Helen McArdle Care Limited

Springfield House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 18 and 20 August 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Springfield House in August 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

Springfield House provides personal care for up to 69 older people, including people with dementia related conditions. Nursing care is not provided at the home. At the time of our inspection there were 70 people living at the home.

A manager was in post who had applied to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered 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.

Summary of findings

We found that care was delivered safely and appropriate steps were taken to protect people from being harmed. Staff were trained in and understood the importance of their duty of care to safeguard people against the risk of abuse.

People living at the home confirmed they felt safe with the staff who cared for them. The home was clean, comfortable and well equipped. Safety checks were conducted to ensure people received care in a safe environment.

People were supported to meet their health needs and access health care professionals, including specialist support. Medicines were managed safely to promote people's health and well-being.

There was a varied menu with choices and people told us they enjoyed the food. Nutritional needs and risks were closely monitored and people were supported with eating and drinking where necessary. A new process had been introduced to provide people who had a pureed diet with more appetising meals.

New staff were suitably checked and vetted before they were employed. There were sufficient numbers of staff to provide people with continuity of care and to support the running of the home. The staffing ratio had been increased to enhance the care of people living at the home.

Staff were well supported in their roles and met people's needs effectively. Further training was being undertaken and staff were given regular supervision to support their personal development.

People were consulted about and were able to direct their care and support. Formal processes were followed to uphold the rights of those people unable to make important decisions about their care, or who needed to be deprived of their liberty to receive the care they required.

Staff knew people well and the ways they preferred their care to be given. People and their relatives told us the staff were kind, caring and respectful in their approach. Our observations confirmed this and we saw people were cared for with dignity and treated as individuals.

A range of methods were used that enabled people and their families to express their views about their care and the service they received. Any concerns or complaints were taken seriously and properly investigated.

Care was flexible and responsive to people's needs. Assessments of needs and risks were carried out and care plans were in place and regularly reviewed. Recording standards were being addressed to ensure care plans consistently reflected the personalised care provided. A variety of activities were made available to encourage stimulation and help people meet their social needs.

The management arrangements ensured good leadership and the home had an open and inclusive culture. Robust systems were operated to monitor and develop the quality of the service, including acting on feedback and checking the care that people experienced.

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?
The service was safe.

Appropriate arrangements were in place to minimise risks and make sure people were cared for safely. Staff had a good understanding of safeguarding people from harm and abuse and how to report any concerns.

A thorough recruitment process was followed when new staff were employed. There were enough staff to provide people with safe and consistent care.

People were safely supported in taking their prescribed medicines at the times they needed them.

Good

Is the service effective?
The service was effective.

Staff provided effective care that meet people's needs. The staff were given training relevant to their roles and had their work performance supervised and appraised.

The service acted in accordance with mental capacity legislation to ensure people's rights were upheld.

People accessed health care services and were supported to maintain their health and welfare. People were provided with good nutrition and were given support to meet their eating and drinking needs.

Good

Is the service caring?
The service was caring.

People and their families had positive relationships with the staff team.

Staff understood people's needs and preferences and ensured they were treated with dignity and respect.

People were encouraged to express their views and be involved in making decisions about their care and support.

Good

Is the service responsive?
The service was responsive.

People's care needs were regularly assessed and recorded in care plans which were kept under review. Staff provided personalised care and were responsive to people's changing needs.

Various social activities were offered and people were supported to access and engage in their local community.

There was a clear complaints procedure and any concerns raised were investigated in a timely way.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

An experienced manager was in post who had applied for registration.

The manager provided good leadership and was committed to developing the service. There was an emphasis on teamwork and staff had good morale and felt well supported in carrying out their responsibilities.

The culture of the home was transparent and feedback from people and their representatives was sought and acted upon. A proactive approach was taken to continuously monitor and make improvements to the quality of the service.

Springfield House

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 was planned to check whether the provider was 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.

The inspection took place on 18 and 20 August 2015 and was unannounced. The inspection team consisted of one adult social care inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 25 people living at the home and eight relatives. We spoke with the managing director, the head of catering, an operations manager, the manager and deputy manager, the administrator, an activities co-ordinator and with 10 care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at nine people's care records, 21 people's medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and that their personal possessions were safe. Their comments included, "It's perfectly safe here, my needs are perfectly catered for"; "It's a first class service, everything I need is to hand"; "I'm given support with the things I need help with and given the freedom to live quite independently"; and, "Nothing is a trouble to anyone." People and their relatives told us the home was cleaned and maintained to a good standard. One person said, "It's spotlessly clean."

