Silverfield Care Management

Northfield Manor

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

Summary of findings

Overall summary

The inspection of Northfield Manor took place on 30 and 31 March 2016 and was unannounced. At the last inspection on 18 June 2014 the service met all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were superseded on 1 April 2015 by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Northfield Manor was registered to provide care and accommodation for up to 45 older people, but we were told that it operated with a maximum of 39. At the time of our inspection there were 36 people using the service. The home was situated in a residential development on the outskirts of the market town of Driffield. It was divided into two separate units; the main house where the majority of people resided and the Rose Garden unit where people living with dementia resided. Bedrooms were mainly single occupancy but there were four shared bedrooms. There were extensive and well maintained gardens where plenty of gardening activity took place in greenhouses and flower beds in the spring and summer months. There was a large decking area off one of the lounges where people sat and enjoyed the weather. The large dining room also provided a focal area for activity and socialising. The service had a separate unit for people living with dementia, where they had their own secure garden and single occupancy bedrooms. The service held the 'Positive about Disabled People Symbol', which was evidence of its commitment to equality of opportunity. Its values were 'warmth, security, dignity, respect and choice'.

The registered provider was required to have a registered manager in post. At the time of our inspection there was a manager that had been registered and in post for the last two years. 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.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. Risks were also managed and reduced on an individual and group basis so that people avoided injury of harm wherever possible.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Staffing numbers were sufficient to meet people's needs and we saw that rosters accurately reflected the people that were on duty. Discussion was held with the registered manager and registered provider to assess night time staffing levels and to look at some one-to-one hours. The registered provider carefully followed recruitment policies, procedures and practices to ensure staff were suitable to care for and support vulnerable people. We found that the management of medication was safe.

People were cared for and supported by qualified and competent staff that were regularly supervised and had their performance checked as part of an appraisal system. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their health and wellbeing. The premises were suitable for providing care to older people and particularly to those people living with dementia, as the environment was planned, decorated and furnished so as to be conducive to their needs.

We assessed that people received compassionate care from kind and considerate staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook care and support tasks.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible. This ensured people were respected, that they felt satisfied with the care they received and were enabled to take control of their lives.

We saw that people were supported according to their person-centred care plans. These care plans reflected people's needs well and were regularly reviewed. People had the opportunity to engage in a variety of pastimes and activities if they wished to in order to keep their minds and bodies active, as some activities stimulated the brain and others helped to maintain living skills.

An effective complaint procedure was in place and people had any complaints investigated without bias. People that used the service, relatives and friends were encouraged to maintain relationships aided by frequent visits, telephone calls and sharing of each other's news. People had very good family connections and support networks and these were encouraged and supported by the staff.

The service was well-led and people had the benefit of this because the culture and the management style of the service were positive, inclusive and clearly transmitted to everyone that lived or worked at Northfield Manor. There was an effective system in place for checking the quality of the service using audits, satisfaction surveys, meetings and good communication.

People had opportunities to make their views known through direct discussion with the registered provider or the staff and through more formal complaint and quality monitoring formats. Information gathered about the service delivery was analysed and used to make improvements in any area identified as having a shortfall. People were assured that recording systems used in the service protected their privacy and confidentiality, as records were well maintained and were held securely on the premises.

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 protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were also managed and reduced so that people avoided injury or harm.

The premises were safely maintained, staffing numbers were sufficient to meet people's need and recruitment practices were carefully followed. People's medication was safely managed.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent staff that were regularly supervised and received annual appraisals of their performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their health and wellbeing. The premises were suitable for providing care to older people and to those living with dementia, as the environment was conducive to meeting their needs.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind and considerate staff. People were supplied with the information they needed and were involved in all aspects of their care.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. People had the opportunity to engage in a variety of pastimes and activities to keep their minds and bodies active.

People had any complaints investigated without bias and they were encouraged to maintain fulfilling relationships.

Is the service well-led?

Good

The service was well led.

People had the benefit of a well-led service, where the culture and the management style of the service were positive and inclusive. The assessing and monitoring of the quality of service delivery was effective, as it helped to improve the care and support that people received. People had opportunities to make their views known and have these acted upon.

People were assured that recording systems in use protected their privacy and confidentiality and all records held in the service were well maintained and held securely.

