Prestwick Care Limited

Brooke 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?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 23 November 2016 and 5 December 2016.

We last inspected Brooke House in June 2015. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Brooke House is a purpose built care home that provides personal and nursing care to a maximum of 50 older people, including people who live with dementia.

The service did not have a registered manager. A manager was in place who was in the process of registering with the Care Quality Commission. 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.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. Other people could tell us they felt safe. People appeared contented and relaxed with the staff who supported them. People and relatives said staff were kind and caring

Appropriate training was provided and staff were supervised and supported. Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Records were in place that reflected the care that staff provided.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

Staff and people who used the service said the manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

People had the opportunity to give their views about the service. The manager acted on feedback in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support. Good relationships existed and staff were aware of people's needs and met these in

a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates were made available to represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with activities and entertainment. People had information to help them complain. Complaints were investigated and any action taken was recorded.

Is the service well-led?

Requires Improvement

The service was not well-led in all areas.

A manager was in place but they were not yet registered with the Care Quality Commission.

Staff and relatives told us the manager was readily available to give advice and support. They were complimentary about the changes that had been made in the home.

The home had a quality assurance programme to check on the quality of care provided.

Brooke 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 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 23 November 2016 and 5 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience on the first day of inspection.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 service as part of 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 CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 12 people who lived at Brooke House, 11 relatives, the registered provider, the compliance manager, the manager, the deputy manager, one registered nurse, eight support workers, the activities co-ordinator and two members of catering staff. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for five staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and

quality assurance audits the manager had completed.

Good

Is the service safe?

Our findings

Due to their health conditions and complex needs not all people were able to share their views about the service they received. Other people told us they were safe. One person commented, "I feel safe, I've been here a long time." Another person told us, "Yes I feel safe, staff look after me well." A relative commented, "There always seems to be enough staff, but they can be busy."

We considered there were sufficient staff to meet people's needs at the time of inspection. We saw improvements had been made to staffing levels since the last inspection as staffing levels had increased. The manager told us staffing levels were determined by a dependency tool. This was used monthly to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. We were told there were 50 people who were living at the home supported by two nurses and eleven support workers. Staffing rosters and observations showed during the day on the top floor 18 people were supported by four support workers, this included one support worker who was providing one to one support to a person and one registered nurse. On the middle floor 15 people were supported by four support workers, this included one support worker who was providing one to one care to a person and one team leader. On the ground floor 18 people were supported by three support workers and a registered nurse. These numbers did not include the manager who was also on duty each day. Overnight staffing levels included from 8:00pm until 8:00am one nurse and six support workers.

The manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the manager. The safeguarding record showed 20 safeguarding alerts had been raised since January 2016. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. We were told learning took place from safeguarding incidents. The provider's PIR stated there were plans for, 'A reflective practice document to be used during staff meetings in order to fully discuss lessons learnt from complaints and safeguarding.'

Staff had an understanding of safeguarding and knew how to report any concerns. Records showed and staff confirmed they had completed safeguarding adults training. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the manager. Staff members' comments included, "If any issues I'd report it to safeguarding", "If I was concerned I'd report it to the senior" and "I'd inform the nurse in charge if I had any concerns."

Risk assessments and their evaluations were up to date. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for losing weight, choking, falls and pressure area care. Records contained information for staff on how to reduce identified risks. For example, a risk assessment for one person stated, 'I'm at high risk of falls' and

their care plan for mobility stated 'I need two members of staff to assist me to get up with the help of my stand aid.'

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

People were supported with their medicines safely. Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. As they administered the medicines they explained to people what medicine they were taking and why. Personalised care plans were in place to inform staff how people should be supported with their medicines. For example, one care plan detailed, 'I like staff to give me my medicines one at a time from a spoon and I will have a good drink when I take them. If I refuse my medicines on more than two days I need staff to inform my GP.' People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Systems were in place to ensure that all medicines had been ordered, stored securely, administered safely and audited. This included for controlled drugs, which are medicines which may be at risk of misuse. Staff told us they were provided with the necessary training and staff who were not nurses, who administered medicines told us they felt they were sufficiently skilled to help people safely with their medicines.

Information had not been available at the last inspection about the use of 'when required' medicines. We saw a protocol was now in place to advise staff about the use of 'when required' medicines which may be required when people were in pain, agitated or distressed. People's medicines care plan recorded the different level of support needed by each person. The information was detailed and provided staff with a consistent approach to the administration of this type of medicine and when it should be given.

The medicines policy included the correct procedure to advise staff about the use of covert medicine. Covert medicine refers to medicine which is hidden in food or drink. Guidance for best interest decision making, necessary when a person does not have mental capacity, adhered to the National Institute for Health and Care Excellence (NICE) guidelines. 'A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.'

