away from the main lounge. This area was quieter but also allowed them to see staff and people passing so they could chat to them. We also saw people could go out into the garden area or to a small shelter which allowed them to smoke in safety. People told us they could choose what they wanted to do. They said, "There are activities to join in if you want, and trips out. It's up to me if I join in" and "It's my choice that I have come to my room. I have lots of films and things that I like to watch." This showed people were able to make personal choices about how they spent their day.

Staff told us they were committed to supporting people and enjoyed working at the home. Staff said, "I love getting up and coming to work"; "I'm not here for the money; I enjoy doing what I do. It's about the people here" and "I like mingling with them and seeing what they like. You are here to support the residents. They enjoy you having a laugh with them."

We saw people's wellbeing was monitored and maintained. People's care plans indicated they had access to general practitioners, opticians, dentists and other health professionals, when they required them. People told us they could ask staff to request a visit by their general practitioner, if they wanted one. During our inspection staff told us one person was not feeling well. We saw staff monitored the person's condition and then requested general practitioner to visit and assess them.

The registered manager told us no one at the home currently used or accessed an advocate or advocacy service. We saw evidence from one person's care file that an Independent Mental Capacity Advocate had previously been involved in helping a person to make a decision about their care.

People told us staff treated them with dignity and respect. One person said, "All the staff treat me with respect; they always do." It was recorded in people's care plans that they had been asked to indicate if they were happy to be cared for by male/ female care workers. One person told us, "Yes I have been asked, but I don't mind the male care worker, he is a nice young lad." Staff told us how they helped maintain people's dignity when they required care. They told us how they always kept people properly covered during personal care activities and that they ensured the door was closed and the room's blinds or curtains were drawn. We witnessed doors kept closed during personal care and care workers opening curtains after care had been delivered. We also witnessed staff slipping discretely out of people's room during personal care, to ensure their dignity and privacy was maintained. This meant staff understood about maintaining people's dignity and applied the concepts when they delivered care.

Is the service responsive?

Our findings

People and their relatives told us they were involved in their care. One person told us, "I feel very involved in my care; I could change anything if I wanted to." One person's relative told us, "They are very good at involving us in care and involving us if there are any problems."

We saw people had individual care plans in place to ensure staff had information to help them maintain their health, well- being and individuality. Care plans involved a range of assessments covering such areas as; their mobility, their nutritional needs, their personal care needs and any identified health issues. We saw care plans had been developed to address people's specific needs and individual likes and choices were included in their care plans. For example, we saw one care plan indicated a person enjoyed soaking in the bath and another person, who had mobility issues, liked to relax in a comfortable chair. A person told us, "I like to relax in a bath, it helps with my pain."

We saw people's needs were reassessed on a monthly basis and the care plans and actions were updated. We noted in some care plans, whilst the care had been reviewed and changes documented, these changes were not transferred to the main care plan documentation. This meant it was not always clear when and how care had changed and whether new preferences or actions had been added. We spoke with the registered manager and the deputy manager about this. They told us they would review people's care plans and ensure that the most up to date information was clearly stated.

People told us there were a range of activities available at the home. One person told us, "There is always something to do. The other day we had someone in playing the Northumbrian pipes. That was a good day that was. It was lovely." Another person told us, "There are lots of activities you can join in with; arts and crafts, going out for drives. We have been to Beamish, Amble and Seahouses." We observed one person being supported to attend a local gym for a weekly session.

We spoke with the personal assistant liaison (PAL) workers who supported activities in the home. One PAL worker told us her job was to ascertain what people would like to do and arrange activities to suit their needs. The liaison worker said she, "Tried to give everyone a chance to do something." We saw people were engaged in making decorations for a forthcoming Halloween party at the home. People were chatting, laughing and sharing jokes around the table and enjoying the social interaction.

We asked the liaison worker about activities for people living with dementia and how these were organised at the home. She told us, "This role has opened my eyes to how difficult it is living with dementia." She said, "You have to be very flexible. Perhaps you just sit and hold their hand or have a conversation with them; let them know you are there with them. Just holding the hand of someone who is distressed and frightened can be a real help." The liaison worker told us how she was in the process of developing scrap books for people in the home. She was intending to put photographs and art work in. She hoped it would give people something to look at and talk about. She said it would also give something that families could take away and treasure. The registered manager told us he was trying to move away from purely events based activities and look to develop more individual and person centred programmes for people that would better reflect the support that people living with dementia required.