Northfield Manor

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.

The inspection of Northfield Manor took place on 30 and 31 March 2016 and was unannounced. One Adult Social Care inspector carried out the inspection. Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from the local authorities that contracted services with Northfield Manor and reviewed information from people who had contacted CQC, since the last inspection, to make their views known about the service. We had also received a 'provider information return' (PIR) from the registered provider. A PIR 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 ten people that used the service, two relatives and the registered manager. We spoke with four staff that worked at Northfield Manor. We looked at care files belonging to three people that used the service and at recruitment files and training records for three staff. We looked at records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems that were implemented. We looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We spent a short time on the 'dementia unit', where we also observed people and staff interactions. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Northfield Manor. They explained to us that they found staff to be "Friendly and reassuring." Visitors we spoke with said, "I have no worries about my relative's safety here" and "I can rest easy that my relative is safer than at home on their own."

We found that the service had systems in place to manage safeguarding incidents and that staff were trained in safeguarding people from abuse, some at advanced level. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents. We saw the records held in respect of handling incidents and the referrals that had been made to the local authority safeguarding team. These corresponded with information the registered manager had sent us in formal notifications. There had been three safeguarding referrals in the last two years. All of this ensured that people who used the service were protected from the risk of avoidable harm and abuse.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious beliefs but no strong needs regarding worship. If necessary these would be adequately provided for within people's own family and spiritual circles.

Everyone was at risk of discrimination because of their age and some because of disability and while we saw no evidence to suggest that anyone that used the service was discriminated against, staff told us that in the past they'd had cause to remind one person that used the service on several occasions that their comments were discriminatory towards other people and staff. The registered manager's accounts of these incidents demonstrated that they and the staff challenged them and gave the same clear message out to everyone, that discrimination would not be tolerated, and the person concerned had their 'residency' terminated after an appropriate period of notice.

People had risk assessments in place to reduce their risk of harm from, for example, falls, poor positioning, moving around the premises, inadequate nutritional intake and the use of bed safety rails. One visitor we spoke with felt their relative was a little restricted because of particular risk assessment action to keep them safe. We discussed this with the registered manager and staff who stated they would look at greater input for the person to enable them to move about with staff support more regularly. The registered manager made a referral to a physiotherapist and occupational therapist to promote more mobility and independence. Exercises were to be encouraged.

When we looked round the premises we found that they were safely maintained. We brought the omission of fire door closers on a bedroom door in the Rose Garden dementia unit and a bedroom door in the main building to the attention of the registered manager. This was immediately passed to the maintenance staff to investigate and address. We were informed that one of these had been fully risk assessed and was for a particular reason and the other would be attended to as quickly as possible.

We saw that the service had maintenance safety certificates in place for utilities and equipment used in the service and these were all up-to-date. These included, for example, fire systems, electrical installations, gas appliances, hot water temperature at outlets, lifting equipment and the passenger lift. We also saw people's personal safety documentation for evacuating them individually from the building in the event of a fire. There were contracts of maintenance in place for ensuring the premises and equipment were safe at all times. These safety measures and checks meant that people were kept safe from the risks of avoidable harm or injury.

The service had accident and incident policies and records in place should anyone living or working there have an accident or be involved in an incident. Records showed that these had been recorded thoroughly and action had been taken to treat injured persons and prevent accidents re-occurring. People were protected wherever possible.

When we looked at the staffing rosters and checked these against the numbers of staff on duty during our inspection we saw that they corresponded. At the time of our inspection there were sufficient staff on duty in the main house and on the dementia unit to meet people's needs. We saw that the rosters planned to have five or six care staff on duty throughout the day and three waking night staff. The staffing levels in operation were based on a dependency staffing tool that the registered manager used.

People and their relatives told us they thought there were enough staff to support people with their needs. One relative said, "There is usually enough staff around, although very rarely it can happen that the shift is short". One person that lived at Northfield Manor said, "I have found there has always been someone to help me when I've needed it". Staff told us they covered shifts when necessary and usually found they had sufficient time to carry out their responsibilities and to take time chatting to people and assisting them with some pastimes or activities. One staff said, "It is difficult sometimes when staff are off ill and although we don't get paid when we are ill, some staff still take a lot of time off."