The relatives we talked with confirmed they felt their family members were safe. One relative told us they had been contacted by staff to confirm the identity of another relative they had not met before when they came to take their family member out. They said, "That gave me peace of mind that they take safety and security seriously."

Safeguarding leaflets from the local authority were displayed in the home for information. Each person was also provided with a guide to the service that informed them about their rights to be protected from harm and abuse. The manager told us the service aimed to help people understand their rights and was open and transparent about safeguarding issues with people and their families.

The home had a range of policies and procedures that formed the service's safeguarding framework. This ensured the manager and staff had clear guidance to refer to about their responsibilities and the processes to be followed if safeguarding issues occurred. All new staff were introduced to the policies during induction and given safeguarding training that was updated annually. Staff also had access to the provider's whistle-blower hotline if they needed to raise any concerns about poor practice. The staff we spoke with had a good understanding of what constituted abuse and were confident about reporting any concerns about people's safety.

In the past year safeguarding issues had been appropriately notified to the relevant authorities. Most of the referrals had related to incidents of potentially harmful behaviour between people with dementia related conditions. The manager told us they had analysed the incidents, increased staffing levels, reviewed the staff skills mix and training, and arranged more social stimulation. They felt these actions had led to a calmer environment and atmosphere on the unit for people living with dementia that aimed to prevent incidents re-occurring.

Systems were in place for the safekeeping of people's personal finances. To avoid any conflict of interest, no-one within the service acted as an appointee (a representative appointed on behalf of a person) for those people who needed support with their finances. The service had established where relatives or solicitors supported people, including clarifying legal status such as power of attorney for managing finances. Suitable records were maintained of cash deposited and repaid to people for their personal spending and for any purchases made. The entries were witnessed and countersigned, wherever possible by the person, and backed by receipts. The administrator was following up the need for itemised receipts with a visitor who on occasions sold items to people within the home. Monthly audits of the records and cash balances were undertaken and a full financial audit was conducted annually to ensure people's money was being handled safely.

All necessary recruitment information was obtained to check the suitability of new staff before they were employed to work at the home. This included checks of criminal records, health screening and completion of an application form giving details of employment history, qualifications and training. Proof of identity and two references, including one from the last employer, were sought and applicants were interviewed. An employee checklist was used to verify all pre-employment checks had been made and demonstrate that a thorough recruitment process was followed.

The manager told us they had evaluated staffing when they took up post and arranged for the numbers of care staff to be increased. The staffing had continued to be reviewed each month, taking account of the numbers of people living at the home, their care needs and levels of dependency. The manager said there were sufficient staff employed and capacity to cover absence from within the team. When necessary, bank staff and staff from the provider's other care services provided cover and external agency staff were rarely used to ensure people received continuity of care.

Rosters were planned well in advance and the current levels were 13-14 care staff across the day and seven at

Good

Is the service safe?

night, always including seniors on each floor to lead shifts. The manager and deputy manager worked in a supernumerary capacity and the home had staff with dedicated roles for administration, co-ordinating activities, catering, laundry and housekeeping. A tiered on-call system was operated that enabled staff to get support at any time from management and to escalate emergencies to senior managers within the company.

During the course of the inspection we observed staff were able to care for people safely and at a relaxed pace. There was a higher ratio of staff allocated to work with people on the Grace unit, allowing people with dementia to be more closely supervised. No concerns about staffing were expressed by any of the people living at the home or their relatives. Two relatives told us they had visited the home early in the morning and late at night and had found staffing levels and care to be as they expected. One relative said, "I call in at all times, unannounced and everything is always perfect." Staff told us they felt that staffing was suitably organised to meet people's needs.

Risks to people's safety were assessed using tools to review risks associated with moving and handling, falls, nutrition, and skin integrity. Separate assessments were completed into other aspects of personal safety including choking, distressed behaviour, and self-administering medicines. Management of risks was also built into care plans to guide staff on how to prevent people from being harmed during their care delivery.

