Tamaris Healthcare (England) Limited

Bannatyne Lodge Care Home

Inspection report

Manor Way,
Peterlee.
SR8 5SB
Tel: 0191 5869511
Website: www.fshc.co.uk

Date of inspection visit: 9 and 16 April 2015
Date of publication: 22/06/2015

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

This inspection took place on 9 and 16 April 2015 and was unannounced. This meant the staff and the provider did not know we would be visiting. The home was last inspected by CQC on 27 January 2014 and required improvements to make the service safe and effective.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection there was a new manager in post who was applying to become registered.

Bannatyne Lodge Care Home is a purpose built care home in the town of Peterlee, County Durham. It provides general nursing, residential, respite and palliative care for up to 50 older people over two floors. On the day of our inspection there were 28 people using the service.

People who used the service and their relatives were complimentary about the standard of care at Bannatyne

Summary of findings

Lodge Care Home. Without exception, everyone we spoke with told us they were happy with the care they were receiving and described staff as very kind, respectful and caring.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Training records were up to date and staff received supervisions and appraisals.

There were appropriate security measures in place to ensure the safety of the people who used the service. The provider had procedures in place for managing the maintenance of the premises.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia type conditions.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We looked at records and discussed DoLS with the manager, who told us that there were DoLS in place and in the process of being applied for. We found the provider was following the requirements in the DoLS.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. We also saw staff had completed training in the Deprivation of Liberty Safeguards.

People were protected against the risks associated with the unsafe use and management of medicines.

We saw staff supporting and helping to maintain people's independence. People were encouraged to care for themselves where possible. Staff treated people with dignity and respect.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at meal times when required.

The home had a programme of activities in place for people who used the service.

All the care records we looked at showed people's needs were assessed. Care plans and risk assessments were in place when required and daily records were up to date.

We saw staff used a range of assessment tools and kept clear records about how care was to be delivered.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists.

The provider consulted people who used the service, their relatives, visitors and stakeholders about the quality of the service provided.

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.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. There were sufficient numbers of staff on duty in order to meet the needs of people using the service.

Staff had completed training in safeguarding of vulnerable adults and knew the different types of abuse and how to report concerns.

The provider had procedures in place for managing the maintenance of the premises.

Good

Is the service effective?
The service was effective.

Staff were supported to provide care to people who used the service through comprehensive induction and a range of mandatory and specialised training.

People had access to food and drink throughout the day and we saw staff supporting people when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home.

Good

Is the service caring?
The service was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

Bedrooms were very individualised with people's own furniture and personal possessions.

Good

Is the service responsive?
The service was responsive.

Care plans and risk assessments were in place where required.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Good

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

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Good

Summary of findings

Staff we spoke with told us they felt able to approach the manager and felt safe to report concerns.

People who used the service had access to healthcare services and received ongoing healthcare support.

Bannatyne Lodge 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 was planned to check 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 9 and 16 April 2015 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by an adult social care inspector, an adult social care inspection manager, a specialist adviser (nurse) and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had expertise in older people's services.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding and infection control staff.

During our inspection we spoke with fourteen people who used the service, five relatives and one friend. We also spoke with the manager, the peripatetic regional manager, the care quality facilitator, an agency nurse, the personal activities leader, five care staff, the administrator, the cook and a domestic.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for five members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as audits, surveys and policies.

For this inspection, the provider was not asked to complete 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 spoke with the manager about what was good about their service and any improvements they intended to make.

Good

Is the service safe?

Our findings

Bannatyne Lodge Care Home is a purpose built care home in the town of Peterlee, County Durham. It provides general nursing, residential, respite and palliative care for up to 50 older people over two floors. People who used the service and their relatives told us, "Yes, I do feel safe in here. The staff treat me with great kindness all of the time", "I am happy here and I do feel safe. It is better for me because I lived on my own and I had no one at night if I felt poorly", "I know mam is safe and is being well cared for. It has taken a lot of worry off my shoulders" and "Mam is very safe and has settled in here very well. I am happy she is well care for".

Bannatyne Lodge Care Home is a two storey, detached building set in its own grounds. The home comprised of 50 single bedrooms, all of which were en-suite. We saw that the accommodation included several lounges, two dining rooms, several communal bathrooms and shower rooms on each floor. All were spacious and suitable for the people who used the service. There was also a garden with a patio area. We saw the home was very clean, well decorated and maintained. It was warm and comfortably furnished with no unpleasant odours. We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs, wheelchairs, walking frames and pressure cushions. We saw the slings, hoists and passenger lift had been inspected in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) in February 2015. We saw windows fitted with restrictors to reduce the risk of falls and wardrobes in people's bedrooms were secured to walls. Maintenance checks had been carried out for window restrictors, in April 2015.