One staff member expressed that there were occasions on the Rose Garden unit when two staff on duty was not enough, because several people needed support with meals and if a person was ill in bed or receiving 'end of life' care then they required two staff to support them. We saw that there were sufficient staff on duty to meet people's needs at the time of our inspection, but on the Rose Garden unit one person remained in bed and shouted several times to attract attention. They clearly wanted staff to spend time with them and we discussed with the registered provider about assessing them for some one-to-one time.

Night time staffing levels were discussed with the registered manager and registered provider as it was explained to us that one staff worked on the Rose Garden unit and one worked in the main house at night with a care manager (senior) 'floating' across the two units. People on the Rose Garden unit had alarms on their bedroom doors to alert staff to any one of them getting up in the night, but we were informed that the unit might be unstaffed for short periods if extra support was needed in the main house and vice versa. The registered manager said they would complete an assessment of the night staffing arrangements and monitor the frequency of possible occasions when this might happen.

The registered manager told us and the files we looked at confirmed they used thorough recruitment procedures to ensure staff were suitable for the job. They ensured job applications were completed, references taken and Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Files also contained evidence of staff identities, interview records, health questionnaires and correspondence about job offers. We found that staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. We saw that medicines were obtained in a timely way so that people did not run out of them. This was achieved with the aid of a company that collected prescriptions on behalf of the Northfield Manor and delivered the items to the service. Medicines were stored safely, but separately in respect of the main house and the Rose Garden unit and there were suitable medication fridges in use for items that required cooler storage.

Medicines were administered on time using a monitored dosage system (MDS), recorded correctly on the MAR charts and disposed of appropriately. MDS is a measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken when. All unused medicines were safely handled, stored appropriately and returned to the dispensing pharmacy for destruction.

We saw that the controlled drugs held in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001), were checked daily in respect of safe storage and stock control. All 'as and when required' medicines were stock checked each time they were administered. All of these checks were recorded and helped to keep people safe from harm and from medication errors.

People said they were very satisfied with the arrangements in place for the safe handling and administration of their medication when we asked them for their opinion about the management of medicines. One person said, "My meds are brought to me each morning and staff watch me take them. I'm happy with that."

Good

Is the service effective?

Our findings

People we spoke with felt the staff at Northfield Manor understood them well and had the knowledge to care for them. They said, "The staff are very good" and "Staff are alright, we have a bit of fun together, but they get the job done, even so."

We saw that the registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. The registered provider had an induction programme in place and reviewed staff performance via one-to-one supervision and an appraisal scheme, both of which were delegated to certain staff in the staffing structure.

Staff told us they completed mandatory training (minimum regularly refreshed training as required of them by the registered provider to ensure their continued competence). They told us they had the opportunity to study for qualifications in health and social care.

Staff training files confirmed the training completed and qualifications held by staff. There was evidence that one of the care managers (senior staff) had completed dementia care mapping and moving and handling assessment training. Other records showed that staff had completed, for example, fire safety, moving and handling and hoist use, infection control, safeguarding adults and medication administration training. Other topics covered included the Mental Capacity Act, first aid and health and safety.

At the time of our inspection some staff were completing in-house training with the company. This was based on information supplied by Bradford University on 'Person-centred Dementia Care in Homes.' We were told by the registered manager that two staff were booked on East Riding of Yorkshire Council's 'Nutrition Mission' course, which looked at nutritional intake for everyone with the view to increasing optimal health. Nutrition Mission is an educational campaign designed to provide the public with reliable, professional nutrition information and guidance. There was also an initiative in the service to involve staff in training that required them to experience a day as a 'service user' to know what it was like.

Staff had received regular supervision and there was evidence of this in their staff files. They confirmed with us that they met with a line-manager to discuss issues within their roles and concerns about individual people they cared for. They took part in an annual appraisal scheme to develop their practice and performance, for which meetings were held and recorded.

Communication within the service was good between the management team, the staff, people that used the service and their relatives. Methods used included daily diary notes, memos, telephone conversations, meetings, notices and face-to-face discussions. Some social media networks were used by people and their relatives to keep in touch with each other and staff assisted people with this if necessary.

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. The registered manager understood their responsibility regarding the MCA and DoLS, there were several DoLS authorisations in place for people and these were kept regularly under review.