Monthly audits of health and safety and infection control were carried out to ensure people were cared for in a safe and hygienic environment. Continuity plans were in place for emergency circumstances including disruption to facilities and in the event of people needing to be evacuated from the home.

Care records showed that staff contacted families to inform them when accidents or incidents occurred, and of the actions taken to keep people safe. Accidents were analysed on a monthly basis and this had identified a trend of people having unwitnessed falls in their bedrooms. The deputy manager said some people had sensor mats to alert staff if they attempted to get up unaided. The manager told us they had also implemented extra staffing, hourly 'comfort checks', and directed staff to check people had the call system within reach. Further analysis demonstrated that these actions had resulted in a reduced number of accidents.

Prescribed medicines were ordered monthly and kept in designated rooms which were alarmed and locked. All storage facilities, including medicines trollies, were clean and well organised. These measures ensured people had sufficient stocks of their medicines and that they were held securely.

Staff received training in the safe handling of medicines and annual assessments were carried out to check their competency and skills. People who were supported with their medicines told us they received them on time and that staff watched them to make sure they had been taken. We observed a senior care assistant giving medicines and saw they did this in an unhurried way and explained to people what their medicines were for. They followed the correct procedure of completing the records once they had confirmed that people had taken their medicines.

Appropriate information was available for each person within their medicine administration records, including a photograph for identification, details of 'as required' medicines and any allergies. Instructions about routines and particular medicines requirements were also set out in people's care plans. For example, the importance of timing of medicines prescribed for a person with Parkinson's Disease. Medicine administration records were appropriately completed, including any reasons why medicines had not been given. Some missing dates and a witness signature in the controlled drugs register were brought to the attention of a staff member and the manager. Audits were routinely conducted to check the treatment rooms and medicines administration to assure people their medicines were being handled safely.

Good

Is the service effective?

Our findings

People living at the home and their relatives were satisfied with the care and felt the staff had the training and skills to provide the care and support that was required. People's comments included, "The girls are lovely, they work very hard and it's not an easy job" and, "I feel completely happy here." A person staying for respite care said, "They're all lovely, very friendly and very helpful. My room is quite large with its own shower."

A relative we spoke with said they had no worries at all, as they knew their family member was well looked after. They said their visits were quality time with the person and they didn't have to worry as they had when the person lived at home. Relatives told us they called into the home at any time and were kept well informed about their family members' welfare. They said staff telephoned to update them about any health or other issues and staff were reassuring in their approach which prevented them from being unduly concerned.

People told us their health needs were met and they were visited by health care professionals, including a local GP who attended the home weekly. Care records showed people were referred to and received input from a range of professionals to help meet their physical and mental health needs. Specialist support was accessed such as psychiatry, a memory team and community psychiatric nurses, occupational therapy, speech and language therapy (SALT) and dietitians. Professional's advice was built into care plans though we noted strategies from a SALT for a person who had difficulty swallowing had not been fully transferred into their care plan. Medical history information was gathered and some people had advanced health care plans which detailed their wishes and the care and treatment to be provided in certain situations, such as when they became seriously ill. Information was also held in care records that informed staff about specific medical conditions. Reassessments were carried out when people's needs could no longer be met at the home to ensure they were transferred to appropriate nursing care settings.

We observed that staff interacted well with people and took time to meet their needs effectively. The staff did not rush people and assisted them in ways which did not compromise their independence. For example, they supported people to use their mobility aids when moving from one area to another and encouraged people to have enough to eat and drink at mealtimes. We saw appropriate care was given to frailer people including safe assistance with moving and handling and one-to-one support with meals and drinks.

Each person had their nutritional needs assessed and care plans were in place to address eating and drinking needs. People who were at risk due to weight loss or poor appetite were weighed weekly and other people were weighed on a monthly basis. The manager monitored weights and reported on the actions taken in response, including communicating with catering and senior staff and referrals to dietitians. A varied and balanced diet was provided and records were kept of food and fluid intake for those people identified as being nutritionally at risk. Homemade cakes and biscuits with drinks were served between meals and fresh fruit was prepared and offered. Jugs of water were provided in bedrooms and water dispensers were available to encourage people to drink adequate amounts.