Call bells were placed near to people's beds or chairs and were responded to in a timely manner. We asked residents if their call bell was answered quickly during night hours if they needed assistance. People told us, "Yes, they are very good. They come to see what you want and you don't have to wait long", "They are very good and helpful. If I need to go to the toilet, which I do through the night, they come to me in just minutes", "Never had any problems. Sometimes you have to wait for a few minutes but they come as soon as they can" and "If there was more staff it would help the staff who is already here. They are busy all the time and extra hands would help."

The nurse call system had been serviced in February 2015.

We looked at the records for portable appliance testing, emergency lighting, periodic electrical certificate and gas safety certificate. All of these were up to date. Accidents and incidents were recorded and the manager reviewed the information in order to establish if there were any trends.

Hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

We saw a fire emergency plan on each floor which displayed the fire zones in the building. We saw fire drills were undertaken in 2014 and a fire risk assessment was in place. Weekly fire alarm checks were completed and checks on fire extinguishers were up to date. We looked at the provider's personal emergency evacuation plan (PEEP) policy. This described the emergency evacuation procedure for the home and for each person who used the service. This included the person's name, date of birth, room number and floor, number of staff required to assist them, any assistive equipment required and personalised evacuation procedure. This meant the provider had arrangements in place for managing the maintenance of the premises and for keeping people safe.

We discussed staffing levels with the manager and the peripatetic regional manager. We saw the home employed only one nurse substantively and she was due to start maternity leave in the summer. The manager told us that the home currently had vacancies for four nursing staff and confirmed that she was in the process of recruiting new staff. The manager also told us that the levels of staff provided were based on the dependency needs of residents established through the care home equation for safe staffing (CHESS) and any staff absences were covered by existing home staff and regular agency nurses.

We saw there were six members of staff on a day shift, which comprised of a nurse, a senior care assistant and four care assistants. The night shift comprised of a nurse, a senior carer and two care assistants. The home also employed a deputy manager, a nurse, an administrator, a

Good

Is the service safe?

cook, a kitchen assistant, a personal activities leader, a domestic and a maintenance man. We observed plenty of staff on duty for the number of people in the home. People and their relatives told us, “If you were not happy with the people who help us in here then you would not be happy anywhere” and “They treat my dad with kindness, he has never said anything that would indicate he is not well looked after”.

We saw a copy of the provider’s safeguarding adult’s policy, which provided staff with guidance regarding how to report any allegations of abuse, protect vulnerable adults from abuse and how to address incidents of abuse. We saw that where abuse or potential allegations of abuse had occurred, the manager had followed the correct procedure by informing the local authority, contacting relevant healthcare professionals and notifying CQC. We looked at five staff files and saw that all of them had completed training in safeguarding of vulnerable adults. The staff we spoke with knew the different types of abuse and how to report concerns. This meant that people were protected from the risk of abuse.

We looked at the selection and recruitment policy and the recruitment records for five members of staff. We saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passport, birth certificate, driving licence, marriage certificate, bank statement and utility bill. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained.

We looked at the disciplinary policy and from the staff files we found the manager had disciplined staff in accordance with the policy. This meant the service had arrangements in place to protect people from harm or unsafe care.

We looked at the provider’s management of medicines policy dated 19 December 2014. The policy covered all key aspects of medicines management. We observed and discussed the medicines procedure with the nurse on duty and the senior carer. We saw the administration of medicines complied with appropriate administration standards. We saw medicines were stored securely. Medicines requiring storage within a locked fridge were stored appropriately and the temperature of the fridge was monitored regularly.

Staff who administered medicines were trained and their competency was observed and recorded by senior staff. Staff told us, “We have training yearly through E-learning and also Boots provide training for the home”. This meant that the provider stored, administered, managed and disposed of medicines safely.

Good

Is the service effective?