We saw that people consented to care and support from staff by either saying so or by conforming to staff when asked to accompany them and by accepting the support they offered. There were some documents in people's files that had been signed by people or relatives (when people lacked capacity) to give permission for photographs to be taken, care plans to be implemented or medication to be handled on their behalf, for example.

People had their nutritional needs met by the service because people had been consulted about their likes and dislikes, allergies and special diets and the service sought the advice of a Speech and Language Therapist (SALT) when needed. The service also provided three nutritional meals a day plus snacks and drinks for anyone that requested them, particularly at supper time. There were nutritional risk assessments in place where people had difficulty swallowing or where they needed support to eat and drink. We discussed with the cook how they catered for people with special diets: vegetarian, weight reducing, food allergies. The cook was knowledgeable about people's dietary needs and had strategies for maintaining their health and wellbeing through appropriate dietary intake.

Menus were on display for people to see what was on offer and people told us they were satisfied with the meals provided. They said, "I find the food is quite alright", "Food is very good" and "The food varies, though they manage to offer me vegetarian options." Staff explained they were aware of people's special dietary needs, as one person was vegetarian and two people were diet controlled diabetics and they said this had to be carefully monitored.

We saw that people had their health care needs met by the service because people had been consulted about their medical conditions and information had been collated and reviewed in relation to changes in their conditions. We were told by staff that people could see their GP on request and that the services of the district nurse, chiropodist, dentist and optician were obtained whenever necessary. Health care records held in people's files confirmed when they had seen a professional, the reason why and what the instruction or outcome was. We saw that diary notes recorded where people had been assisted with the health care that had been suggested for them.

For those people that used the service who lived with dementia we found that the environment on the Rose Garden unit was conducive to meeting their needs. There was appropriate signage, plain carpets and walls, memory boxes outside people's bedrooms and specific colour schemes to enable people to identify their bedrooms, all of which enhanced their quality of life by nurturing a better environment for people living with dementia.

People regularly engaged in baking bread or cakes and so comforting and homely smells were often encountered in the dementia unit. People were sat around a table watching a couple of people baking sausage rolls and a sponge cake, facilitated by the activities coordinator and there was a calm, engaging atmosphere. The Rose Garden unit lounge was decorated in a 1960's to 70's style and had a memorabilia display from that era. Music playing on a record player reflected the period as well and was changed upon people's request. There was a small sensory room on the Rose Garden unit, which contained mood lighting, a fish tank and soothing music. Board games and books were also stored here for people to use if they wished.

The Rose Garden unit had a sensory garden for people living with dementia. Initiatives had been implemented to offer as much 'normalisation' as possible. These initiatives included night staff wearing dressing gowns to orientate people living with dementia in observing night time as a time to sleep. They included growing fruit and vegetables for use in the seasonal dishes on the menu and providing those living with dementia with their own vegetable and herb garden, produce which they harvested and used to cook with. An appropriate environment for people living with dementia incorporates design and building layout, colour schemes, textures, experience, light, sound and smell and Northfield Manor's Rose Garden unit was achieving this.

The main house had been refurbished since our last visit and changes to facilities now resulted in a café style dining room, a gentleman's lounge and a modern hairdressing salon. The extensive gardens, with greenhouses where people could take part in gardening activities, had been available for many years and were added to each year.

Good

Is the service caring?

Our findings

People we spoke with told us they got on very well with staff and each other. They said, "The girls are all very nice and it is home from home here," "I like it here, we have a knit and natter group that I love to join in with, though my knitting is not that good" and "The staff look after me well and are kind and caring." Two ladies in the main lounge with full capacity, and one had good mobility, had appointed themselves as custodians of the emergency call bell. This gave them a role, which they enjoyed having. This was not required because of staff shortages, but because not everyone could mobilise and access the call bell. They explained that they were 'eyes and ears' for anyone that was in need of assistance from the staff. People that used the main lounge were like members of an extended family and so these two ladies understood their needs and signals for help.

We saw that staff had a pleasant manner when they approached people and as one person we spoke with in the gentleman's lounge said, "Staff are very kind and not at all nasty" and "Staff are very helpful." Some of the staff had been employed at Northfield Manor for many years, while others were relatively new. The management team led by example and were polite, attentive and informative in their approach to people that used the service and their relatives. Management and staff gave the sense that people mattered very much and were therefore caring in their approach to meeting their needs. All of this alleviated people's anxieties and so their wellbeing was maintained.