The provider's head of catering explained and demonstrated the use of two innovative products they had researched in Germany. One product enabled pureed food to be fortified, given texture and moulded to resemble the original shapes, such as cuts of meat and vegetables, and could be eaten with a knife and fork. This had been used to good effect with one person living at the home who was now gaining weight and enjoying their food. We saw this person's meal at lunchtime was attractively presented, colourful and looked appetising. Another person was being provided with this diet temporarily whilst they recovered from an injury that prevented them eating solid foods.

The second product sourced was a powder that could be added to a variety of drinks and, using an air pump, created bubbles/foam. This aimed to provide a refreshing alternative to oral care swabs which were used when people were receiving care at the end of their lives. We were told it could also be used to help stimulate people's taste buds if they were experiencing loss of appetite. Training in both products and techniques had been given to catering staff and head of services in each of the provider's care homes. Presentations of the products and their benefits were also taking place and being publicised on a care home website. This showed us the provider was committed to developing initiatives to enhance how people's nutritional needs were met.

The people and relatives we talked with were happy with the environment and the maintenance of the home. One

Good

Is the service effective?

relative told us, "If any repairs are required they are dealt with quickly or put on a job list if they are not urgent, such as hanging a picture on a wall." The home was clean and well maintained and had a secure entry and exit system and a bright and welcoming reception area. All areas of the home were spacious and decorated and furnished to a high standard. Bedrooms were personalised with people's furnishings and personal effects and all had ensuites. Appropriate aids and equipment were provided to meet people's needs and ensure their comfort, including specialist beds, moving and handling equipment and assisted bathing facilities.

People living at the home told us they made everyday decisions about their care. They said staff asked their permission before entering rooms or providing any assistance and this was confirmed by our observations. Information had been obtained to verify where people had relatives or other representatives with legal status to act on their behalf. When necessary, an assessment of mental capacity was carried out to determine a person's ability to make significant decisions about their care and treatment. In some instances the assessments had led to formal 'best interest' decisions being made and evidence of these decisions was held in care records to guide staff's practice.

Policies and procedures were in place and staff were given training on the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that the least restrictive option is taken when people need to live in a care setting in order to receive the care and treatment they require. The manager confirmed that formal processes had been followed to authorise the safeguards for a number of people living at the home to ensure their rights were upheld.

The staff we talked with had good knowledge and understanding of people's needs and how to support them effectively. They described having had good, in-depth induction training before they started work which had prepared them for their roles. One staff member told us, "I had a good mentor, read the care plans and worked with the senior carers" and, "I've just finished my NVQ Level 3." A senior carer who had progressed from being a care worker said they had completed a six week course on caring for people with dementia. They had also received extra training around their senior care responsibilities, such as providing individual supervision. Staff told us there were good opportunities for training, with a mix of classroom based and e-learning courses. For instance, a housekeeper said they had enjoyed a dementia care course and it had given them lots of information they had previously been unaware of. The provider had established their own training academy earlier in 2015 that was overseen by a training manager. One staff member told us "I like the academy, it was a good idea."

The manager told us when they first started they had needed to organise a lot of training which needed to be refreshed to bring staff up to date. Records showed that 'mandatory' training in safe working practices was well on course for all staff to have completed. The numbers of staff who had completed some of the other training required to meet the provider's training standards had been identified as lower than expected. These related to areas of care including falls prevention and tissue viability and awareness of specific health conditions such as strokes and Parkinson's Disease. The manager had therefore prioritised topics and was ensuring that courses were allocated each month for staff to undertake.

Staff told us they were well supported and had regular supervision. There was a delegated system in place for all grades of staff to receive supervision six times a year and an annual appraisal. The manager kept an overview and the schedule showed the majority of staff had been provided with supervision at the required frequency to enhance their personal development.

Good

Is the service caring?

Our findings

People living at the home were positive about the care they received. They told us, “We all like living here, you can’t fault the care, the food or the staff”; “Everything is quite alright, I’ve absolutely no complaints”; “I’ve got a nice room, they’re all nice people, the food’s nice and I’ve no concerns”; “There’s always a friendly face to cheer you up if you’re feeling a bit low”; and, “Everyone is so polite and friendly. It’s so comfortable and the staff are so caring.”