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were

records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "There's a lot of training", "I've just been doing training about eye care", "There's staff training taking place today", "I'm doing a National Vocational Qualification (NVQ)" (now known as the diploma in health and social care), "We do face to face training", "I've done training about dignity in care" "I've done most of my training" and "We do refresher training to make sure we keep up to date."

The staff training records showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included dementia care, nutrition, catheterisation, tissue viability, end of life care, sepsis, epilepsy, Parkinson's disease, dignity awareness, equality and diversity, pressure ulcer prevention and diabetes awareness. The provider's PIR stated '21 staff were working towards a national vocational qualification (NVQ) at level 2.' The organisation had recently employed a clinical trainer who was responsible for ensuring the registered nurses' clinical competencies were kept up to date.

We spoke with members of staff who were positive and able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. A staff member told us, "I love it, it's the best job so far." Staff were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the manager. Staff said they could also approach the manager at any time to discuss any issues. Staff also received an annual appraisal with a six monthly review to evaluate their work performance and to jointly identify any personal development and training needs.

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. Senior staff then cascaded the information to support workers. This was to ensure staff were made aware of the current state of health and wellbeing of each person. We saw handover records contained information about the care provision and the state of well-being for each person over the previous 12 hours. Staff told us the diary and communication book also provided them with information. Their comments included, "Communication is good," "We use a handover sheet that tells us how people have been," "Communication is good from the nurses" and "We get information from the nurses."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and were due to receive updated training in the MCA and the related DoLS at the beginning of March 2017. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Relatives told us they were kept informed by the staff about their family member's health and the care they received. The manager told us they were keen to take part in the care homes project, a health initiative taking place in a number of homes across Newcastle and Gateshead. This involved a weekly clinic being held at the home that was run by the General Practitioner and specialist nurse for older people. This was a vanguard model of care initiative as promoted by the government. It was established by community health professionals to review people's acute health needs to make sure they were treated promptly and one of the aims was to help reduce the number of hospital admissions.

Staff received advice and guidance when needed from specialists such as, the community nurse, falls co-ordinator, psychiatrist and GPs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and psychiatrists. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

Systems were in place to ensure people received drinks and varied meals at regular times. Meals were well presented and people told us they had a choice at meal times. People were encouraged to make choices about their food. Menus in dining rooms advertised a choice of two hot meals at meal times. Food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received nice food. Their comments included, "Food is very good," and "There is loads to eat."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a cultural specific diet were checked before admission to ensure they were catered for appropriately. They told us they received verbal information from nursing staff when people required a specialised diet. We saw a board was

available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements. The cook explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. People received drinks in between meals and the tea trolley provided a variety of drinks and biscuits.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care provided by staff. Their comments included, "I couldn't ask for anything better, I get the best of care", "I am really happy here" and "It is a lovely place." Relatives comments included, "I'm happy enough with [Name]'s care", "Staff are friendly and approachable" and "The care is brilliant."

We observed the atmosphere was calm, relaxed and tranquil. Throughout the home staff interacted well with people. They were kind and caring and they spent time engaging with people and not only supervising them. Some people had complex needs and we saw staff interacted well with people who we saw were relaxed with them. We saw staff engaged with people in a friendly and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention. For example, "Do you want another cuppa," and "Do you want some help with that."

We observed the lunch time meals on both floors of the home. We saw the meal time was relaxed and unhurried. Written and pictorial menus about food were available to help people make a choice of food. We saw at lunch time people were verbally offered a choice of meal, if a person was undecided they were shown two plates of the available meal to help them make the choice by smell and visually. People sat at tables that were well set with tablecloths, napkins and condiments and staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served.

Staff we spoke with understood their role in providing people with caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Care plans documented people's support needs if they were in pain. For example, one care plan stated, 'I need staff to be aware of changes in my behaviour. If I am crying or have a fraught expression.'

Care plans provided information about how people communicated. Examples in care plans recorded, 'I am able to answer questions about choosing my meals.' This information was available for staff to provide guidance about how a person should be supported.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. Care plans provided information for staff to help support the person if they could no longer

communicate their preferences. For example, one care plan stated, 'I prefer a female staff member to assist me with personal care.' Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. People told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities and bathing. We heard a person who was unsure about having a bath was offered a bath or a shower. Care records provided information for staff that detailed people's level of comprehension and how they could be enabled to make a choice. Examples included, 'I need one member of staff to assist me. I would like them to explain what they are doing' and 'If I'm tired I'm not good at making decisions. The best time is before lunch when I am more alert.'

There was information displayed in the home and in the information pack people received before they moved into the home about advocacy services and how to contact them. The manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met. The provider's PIR also stated, "A palliative care champion has been recently implemented within the home.' This was to ensure people were supported to receive appropriate pain relief and dignified and peaceful care at such an important time at the end of their life.

Good

Is the service responsive?