We saw that everyone had the same opportunities in the service to receive the support they required and yet were treated as individuals with particular needs that were to be met according to individual wishes. Staff said, "I treat people here exactly how I treat my own family", "People have their special needs and we ensure such as personal care is done how they want it" and "I have a relative living here, so I know people are well cared for." Care plans, for example, recorded people's individual routines and preferences for daily living, foods, outings with family members or just spending time with others. They also recorded how people wanted to be addressed and staff knew these details and responded to them accordingly. We found that people were experiencing a satisfactory level of well-being and were quite positive about their lives.

While we were told by the management team that no person living at Northfield Manor was without relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. Information about advocacy services was provided on the resident notice board.

People we spoke with told us their privacy, dignity and independence were always respected by staff. People said, "Staff are very good at maintaining our dignity" and "Staff are respectful, ask me if I'd like help with a shave and never make me feel uncomfortable." We saw that staff only provided care considered personal in people's bedrooms or bathrooms. They knocked on bedroom doors before entering and ensured bathroom doors were closed quickly if they had to enter and exit, so that people were never seen in an undignified state. Staff said, "I think about how I would want to be cared for", "People in double rooms have screens to offer them privacy. We are discreet about people's continence issues, but in reality there are

few accidents here" and "People are respected, staff have several years' experience of, for example, dealing with people at the end of their lives and they are treated compassionately. We get very good support in this from GPs and district nurses."

Good

Is the service responsive?

Our findings

People we spoke with felt their needs were being appropriately met. They talked about staff assisting them to mobilise, use the bathroom, take their medication and support them with other care needs. We saw that one person had an assessment carried out by the Speech and Language Therapist and other people were supported with their mobility and transfers on several occasions on one of the days we inspected. All of these and other arrangements were recorded within people's care plans.

We looked at three care files for people that used the service and found that the care plans reflected the needs that people appeared to present. Care plans were person-centred and contained information under twelve areas of need, to instruct staff on how best to meet people's individual needs. They contained photographs of people, assessments of need, 'patient passports' (information for healthcare professionals on how best to support a person if admitted to hospital) and personal risk assessment forms to show how risks to people would be reduced. These risk assessments included pressure relief, falls, moving and handling, nutrition, bathing and fire safety. We saw evidence that care plans and risk assessments were reviewed monthly or as people's needs changed. Other important documentation was held about people, which included 'do not attempt cardio-pulmonary resuscitation' forms, advanced decisions, monitoring charts, daily records and accident/incident reports.

The registered manager told us that staff had responsibilities as 'champions' for medication, diabetes, reminiscence, moving and handling, safeguarding adults from abuse, dementia care, infection control and mental health. 'Champions' are staff appointed as leaders in a specific subject who learn about how they can care and support people more effectively in that area. They ensure other staff are made aware of the same knowledge, are trained (if necessary) and equipped to follow the identified improved ways of caring. Staff told us they were aware that 'champions' had been appointed for dementia care, safeguarding and moving and handling for some time, but that other 'champions' were not so well established and so the impact of some of them was not yet fully demonstrated. Where 'champions' had made an impact was that one was fully trained in dementia care mapping, another in moving and handling and a third in safeguarding adults training as a cascade trainer for the local authority.

There were activities held in-house by an activities coordinator and these were planned and facilitated according to needs and resources available. Staff also facilitated impromptu activities if and when they had spare time to do so. People told us they sometimes joined in with knitting, singing, quizzes, card games, bingo and going out on excursions. People went to the Bridlington Spa music concerts and were looking forward to seeing Daniel O Donnell in September 2016. People attend an annual pantomime and were visited by local school children and a Salvation Army band for carols at Christmas. People hosted several fundraising events: the two largest being fairs in the summer and at Christmas, while afternoon themed teas, singers and a summer barbeque were regular events.

People said, "It's alright here, there is always something to do" and "We often suggest things and staff or the activities lady will set it up for us." We saw evidence in the form of photographs and diary notes that told us what people did for entertainment and occupation. People had their own televisions in their bedrooms or

could congregate in the lounge to watch television together. There were two lounges, one had been occupied by gentlemen and was decorated in a style that they had chosen, and the other was occupied by ladies. Although the different genders had adopted the lounges neither of these rooms were exclusively designated to them and yet one of the rooms was now referred by everyone as the gentleman's lounge.