Relatives told us they felt staff treated their family members with kindness, care and respect. Many commented on the nice atmosphere in the home and told us that visiting was a pleasure. Their comments included, “It’s lovely here, everyone is very friendly. Every single person knows who my relative is. It’s clean, my relative is always clean, there’s no problems with the laundry and there’s never any odours like you sometimes find in these places”; “After my relative came in I would call in any time of day or night from 7.30 in the morning until 11.30 at night just to make sure they were being cared for and they were. My relative doesn’t like going to bed early so one night I came at 11pm and they were just sitting with the carer at the desk colouring in. That put my mind at ease”; and, “My relative is happy, I’m happy, everyone is very friendly, helpful and kind.”

Our observations of care practices confirmed what people and their relatives told us. There was a calm and welcoming atmosphere and people looked relaxed and comfortable. The staff we talked with understood people’s diverse needs and the support they required. They addressed people appropriately and were respectful when engaging with them. Staff were sensitive in their approach and attitude. For example, where a person had marks on an item of their clothing following lunch, a staff member said, “Shall we get a fresh top because it’s the movie afternoon?” The person replied that this was good idea. We observed a care assistant made breakfast for a person who chose to get up late and spent time gently encouraging them to eat and drink in a very dignified way. Another person was frequently distressed and we saw staff regularly checked on their well-being, going into their bedroom to chat and offer drinks and snacks. During a bingo session we observed the activities co-ordinator spoke the numbers to a person who was partially sighted so they could call the numbers out. When group activities were taking place staff took time to sit and talk with those people who had chosen not to take part to ensure they felt included.

We found the care environment was designed in such a way that it supported interactive living, with people and their families and friends able to access a range of facilities. These included plenty of communal rooms and small seating areas, an event suite with a licensed bar, space set aside for computers with internet access, and a hairdressing salon with a nail bar. The dining area on the ground floor was in the style of a café/restaurant with an adjoining orangery and an attractive, accessible garden. People and their visitors made good use of the facilities and particularly enjoyed being able to have meals and drinks together. A relative told us, “Seven of us had Sunday lunch with mum last week and it was lovely.” Staff on the Grace unit told us the garden was a favourite spot and was well used by people in warmer weather. Some people used Skype and email to keep in contact with their families and other people who were important to them.

At lunchtime we found that staff provided a good level of service and the mealtime was a pleasant and sociable experience for people. The food looked appealing and people were given choices of meals, desserts and hot and cold drinks. Attention was paid to detail, for instance, offering parmesan cheese to add to the pasta dish that some people were having. Where a person wasn’t eating what they had chosen, we saw a care assistant asked them what they would like instead. The person chose to have a banana and were offered brown or white bread with it and asked whether they wanted to have the bread buttered.

When people were unable to choose from the menu, staff took plates of food to show them and explained what was on offer. One person chose to have both dishes from the menu and this was readily accommodated. Adapted crockery was available and this was used to help people eat independently and protect their dignity by avoiding spillage. Support with eating was provided sensitively and at the individual’s pace. Some people had chosen to have their meals in their rooms and this was respected. We informed the manager that none of the people we spoke with in one dining room knew what was on the menu that

Good

Is the service caring?

day. They acted on this by reminding staff to put copies of the daily newsletters in bedrooms and arranged for menu stands to be purchased so the menus could be displayed on the dining tables.

People told us they were given choices and liked the meals. Their comments included, "The lunch was very nice"; "I always enjoy the food"; and, "There's usually something I like." One person told us they preferred a particular breakfast cereal and had been told this was stocked, however they said it was often not available as staff forgot to send it up from the kitchen. A person who lived in the apartments adjoined to the home said, "I often use the cafe and the food is really lovely and the portions are more than adequate. Family can join you too and I believe there's going to be a family evening meal."

People told us their privacy and dignity were respected and said staff asked or knocked at their door before entering their rooms. They were well groomed and told us they could have a bath or shower whenever they wanted. A visitor commented, "The residents are always clean and tidy and their clothes are co-ordinated. There's a lovely atmosphere and you never hear a raised voice." We observed that personal care was undertaken discreetly and any requests for assistance, such as help to go to the toilet, were facilitated promptly.