People we spoke with told us they had few complaints about the service, but would speak to the registered manager if they had any concerns. People said, "I've never had to make a complaint, but would see the manager if I did; but there is no need really" and "I've never had to make a complaint. The manager comes round and I would see him." A relative told us, "I've never had to make a complaint. We did raise an issue once and the manager dealt with it straight away and everything was done properly." We looked at the home's complaints records. We saw there were three recent complaints, all of which were in the process of being investigated and that the registered manager had gathered documentary evidence, as part of his investigation into one complaint. Letters acknowledging the receipt of the complaints were on file. We saw a previous complaint had been investigated using the registered provider's complaints process and a full written response sent, following the conclusion of the investigation. This meant people were aware of how they could complain and a process was followed to ensure complaints were dealt with appropriately.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since September 2014. He told us he had been overseeing the home since February 2014. He was present during both days of our inspection.

The registered manager told us he carried out a range of checks and audits on the care delivery at the home including audits of medicine records and systems and monthly reviews of the meals served at the home and the overall dining experience. We saw where issues were identified then action was taken to improve the situation. For example, we saw the need to refresh the furniture in the lounge area had been noted. The registered manager told us new furniture had been ordered and we saw this was in place. Staff told us the new furniture was better for people, as it was not as upright to sit in. They also felt the design gave the lounge a more homely feel.

The registered manager told us, and staff confirmed a range of meetings took place with various staff groups in the home. We saw copies of minutes from health and safety meeting, meetings with nursing staff and meetings with kitchen staff. Staff told us they were able to express their views in these meetings and they felt they had their points listened to. The registered manager said he used the clinical governance meetings to improve care and we saw issues relating to individual care matters were considered at this meeting. He also told us there was a system whereby a policy was highlighted each month and staff were required to read and update their knowledge of the area and the issue was highlighted at the various meetings. We spoke with a community matron and a local general practitioner. They told us staff contacted them for advice and joint working had increased in recent months.

Staff told us they felt very positive about how the home had improved over recent months and were constructive regarding the support and the leadership of the registered manager. Comments from staff included, "(The manager) is one of the best bosses I have had. He encourages us all to interact and work together"; "I've worked in other places, but not like this. He encourages us all to work together" and "Things are better than they were nine months ago. He always has time for you and puts you at your ease. (The manager) is concerned about the home and the residents."

However, some members of staff told us they often did not feel valued by the higher organisation. They felt there was no clear recognition for their efforts and "all the extra hours that we put in". One staff member told us, "There should be some recognition for loyalty. No one says 'thank you'; although (the manager) always says thank you."

People told us the atmosphere at the home was good and they felt the attitude of the staff was very positive. People said, "The staff always look and seem happy" and "There is load of laughter going on. I lark around with them. I couldn't do with being anywhere else."

People told us there were meetings between the registered manager and people who lived at the home, or their relatives. We saw agendas and minutes for these meetings. The minutes indicated actions the registered manager had taken in response to issues raised at the meetings. For example, we saw in one set of minutes the registered manager had explained that the lack of activities had been due to staff maternity leave and he was addressing the issue. We noted later comments indicating a member of staff had been placed in charge of activities during this period.

The registered manager told us he reviewed accidents and incidents using the information recording system. We saw notes reviewing any issues were included on the accidents and incidents printout.

With the exception of the supervision processes, we found records were up to date and complete. People's care records were regularly reviewed and updated along with food and fluid and positional charts. Safety records, such a fire checks, gas safety and Lifting Operations Lifting Equipment Regulations (LOLER) checks on equipment were in place. Portable appliance testing (PAT) of small electrical equipment was up to date and checks on medical equipment, such as nebulizers or suction pumps, had been undertaken.

When we planned the inspection we noted from our records that the registered provider had not submitted any notifications to the Commission regarding accidents or incidents at the home since September 2013. Two notifications regarding safeguarding incidents had been received in 2014. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. The submission of notifications is important to meet the requirements of the

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law and enable us to monitor any trends or concerns. We saw from records maintained by the home there had been at least three serious injuries, where notification should have been made, and one potential safeguarding incident. The registered manager acknowledged he had failed to make the necessary notifications to the Care Quality Commission in relation to accidents at the home and potential safeguarding events. He told he had not realised the breadth of issues that required notification.

This is a breach of Regulations 18 (1) and (2) of the Health and Social Care Act 2008 (Registration) Regulations 2010. We have written to the provider asking them to confirm the details of any accidents/ incidents and safeguardings taking place at the home and will deal with this matter outside of the inspection process.

The registered manager told us his main challenge over the next few months was to work with staff to continue to advance care standards, to continue to implement changes in practice and develop the staff as a team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to enable them to deliver care and treatment safely and to an appropriate standard because staff did not receive appropriate supervision and appraisal.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, consent of service users in relation to the care and treatment provided for them.**