The activities coordinator had arranged for some fertilised chicken eggs in an incubator to be brought into the main lounge where people had been able to watch them hatch over several days. The chickens were going to be adopted by the people that lived at Northfield Manor and reared for their eggs. Some people were meeting in the lounge for a 'knit and natter' session which was run by volunteers and incorporated knitting for charity while chatting and socialising. This was being experienced by people sitting on the periphery of the activity as well, by those who did not want to knit but enjoyed the conversation. Staff also informed us that some people had been on outings to The Deep (aquarium), local garden centres and local pubs for lunch.

We saw that the staff used lifting and hoisting equipment for assisting people to move around the premises and that this was used effectively. People were assessed for use of hoisting equipment and there were risk assessments in place to ensure no one used it incorrectly. Other items included slide sheets for helping people move in bed and supporting belts for helping people to stand. The staff understood that people had their own hoist slings to avoid cross infection and these were kept in people's bedrooms. Bed rail safety equipment was in place on people's beds and these had also been risk assessed for safe use. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. All equipment in place was there to aid people in their daily lives to ensure independence and effective living and, if necessary, they had been risk assessed.

Some people preferred to remain in their bedrooms and only mix with others at meal times or not at all, depending on their personal choice. These people were visited throughout the day by staff checking to see if they needed anything. Some people spent a lot of time on bed rest, rarely getting up and while one person in particular was very self-determining their physical dependence was still high. Therefore all of their personal care needs were met by staff going to them at regular intervals and assisting them with errands and information. They told us that they made all of their own decisions and determined what happened when, where and why.

This was a similar experience for another person we spoke with in their bedroom, but they said the only thing they needed support with was dressing in the morning. However, they said that sometimes when they called for support staff stuck their head round the door to say they would be back as soon as they had finished assisting someone else, but sometimes this was not quickly enough for them. The person explained that this only occurred with a couple of staff, the rest were more efficient. Other people were dependent physically and mentally and required support with positional changes, drinks and food, but they made no comments about support from staff being untimely. These people had monitoring charts that recorded when staff had supported them and we saw these were completed appropriately.

Staff told us that it was important to provide people with choice in all things, so that they continued to make decisions for themselves and stay in control of their lives. People had a choice of main menu each day and if they changed their mind the cook usually catered for them. People chose where they sat, who with, when they rose from bed or went to bed, what they wore each day and whether or not they went out or joined in with entertainment and activities. People's needs and choices were therefore respected. One person said, "I get up and go to bed whenever I like and generally please myself. I can have a choice of tea, coffee or cold drink whenever I want one."

People were assisted by staff to maintain relationships with family and friends. This was carried out in several ways. Staff who were assigned to provide a personal touch to people as their key worker, got to know their family members and kept them informed about people's situations if people wanted them to. Staff also encouraged people to receive visitors and telephone them on occasion. Staff spoke with people about their family members and friends and encouraged people to remember their birthdays, by helping them send cards. One staff member explained how they had assisted a person to print off a picture of their great grandchild (new born but living out of the area) that had been posted on Facebook. They had then taken a picture of the person holding the photograph of the baby and sent this back to the child's mother, as a way of helping the person connect with family members. Other ways of assisting people to keep in touch included a monthly newsletter issued in the service and a letter sent to family members three times a year, which also contained copies of the newsletters. There was a Facebook page and a blog on the provider's website to keep relatives updated with happenings and future plans.

We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. Compliments were also recorded in the form of letters and cards. People we spoke with told us they knew how to complain. They said, "I have no complaints to make, everything here is pretty good, but I would tell the manager if they weren't" and "I've never needed to make a complaint but would speak to the staff."

Staff we spoke with were aware of the complaint procedures and had a positive approach to receiving complaints as they understood that these helped them to get things right the next time. We saw that the service had handled ten complaints in the last year, nine informally and one formally. Complainants had been given verbal or written details of explanations and solutions following investigation. There were records kept of these complaints and whether or not they had been formally managed and addressed. All of this meant the service was responsive to people's needs.