The home had two 'dignity champions' who promoted dignified and respectful care. They had previously held a themed dignity day in conjunction with the activities co-ordinators which had been open to families to attend. People living at the home had been involved in the planning and asked to put forward their opinions about the ways they liked to be valued. The manager and deputy manager carried out dignity observations each month to monitor people's care experiences. These included checking people's well-being and comfort and how staff communicated and interacted. Actions had been taken on findings including prompting staff to spend more time in the lounge and to assist people from the dining rooms in a timely way.

People were given a guide with clear information about what they could expect from using the service. Daily newsletters were prepared which informed people about social activities and upcoming events, facilities available in the home, the menu for the day, and the staff on duty. A range of informative leaflets were also displayed including information on advocacy services, places of interest, and information about dementia and different medical conditions for people and their families to refer to.

We observed that staff took care to adapt their communication to suit people's needs. For example, some staff had learned words that helped them ask questions and clearly converse with a person who was requiring increased support with verbal communication. We saw people living with dementia responded well to staff's tactile communication and approach. Staff were supportive in recognising the individual's perspective of what they were experiencing, demonstrating that they valued the person's beliefs. A relative told us, "Its good quality care and they adapt their approach depending how my relative is feeling as sometimes they can't communicate so the staff use pictures."

People were able to direct their care and make everyday choices such as where they spent their time and took meals, and whether to participate in activities. Some people told us they were involved in their care plan and others said they required little support as they were quite independent. Each of the relatives we talked with confirmed they were involved in decisions about their family member's care. Feedback was sought through care reviews, residents and relatives meetings, and satisfaction surveys, enabling people and their families to give their views about the care and the service they received.

Good

Is the service responsive?

Our findings

People living at the home and their relatives told us they were happy with the care provided. All said they would have no hesitation in making a complaint to the staff or manager if there was ever a need to do so. No-one we spoke with had ever made a complaint. Relatives told us staff were very approachable and willing to help them if they had any concerns or issues. Two relatives said the manager or deputy manager always resolved any issues they had quickly and satisfactorily. One relative told us they had just established a new committee to look towards providing additional social activities and they were hopeful of getting a bank of volunteers to help facilitate activities.

A clear complaints procedure was in place and this was displayed and given to people. None of the complaints logged related to care issues and we found they had been appropriately investigated and responded to.

We observed there were flexible routines and staff were attentive to people's needs and requests. Staff told us times for going to bed and getting up were flexible and depended very much on how a person was feeling or if they had any physical problems that needed time in bed. For instance, one person spent the morning in bed but was helped into a comfortable chair after lunch. The time they spent in the chair had gradually increased as their physical condition had improved. We saw staff answered the call system very quickly and people confirmed they received timely responses when they summoned help. Checks were also kept on the call system to monitor staff response times and ensure people were attended to without delay.

The manager gave us examples of the ways the service had responded to meet people's needs. They told us the Grace unit had been redeveloped and consolidated to a smaller area to improve the environment and quality of care for people living with dementia. The reablement unit of the home was no longer being used for this purpose due to the increased demand for permanent care. Short stay/respite care was now provided only when vacant rooms were available.

Grace is the name the provider has chosen to depict their philosophy of caring for people living with dementia (Graciousness, Respect, Acceptance, Communication and Empowerment). We found these principles were adhered to on the Grace unit and there was an inclusive atmosphere and a real sense of staff working well as a team. Staffing had recently been increased during the day to a senior care assistant and three care assistants to provide increased observation and interaction for the 15 people who lived on the unit. The ambience was relaxed and cheerful, with staff engaging with people and providing activity and stimulation. Each member of staff we observed working in or passing through the unit took time to stop and acknowledge and talk with people. All staff working there had a good understanding of the individual needs of the people they supported.

People living on the Grace unit were able to move freely about and sitting areas had comfortable chairs with rounded corners. A range of memorabilia and nostalgic pictures and items were available to help people interact with their surroundings. Each bedroom door depicted the person's name and photograph to help people recognise their rooms. There was effective signage around the unit, large clocks all showing the correct time, and the weather was displayed. The day's menu was also displayed though this was typed, and not available in alternative formats, which may have made the menus hard to follow for some people.

People's needs had been assessed before admission and a range of assessments were routinely completed on a monthly basis to confirm each person's current needs and level of dependency. Care records showed that some life story work had been undertaken to give staff information about the individual's history, important events in their life, and what they enjoyed. Specific religious or cultural preferences were also noted such as dietary requirements related to people's religious beliefs.