Our findings

People who lived at Bannatyne Lodge Care Home received care and support from trained and supported staff. All the residents we spoke with were confident the staff knew what they were doing when they were caring for them. They told us, "When they get me up in the morning they help me to wash and they help me to dress. I have clean clothes every day", "I am sure they know what they are doing. I get cream on my legs because I have a condition that causes them to itch", "Well yes I do think they know what they are doing. I get helped out of bed, dressed and put in my wheelchair, before I go for breakfast" and "I don't think they would be in the job if they did not know what to do. I know they do training but I think a lot comes naturally to them. They are good people."

We looked at the training records for five members of staff and we saw that staff had received a thorough induction and we saw that mandatory training was up to date. Mandatory training included moving and handling practical and theory, first aid awareness, fire safety, medicines, safeguarding, infection control, food hygiene, health and safety law, conflict resolution, deprivation of liberty, equality and diversity, information governance, allergen awareness in care and control of substances hazardous to health (COSHH). In addition staff had completed more specialised training, in for example, reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR), pressure ulcer prevention, dementia awareness, dignity through action, mental capacity act, palliative care and supporting care documentation. A member of staff told us, "We have plenty of training, mostly e-learning, with some practical sessions".

We saw evidence of planned training displayed in the home. For example infection control and falls training sessions were booked for April 2015 and fire warden training was booked for June 2015. Staff files contained a record of when training was completed and when renewals were due. We looked at the records for the nursing staff and saw that all of them held a valid professional registration with the Nursing and Midwifery Council.

We saw staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff records contained evidence of return to work interviews following periods of sickness and an "expectant mother" risk assessment which included hazards and control measures. This meant that staff were properly supported to provide care to people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We looked at records and discussed DoLS with the manager, who told us that there were DoLS in place and in the process of being applied for. We found the provider was following the requirements in the DoLS.

We saw mental capacity assessments had been completed for two people and best interest decisions made for their care and treatment. We discussed this with the manager who told us this was an important area which she needed to address.

Residents and the visiting relatives with whom we spoke, told us they were able to leave the home if they so wished. However, they were asked to let the staff know they were being accompanied by a relative or a member of staff to keep them safe. They told us, "My family come and take me out in the car. We have a run into the countryside. It is a change for me and we all like it very much", "Yes, the staff take a few of us over to the club across the way. We enjoy all that is going on, everyone speaks to us" and "A member of staff goes to the shop with me. I like my newspaper, I read everything in it. You know what is going on".

We looked at a copy of the provider's consent policy, which provided staff with guidance in understanding their obligations to obtain consent before providing care interventions or exchanging information. We saw that consent forms had been completed in the care records we looked at for care and treatment. There was also an area where residents or their relatives could sign to indicate they had read and agreed with the care plan although this was not signed for all residents.

One of the care records we looked at included a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which means if a person's heart or breathing stops as expected due to their medical condition, no attempt

Good

Is the service effective?

should be made to perform cardiopulmonary resuscitation (CPR). This was up to date and showed the person who used the service had been involved in the decision making process.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. People were supported to eat in their own bedrooms if they preferred. We saw a picture menu displayed in the dining room which detailed the meals and snacks available throughout the day. We observed staff giving residents a choice of food and drink. We observed staff chatting with people who used the service. The atmosphere was not rushed. We looked at records and spoke with the cook who told us about people's special dietary needs and preferences, for example, she told us, "[Name] likes fudge and milky way" and "[Name] loves mash and gravy". From the staff records we looked at, we saw all of them had completed training in food hygiene.

People who used the service and their relatives told us, "The food is alright. We get plenty to eat and if you don't like what is on the menu you can ask for something else. It is cooked well. There is not much I don't like, I am easy to please. The chocolate pudding was lovely", "You can sit where you like, but I sit with three others who I have got to know. We have a good chatter and get on well together. The food is good and there is always a choice", "I always have my food in my own room. I prefer it. The staff are very good, never a problem to them. I enjoy the food; sometimes I can't eat it all but that is me. Yes, plenty of liquids too, tea, coffee juice or just water, whatever you like" and "My mam does like the food, particularly the puddings. She gets a choice and says she gets as much as she wants. Sometimes she has it in her room but other times she gets pushed down to the dining room, it depends on her, she chooses."