Our findings

People told us activities were available if they wanted to take part. Relatives' comments included, "Not all people want to take part in activities, people do like one to one time", "Activities and entertainment are available", "Staff are good at getting [Name] involved to play bingo" and "There are two activities people who work five days a week." A programme advertised activities that were available and these included armchair exercises, skittles, art and crafts, board games, quizzes, one to one time, pamper sessions, reminiscence, snooker, bingo, movie afternoons and baking.

Entertainment and concerts took place. We saw a variety of seasonal entertainment was arranged for over the Christmas period including a Christmas party, local school choir and entertainers. The hairdresser visited weekly and a local member of the clergy visited regularly. Transport was available and people had the opportunity to go out on trips.

The registered nurse informed us arrangements were in place to carry out pre-admission assessments of people to the service. This was to ensure the compatibility of people and to check that staff had the required skills to meet people's needs before they were admitted. There was a good standard of record keeping. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, distressed behaviours, mobility and falls and personal hygiene. Evaluations were detailed and included information about peoples' progress and well-being. A care plan for nutrition recorded,' '[Name] would like staff to put their cup in their hand to have a drink. Put cutlery in their hand and guide them to the plate as they are unable to see.'

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour.

Records were in place to provide guidance to staff if a person became distressed. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. Guidance helped ensure staff worked with the person, to help reduce the anxiety and distressed behaviour. Records were regularly updated to ensure they provided accurate information. For example, one care plan recorded, 'Speak to [Name] in a calm voice. Explain who you are and wait until they feel comfortable and then offer a choice.'

Charts were completed to record any staff intervention with a person. For example, it was recorded when

staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. When personal hygiene was attended to and other interventions to ensure peoples' daily routines were also carried out, were also recorded. This information was then transferred to people's support plans which were updated monthly. These records were used to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Examples included, 'I enjoy listening to music and the company of other people', 'I prefer to go to bed between 9:00pm and 10:00pm' and 'I have my own key and lock my room when I am out.'

We were told resident and relative meetings were held three monthly to discuss the running of the home and any changes. Meeting minutes showed they were held at different times of day to enable more people to attend. People who used the service and relatives told us the manager was approachable and they knew they could approach them at any time to discuss any issues. Relatives' comments included, "Relatives meetings take place" and "Meetings happen."

People said they knew how to complain. Their comments included, "I can speak to any of the staff" and "Mention to staff and they sort it." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and 11 complaints had been received since the last inspection which had been investigated and the necessary action taken. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Requires Improvement

Is the service well-led?

Our findings

A manager was in place who was a registered general nurse and they were experienced in managing care services for older people. They had started employment as manager for Brooke House in October 2016. They were in the process of applying for registration with the Care Quality Commission.

The atmosphere in the home was relaxed and welcoming. People told us they were happy at the home and with the leadership at the home. Staff said they felt well-supported by the management team. They said they could approach them to discuss any issues. The manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff we spoke with were positive about their management and had respect for them. Staff comments included, "Staff attendance was a problem but it has improved", "Good team work we're more organised" and "[Name], manager is very approachable." Relatives' comments included, "Things are much improved since the new manger came here", "There's a different atmosphere", "The manager is good at what they do" and "Since [Name] new manager started there's been a big, big improvement."

The manager told us they had introduced changes to the service to help its' smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns that may be raised.

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes showed topics discussed included training, care planning, staff performance, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and to discuss any issues. A staff member commented, "There's a timetable for meetings, they happen monthly."

There were opportunities for personal development for staff and career progression. The organisation had introduced the nurse assistant practitioner (NAP) post and senior support staff had the opportunity to apply for a position. After appointment they received intensive training and were mentored by a member of nursing staff and the clinical trainer for some months.

The manager assisted us with the inspection together with the head of compliance and clinical governance manager. Records we requested were produced promptly and we were able to access the care records we required. The manager and provider's representatives were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The manager said they were well supported in their role by the provider and area managers. They told us they subscribed to a range of care industry and related publications and kept up to date with best practice and initiatives. These included links with the Alzheimer's Society, the local authority commissioning information forum for providers and the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

A range of auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A weekly risk monitoring report that included areas of care such as safeguarding, complaints, health and safety, staffing and occupancy levels was completed by the manager and submitted to head office for analysis.

Regular analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. Staff told us if an incident occurred it was discussed at a staff meeting. The PIR stated 'Reflective practice was to be introduced' with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Monthly audits included checks on medicines management, care documentation, training, accidents and incidents, falls analysis and pressure area care. Three monthly audits were carried out for catering, infection control, clinical governance and health and safety. A financial audit was carried out by a representative from head office annually. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. Annual surveys were carried out by the provider and results were available on behalf of people who had responded. An action plan was available to show identified areas for improvement as a result of the feedback. We saw the results had been analysed and feedback was available showing what action was to be taken as a result of the survey.