Care plans in the main addressed all identified needs and acute care plans were in place for meeting needs such as short term health conditions. Two people's care plans, including those that had been updated in response to changing needs, lacked detail about the support that staff needed to provide. We brought these to the attention of the manager and deputy manager who assured us the care plans would be amended immediately.

We found that although person centred care was provided in practice, this was not fully reflected in the standards of care planning. Some care plans had been signed by the person and/or their relative to demonstrate they had been discussed and agreed, whilst others had not. Recording was variable and in some cases this had been identified

Good

Is the service responsive?

through audits which highlighted that care plans needed to be more personalised. We saw some care plans were tailored to the individual's needs and preferences whilst others, including 'promoting choice' and 'escort and emergency', were more generic and procedural. The manager confirmed that staff training in care planning and the importance of care documentation was being organised.

Care plans were evaluated monthly to ensure they continued to meet people's needs. Individual care reviews were scheduled every six months to give people and their families opportunities to discuss their care.

There was a half an hour handover at each shift change to provide staff with up to date information about people's well-being. The handovers were given verbally and were recorded with specific details on each person and any changes or incidents affecting their well-being. This enabled all staff to be made aware of essential information and catch up on any issues that had occurred when they were off duty.

The home had a number of lounges equipped with televisions, radios, music, books and board games. Two activities co-ordinators were employed and one or both were on duty each day of the week. A social budget was provided and fundraising events were held to help meet costs. Meetings were held for the activities co-ordinators from all of the provider's care homes to share ideas. The manager told us training in activity leadership was being looked into and both co-ordinators would be asked to study for this qualification.

One of the co-ordinators was trained to deliver the HEARTS process, a combination of therapeutic approaches that aims to enhance people's relaxation, peace and well-being. We were told some care staff had observed the co-ordinator carrying out the process. The manager told us they would consider how the training could be more widely cascaded to enable this approach to become more routinely carried out with people. Work had started on a 'three wishes' campaign, whereby people were asked to make three wishes about what was important to them and progress was being checked monthly. In 2014 people living at the home had made a CD of a Christmas song that was sold at the Christmas Fayre, and a choir was being started up again to practice and make another CD.

We saw the co-ordinators arranged activities and entertainment and produced a weekly programme that was displayed on noticeboards. A separate programme was designed with activities for people living with dementia. Weekly outings were organised in a mini-bus and people had recently visited a garden centre, Beamish Museum, an art gallery, and been out for pub lunches. The co-ordinators kept records of group activities to demonstrate what had taken place and comments about each person's participation. Care staff also kept daily activity records for each person, though many entries just stated people had relaxed in their room. The manager acknowledged these were not an accurate account of the activities people took part in and that individual social care plans could also be further developed.

A relative we talked with told us the home had purchased a soft doll for their family member because they had responded well to it. Doll therapy can be beneficial for people living with dementia in providing sensory stimulation and purposeful activity. Another relative commented, "There is a very good gym but it's not being used because there is no-one trained to use it. I think it could be used for armchair exercises as it has a large mirrored wall and people could see how they were moving."

During our visit we saw different activities were carried out that people had the opportunity to take part in. For instance, there was a 'singing for the brain' session led by a visiting practitioner. This initiative was started by the Alzheimer's Society and aims to bring people together through singing and help them express themselves and socialise with others. People and the staff enthusiastically joined in, singing, playing instruments, and taking photographs. They clearly enjoyed the session and had fun as there was much good humoured banter and laughter. On the Grace unit we saw five people were smiling and enjoying themselves as they joined in with armchair exercises to music. Another care assistant then took over, producing scarves from the rummage box. Later there was an option to colour or paint and a movie afternoon. Overall we found there was a good level of stimulation and activities provided to help meet people's social needs.

Good

Is the service well-led?

Our findings

A new manager had taken up post in April 2015. They were an experienced manager and had applied to the Care Quality Commission to become the registered manager. The manager told us they were well supported in their role by the deputy manager and senior managers and directors within the company who had defined responsibilities.

The manager said they had been given time to get to know people, their families and the staff.