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at Bannatyne Lodge Care Home. Without exception, everyone we spoke with told us they were happy with the care they were receiving and described staff as very kind, respectful and caring. People told us, "The staff are lovely; they will do anything at all for you. They help me a lot, never unkind and always treat me with respect", "There is nothing at all to grumble about. I get all the help I need. They are always cheerful. I am well cared for. I could not ask for more" and "Well there is no place like home but this is the next best thing. Really nice caring people who are worth their weight in gold"

People we saw were well presented and looked comfortable. We saw staff talking to people in a polite and respectful manner. Staff interacted with people at every opportunity, for example encouraging them to engage in conversation or asking people if they wanted help when they passed them in the lounges or in their bedrooms. A resident told us, "We have a good bit of fun with him, pointing to a carer; he likes a joke and a laugh".

We observed staff interacting with people in a caring manner and supporting people to maintain their independence. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. We spoke with a relative who told us, "I know my mam is treated very well indeed, otherwise she would be telling me. I don't have any worries at all about the help and care she gets, I have seen them in action and it has always been good". This meant that staff treated people with dignity and respect.

Staff demonstrated they understood what care people needed to keep them safe and comfortable. We observed two members of staff aiding residents in wheelchairs to move safely from their wheelchairs onto dining room chairs. Throughout the transfer from wheelchair to chair the carers helped, unhurriedly, the residents to stand and move slowly into a sitting position. Staff constantly reassured the residents, until they were seated and comfortable. We also saw two residents with walking frames supported, by staff, to move from lounge chairs onto dining room chairs. Staff on both occasions linked their arms through the resident's arms and encouraged them to walk slowly to the dining chairs and sit down.

People who used the service and their relatives told us, "I get hoisted into the bath. Initially I was wary but now I know I am safe because there are always two girls and they make sure I am safe", "I like a shower and I use the stand. I can move slowly but I do feel safe with the stand", "The staff watch over you all the time to make sure you are safe" and "The staff are very careful when they are giving my mam a bath. She likes a bath and has never said she has had any problems and she would tell me if she had". A member of staff told us, "We have to do training before we are allowed to use the hoist. We have to have two staff when we are hoisting people. It is a safety measure". This meant that people were safe and protected from the risk of harm.

We saw the bedrooms were very individualised with people's own furniture and personal possessions and the service provided a small "quiet" lounge on the first floor of the premises where visitors and relatives could meet with people who used the service in private. We asked visiting relatives and a friend of a resident, if they felt able to visit at any time they wished. They told us, "Yes we were told we could visit at any time we wished, which is exactly what we do. My husband and I are regular visitors and we are in the "Helping Hands Group" we support the Home by raising funds for the residents. We enjoy helping, it is the least we can do", "I come in almost every day. I have always been made welcome by the staff. They always give me a cuppa when they give mam one. I tend not to bother them at mealtimes because mam goes down to the dining room", "Always pleasantly greeted by every carer. They are so good to mother and it is a pleasure to visit" and "Yes, able to come anytime I can, which is a bonus when you are working. I have no worries about dad; he is happy and well cared for".

A member of staff was available at all times throughout the day in most areas of the home. Staff focussed on the resident's needs. Staff we spoke with told us, "If you don't care for the people you are looking after, then you are in the wrong job", "I love the residents" and "I love my job".

We looked at daily records, which showed staff had involved people who used the service and their relatives in developing and reviewing care plans and assessments. The residents we spoke with could not remember very much about being involved in their care plans. Relatives were aware of care plans but said it was a while, or sometime ago since they were involved. One exception was a relative whose mother had recently returned from hospital. People

Good

Is the service caring?

who used the service and their relatives told us, “It is sometime since the care plan was discussed but I must say we get a phone call straight away if the staff are worried about mother. We are going away for a few days so we are giving our new contact numbers to the manager just in case we are needed”, ”I can’t remember much about it. I think I had one, my son would know better. I don’t bother about such things”, “Yes, there is something but I can’t recall it being called a care plan, but I am sure it will be alright. I do get well cared for” and “Yes, there is a care plan but it is some time ago. I can’t remember when, but they let me know if there is any kind of a problem, so I am happy enough with that”.

We saw information for residents and their relatives prominently displayed on notice boards throughout the home including, for example, chiropody services, eye examination services, advocacy information, dignity in care champion details, dental care services, food allergens, confidentiality, data protection, the provider’s newsletter “Heart Beat”, memory loss and dementia information.

Good

Is the service responsive?

Our findings

People who used the service felt their health needs were being met. They told us, "I am sure my health needs are met. When I had a chest infection the manager called the doctor in. I was given some antibiotics and they did the trick", "The doctor came out to see me and I was taken into hospital. I had pain with gall stones. The staff got everything ready for me", "I have a district nurse come every other day to dress an ulcer on my foot. I get all the attention I need" and "I will be a hundred on the 2nd August. I am having a dentist calling in today to see to my teeth, well the ones I have left. I don't know why they are bothering".