Good

Is the service well-led?

Our findings

People we spoke with felt the service had a pleasant, family orientated atmosphere. Staff we spoke with said the culture of the service was, "Healthy and nurturing and based on sharing." They said that there was no competition among the staff as everyone "Pulled together." They said they really liked coming to work as Northfield Manor was a lovely place to work. They told us that being short staffed sometimes affected them, but generally the morale among the staff was good. They said they engaged in team building outside of work, for example, by celebrating each other's special birthdays and inside work by working together and 'sharing the load'.

The registered provider was required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been the registered manager for the last two years. The registered manager and registered provider were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made). We saw that notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been notified to the Care Quality Commission.

The management style of the registered manager and management team was open and approachable. Staff told us they could express concerns or ideas any time and that they felt these were considered. Staff said of the registered manager that they were friendly, approachable and considerate, but when necessary they disciplined staff without hesitation. They also told us that issues were not dwelt upon but soon put behind them and they expected staff to quickly move on and improve. The registered manager made their expectations of staff very clear.

There was evidence to show that the management style was progressive and innovative in improving the experience for people that used the service. For example, the registered manager had contacted a local historian to visit and provide talks to people on the local area around Driffield. They attended the local authority Care Sector Forum meetings, or sent a staff delegation, to keep in touch with up-to-date developments in the caring community. They networked with the MacMillan nursing services to hold charity coffee mornings or sponsored dog walks to raise funds and connect with the wider community.

The service maintained other links with the local community through the church denominations, schools, colleges and visiting local stores and cafes. Relatives played an important role in helping people to keep in touch with the community by taking people out shopping or to activities. The activities coordinator arranged outings to local areas of interest or entertainment.

The service had written visions and values, which were 'dignity, quality care, safety, security and choice.' There was a 'statement of purpose' and a 'service user guide' that were kept up-to-date (documents explaining what the service offered) and these also contained aims and objectives of the service. Northfield Manor was accredited with the Investors In People award and worked with a national company who assisted young people into work through work experience placements at the service and via part-time

employment for disabled or disadvantaged workers. We were told that all staff had become 'Dementia Friends' (an Alzheimer's Society initiative to encourage carers and the public in general to learn a little bit more about what it's like to live with dementia and then turn that understanding into action). This was still relatively new, but staff on the Rose Garden unit had implemented several initiatives for activities and had begun to approach people living with dementia differently, so that they felt less anxious. Evidence of this was seen when we visited the Rose Garden unit.

Northfield Manor was registered in 2010 under the Health and Social Care Act 2008 but had been a registered service under prior legislation for over 20years. In 2015 Northfield Manor changed its registration from that of providing nursing care to that of providing only residential care to people that used the service. Those people that received nursing care were re-assessed and some were able to remain while others required alternative placements. All of this was completed sensitively and with the cooperation of the placing local authorities and health commissioners. Therefore nursing care was no longer provided and any nursing needs were supported by the district nursing services.

Changes in the staffing structure were also made to accommodate the loss of trained nursing staff in the service. After some nursing staff had left those that remained and other staff that 'stepped up' in respect of taking responsibility, were competency assessed to ensure they were capable of running a shift at the weekends and at night. Competence was particularly assessed regarding management of medicines.

We looked at documents relating to the service's system of monitoring and quality assuring the delivery of care and support. We saw that there were quality audits completed on a regular basis and that satisfaction surveys were issued to people that used the service, relatives and health care professionals. Consultation meetings were also held.

Audits were carried out on a wide range of topics and areas, for example, on window safety catches, hot water outlets, activities, staff supervisions, infection control measures, staff approach and attitudes, bedroom facilities, care plans, medicines, pressure care and falls. These were carried out at different intervals and information gathered was analysed and used to determine action plans and therefore to make changes or improvements to the service.

Satisfaction surveys that focussed on meals and mealtimes had been issued to people and returned in 2015. These showed positive comments. Satisfaction surveys completed by staff in May 2015 also showed positive comments.

We were told by staff and people that used the service that staff and 'resident' meetings were held to provide everyone with an opportunity to discuss issues, make plans and resolve problems. These were recorded and showed that areas of concern or interest were discussed and addressed to the satisfaction of people and staff.

The service kept records on people that used the service, staff and the running of the business. These were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.