They had evaluated the home's standards and had made a number of improvements since taking up post. These included increasing staffing, restructuring the key worker system, reassessing people's needs, and more regular auditing of the quality of care. The manager understood their management responsibilities and demonstrated values of person centred care. Their vision was to extend people's involvement in how the home was run through meetings and a resident committee, and for people to take part in the staff recruitment process. The manager was developing standards of care recording and the extent of training staff received to keep them updated with best practice. The provider was also trialling electronic care planning and medicines management which we were told would be introduced into the home in the future.

People living at the home and relatives told us the home was well managed and that all staff were very approachable. They said their visitors could come at any time, stay for as long they wanted, and were made to feel welcome by staff. One person said, "I would be very sad if I had to move because it's just wonderful here, it's very well organised." Relative's comments included, "It's much better since there's been an increase in staff. This is really a wonderful place and X (deputy manager) is amazing and will provide you with any information you need and respond to any questions"; "Staff are on the phone straight away, even in the middle of the night if there's a problem"; and, "All of my relatives needs are catered for and if there's anything I need to know I just ask the manager or deputy manager and they sort things out."

Bi-monthly meetings were held to share information and keep people and their representatives involved in the running of the home. Topics discussed included updates about staffing, activities, meals, health and safety and safeguarding and there was evidence that suggestions made were acted on. The home had been rated in the top five care homes in Gateshead in the 2014 survey carried out by a market research organisation. Action had been taken on those areas of the survey which people had rated less favourably, including staffing, meals and complaints management. Findings from the latest internal surveys indicated that people living at the home and visiting professionals rated the service highly.

A relative we talked with described a time when the provider had listened to and acted on their views about alterations to a lounge area. They had met the provider by chance whilst visiting the home and approached them to discuss the reduced lounge space and style of decoration. The relative told us they spent one and a half hours with the provider who agreed to change the plans. The provider had then contacted them directly to ask their opinion on the proposed changes and again after the work was completed. They said, "The lounge is now nice and the wallpaper much brighter and stimulating." This showed us an open and inclusive culture was promoted where people could influence the service.

The home maintained a number of links with the community including people visiting the local library, art gallery and cinema. Clergy from local places of worship visited and held services at the home. An Arthritis Care group held training and advice sessions in the events suite for people living at the home and members of the community. A private physiotherapy service also delivered exercise programmes for people. The manager told us they were looking to re-establish links with the Alzheimer's Society dementia café to build on relationships and benefit people living at the home.

There was a clear management and staffing structure with 'heads of department' and accountable roles for different areas of the service such as catering, housekeeping and activities provision. The manager and deputy manager were accessible to all staff and monitored the day to day care. The manager received daily reports from staff on each unit with significant information about people's safety and welfare. They followed up on any issues from the reports during daily walkarounds and did thorough checks to ensure all necessary action, including updating of care records, had taken place.

The provider ensured staff were given information about company developments, benefits and recognition awards for staff and the employee assistance programme. The

Good

Is the service well-led?

views of staff were also sought in annual surveys. Care staff told us they had a good level of support in their roles and were well led by seniors. They felt there was good leadership and they were confident to express their views about the service, including during supervisions and staff meetings. Their comments included, “The home is well managed and I feel it’s well regarded”; “Things have greatly improved with the new manager”; “The company is absolutely brilliant. Staff are valued and there are employee incentives and rewards, they do a lot for their staff”; and, “We’re so lucky, it’s a really good company and we get great support.” We observed that staff were motivated and worked well together as a team. They appeared happy in their work and confirmed this to us.

The home had a robust system of quality checks and audits. In many instances these looked closely at the care that people experienced. For example, observations of mealtimes and to check that people were being cared for with dignity. The manager and operations manager carried out unannounced visits to the home during the night and at weekends to make sure people were being provided with a good standard of care at all times. The manager appraised their operations manager of resident and staffing issues in detailed monthly reports. These covered areas including any safeguarding alerts and complaints and actions taken in response to clinical issues.

A range of audits were conducted that looked at quality in areas of the service such as medicines management, housekeeping, infection control, the kitchen and catering, care records, the environment and health and safety. The operations manager carried out comprehensive audits every month which included feedback from people and staff and a review of progress in meeting any identified improvements needed. These measures enabled standards within the home to be kept under close scrutiny and for the quality of the service to be developed.