We looked at care records for four people who used the service. All residents had their needs assessed although the nursing records had not been reassessed for some time, for example, one record was dated 18 March 2014. Dependency of the residents had been monitored on a monthly basis and documented in each care plan. This information directly correlated to the information examined with in the homes CHESS workforce planning tool relating to staffing levels. All care files contained a 'connecting with the community: my choices' document that was person-centred and provided a good insight into the individual.

The home used a standardised care planning model based on core care plans covering rights, consent and capacity, drug therapies, continence, nutrition, mobility, personal hygiene, skin integrity, psychological and emotional needs. There were also non-core standardised areas for example, infection, percutaneous endoscopic gastronomy (PEG) feeding, communication, human behaviour, breathing and altered state of consciousness. In a significant number of instances, we found care plans were not sufficiently detailed or person-centred. We discussed this with the registered manager and the peripatetic regional manager who told us the provider was in the process of reviewing and revising its care plan documentation to promote a more person-centred approach. In the meantime staff had been instructed to ensure all new residents care plans would be written in a person-centred way and existing care plans would be rewritten on a scheduled basis.

Each care plan had a risk assessment in place. For example assessments were in place for falls, choking, malnutrition and skin integrity. Risk assessments contained control measures and recommendations from professionals. This meant risks were identified and minimised to keep people safe. Each care plan and risk assessment was reviewed, evaluated regularly and changes were made if needed.

All of the care plans we looked at contained a resident's photograph and all recorded their allergy status. We examined eight nutritional and fluid monitoring documents, including a PEG feeding chart, which is a method of feeding through a tube for people unable to eat or swallow food safely; each demonstrated a high level of compliance. We looked at one positional chart which demonstrated compliance and saw the use of body maps was apparent, although not always used consistently.

We saw records of specialist assessment tools being used in care records for example, malnutrition universal screening tool (MUST) which is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition and Cornell scale for depression which assesses signs and symptoms of major depression in people with dementia. We saw evidence of visits by healthcare professionals. This meant the service ensured people's wider healthcare needs were looked after.

The service employed a personal activities leader. We saw the activities plan on the notice board. This was a daily plan for activities within the home and included a trip to the Labour Club, board games, DVD afternoon, armchair exercises, bingo, pamper afternoon, entertainers, clothes sale and hairdresser. Residents praised the activities leader because, in their opinion, she was very kind, and raised a lot of money to entertain them. People who used the service and their relatives told us, "The activities worker is so very nice. We had a great Christmas and a lovely Easter. We bake and do lots of things. We are having a singer come after lunch. I am looking forward to that", "She is such a good girl and she has a good imagination. If we suggest anything and she can do it, then we do it", "My daughter is involved with Helping Hands. We are lucky to have them because they raise funds for outings. We are helped to have a few hours away from the home. As much as I like it here, it is nice to have a "run out" and "I do what I can to support the home. I attend the meetings every six weeks and help to raise funds. I will do anything I am able to do. I was invited to the Christmas and Easter celebrations. The activities worker is excellent".

We observed several residents and their relatives participating in a sing-along session on the second day of

Good

Is the service responsive?

our visit. We saw how staff encouraged participation and supported those people who required assistance. We spoke to two people and their relatives who attended a church service on a Monday. They told us, "I have been a churchgoer the whole of my life. It is important to me. My daughter and son-in-law come every week and we have a Service every Monday. I do appreciate it", "I know how important it is for mother to attend church, together with us as a family. We are very involved in our church activities and do everything we are able to do to give support" and "I am a Christian and I know my friend likes to go to the Service, I do too. We have been going to the Horden Methodist Church for a lot of years. I come here and I am made welcome. I also come to any fundraising events too". This meant people had access to activities that were important and relevant to them.

People were encouraged and supported to maintain their relationships with their friends and relatives. People and their relatives told us, "We are always made so very welcome when we visit. We find the staff to be knowledgeable about mother's needs and they are so caring towards her, which is a relief to us", "I am kept fully informed about my mum, if she is unwell I get a telephone call and know there will be no objection to me visiting as often as I am able", "I have a friend who comes to see me every week. I like to see her, she keeps me up to date with what is happening to other friends and people I know" and "Staff have encouraged me to keep in touch with my friend, which is what I want to do". This meant people were protected from social isolation.

All the people we spoke with and their relatives told us they could make choices about how they wanted to receive the care they needed at Bannatyne Lodge Care Home. They told us they were able to go to bed and get up at whatever time they wished, for example they said, "I like to go to bed around ten o'clock. I get up a bit early and staff come in through the night to see I am OK", "I like to go to my room and watch my television. I like to watch the news and the soaps. I go to bed when I want too. I am never ever told I should go to bed", "I decide when I am ready for bed. The girls always call in to say goodnight. They help me up in the mornings. I choose what I want to wear and they help me" and "I can indeed go to bed and get up when I want to. I don't have a fixed time. It depends what I get interested in on the television".

We saw a copy of the complaints policy on display in the reception area. The people and the relatives we spoke with were aware of the complaints process. They told us, "If I had a complaint about anything I was concerned about, then I would make a complaint to the manager. To date I have not had the need to do so", "I certainly do know how to make a complaint and I would make one, if I needed to", "I would not hesitate to make a complaint if I was unhappy about any situation concerning my mam. I would go straight to the manager" and "If it ever became necessary, I do know the complaints procedure, and would make a complaint. However I am happy to say mother is so well cared for I don't envisage any problems". We saw that complaints were recorded, investigated and the complainant informed of the outcome including the details of any action taken. This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a new manager in post who was applying to become registered with CQC. A registered manager is a person who has registered with CQC to manage the service.

Staff we spoke with were clear about their role and responsibility. They told us they felt supported in their role and were able to approach the manager or to report concerns. Staff told us, “I enjoy working here”, “I have seen improvements since the new manager has been in post, she has good ideas”, “The managers good, she knows what she wants”, and “Staff morale was very low. Having the new manager has provided hope and morale is going back up”.

We looked at what the manager did to check the quality of the service. We saw the manager carried out a daily walk around of the home, including checks of the communal areas and the well-being of people who used the service. The manager also completed a monthly client checklist which included people’s name and room number, weight, nutrition, skin integrity and equipment.

We saw monthly audits were undertaken for care plans, incidents, supervisions, complaints, health and safety and medicines. All of these were up to date and included action plans for any identified issues. We saw that the home completed a quality dining audit every six month and had been awarded a “5 Very Good” Food Hygiene Rating by the Food Standards Agency on 17/06/2014.

We looked at what the manager did to seek people's views about the service. We saw the home had implemented a “quality of life programme”. We spoke with the care quality facilitator who told us how the programme was designed to improve the experience of residents through a variety of electronic tools, including iPad, which collected feedback from a range of sources including staff and customer feedback. The feedback is communicated directly to the provider and the manager to enable them to address any issues immediately for example if they had experienced issues with the laundry service in the home or they were unhappy with the meals. The care quality facilitator provided us with an online demonstration of the system and we saw visitors completing feedback on the iPad during our inspection.

We saw residents’ meetings were held regularly. We saw records of a resident and relatives meeting held on the 8 April 2015. Thirteen residents, seven relatives and six staff attended and discussion items included staffing, the environment and equipment.

We saw a 'Questionnaires, Suggestions and Comments Feedback' notice board displayed in the entrance to the home. The notice board demonstrated the registered manager had recently sought views and comments, about the home, from people in a residents/relatives meeting on 11 February 2015. The responses received included that people were concerned about the lack of a permanent manager and staffing levels, they had requested another assisted bath and a hairdresser. The board displayed the actions taken by the provider. For example the provider had appointed a new manager and three new care assistants, a new assisted bath had been purchased and was awaiting delivery/fitting and a new hairdresser had been employed.

Staff meetings were held regularly. We saw a record of a staff meeting dated 5 February 2015. Discussion items included the importance of training, documentation, infection control and menus, focusing on under nutrition and the environment. 10 staff attended. We also looked at a meeting record dated 23 March 2015 which discussed cleaning rotas, care plans, teamwork, recruitment, and the whistleblowing policy.

This meant that the provider gathered information about the quality of the service from a variety of sources and had systems in place to promote continuous improvement.

We saw a copy of the provider’s business continuity management plan dated April 2015. This provided emergency contact details, identified the support people who used the service would require in the event of an evacuation of the premises and contained information about alternative accommodation in the event people needed to be relocated.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GP, dentist and optician. This meant the service ensured people’s wider healthcare needs were being met through partnership working.