Tamaris Healthcare (England) Limited

Lea Green Court Care Home

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 11 May 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We last inspected Lea Green Court in April 2015. At that inspection we found the service was in breach of the legal requirements in force at the time with regard to Regulations 12, 9 and 15 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. This was because people were at risk of unsafe care and treatment, records did not accurately reflect people's care and support needs and the premises were not well maintained.

The home provides nursing care and support for up to 45 older people, some of whom live with dementia or a dementia related condition.

A registered manager was in place. 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.

We found significant improvements had been made to the service. People and staff told us they felt safe and there were enough staff on duty at all times to provide safe and individual care to people. There was more emphasis on providing person centred care to ensure people received care and support in the way they wanted and at times they chose. Staff had time to interact and spend time with people and not just when they carried out tasks.

Risk assessments were in place and they now identified current risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way.

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.

Records had been updated and they were regularly reviewed to reflect people's care and support requirements. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions for themselves.

Staff received other opportunities for training to meet people's care needs and in a safe way. A system was in place for staff to receive supervision and appraisal.

Menus were more 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. Some activities and entertainment were available for people. However, we have made a recommendation that more activities and stimulation should be made available for people including people who live with more severe dementia.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

Staff and people who used the service said the registered manager was supportive and approachable. Communication was more 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.

Changes had been made to the environment. It was cleaner and areas had been refurbished to improve infection control.

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

Improvements had been made to ensure the service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Staffing levels were sufficient to meet people's current needs safely. People received their medicines in a safe way. Risk assessments were up to date and identified current risks to people's health and safety.

People were protected from abuse and avoidable harm. Appropriate checks were carried out before new staff began working with people. Staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

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

Is the service effective?

Good

Improvements had been made to ensure the service was effective.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

Communication had improved and effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

Improvements had been made to menus to ensure people received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Improvements had been made to the environment so it was well maintained.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Staff now spent time with people and interacted and engaged with them not just when they provided support.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. 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.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

The service was responsive.

Improvements had been made to 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 some activities but we have made a recommendation with regard to activities to ensure people have more stimulation. People had the opportunity to access the local community.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was supportive and could be approached for advice and information.

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

Improvements had been made by the provider and were being maintained by the registered manager and management team to

promote the delivery of more person centred care for people.

Lea Green Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 May 2016 and was unannounced. The inspection team consisted of an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection we reviewed the information we held about the service. 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. We also contacted health and social care professionals who worked with the service. We received no current information of concern from these agencies.

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 ten people who lived at Lea Green Court, six relatives, the manager, two visiting health care professionals, one registered nurse, six support workers, the activities organiser and two members of catering staff. We looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. 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

At our last inspection in April 2015 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service and unsatisfactory standards of hygiene and infection control. We reviewed the action plans the provider sent to us following the inspection. These included details of how they planned to ensure compliance with legal requirements.

At this inspection we found improvements had been made to ensure people received safe care and treatment. Improvements had been made in medicines management and risk assessments reflected current risks to people's health and safety. There was improved infection control and the environment was better maintained.

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. People's comments included, "I feel safe here," and "Staff give me the help I need. I just need to ask and they help." Relative's comments included, "There's always someone [staff] in the room or not far away," "[Name] is well cared for on the whole," "The home is as good as anywhere," "I know [family member] is safe here," "Paperwork comes second to the care of those who live at the home," "They put the patient first," "If staff see someone needs help they see to them or answer the call bells straight away," "Staff can seem stretched at times," "Most of the time there are enough staff," and "I think there are enough staff, I know more have been employed."

The registered manager told us staffing levels were determined by a dependency tool. This was used weekly to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. At the time of inspection there were 38 people living at the home. They were supported by one registered nurse, one senior support worker and seven support workers. The registered manager told us there would usually be two registered nurses on duty during the day but there was a vacancy and they were currently recruiting to the vacant post. From our observations, people's feedback and looking at staffing rosters we considered there were sufficient staff to meet people's needs at the current time. We saw the provider had taken other action to ensure staff were available to support people. The nurse in charge of each shift had the responsibility to ensure staff were appropriately deployed around the home. We saw staff were always available to supervise people and respond promptly to people's calls for assistance.

Staff had receiving e-learning training about safeguarding and had an understanding of safeguarding and knew how to report any concerns. Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and they knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager or senior person on duty. The registered manager told us local authority 'Safeguarding Alerter Training' was planned to give staff some insight into the role of the different agencies after a safeguarding alert was raised with the local authority.

The registered 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 registered manager. Six safeguarding alerts had been raised since the last inspection. 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.

Risk assessments and their evaluations, which had previously not been up to date to reflect current risks to people, were now 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 choking, losing weight, falls and pressure area care.

We checked the management of medicines and found previous concerns had been addressed with regard to the use of 'when required' medicines which may have been required when people were in pain, agitated or distressed. People had a medicines care plan, which detailed the differing level of support needed by each person. The guidance was detailed and provided staff with a consistent approach to the administration of this type of medicine and when it should be given. For example one person's care plan stated, "If [Name] displays excessive shouting this can be indicative of pain or discomfort, nurse to check …"

People were supported with their medicines safely. We observed an agency member of staff, who did not know the people living in the home, checked with another member of staff to confirm who the person was. They did this, as well as verifying the person's photograph on the medicine chart, to ensure they administered the medicine to the correct person. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

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.

At the last inspection we had concerns about the standards of hygiene and cleanliness around the building. We looked around the building and saw improvements had been made. There was effective odour control. All areas of the building looked clean. Records showed cleaning schedules were in place that were checked and signed off weekly by the registered manager. The environmental audit carried out by the regional manager, who visited the home regularly, also included signing off these internal checks to ensure the environment was clean with a good standard of infection control. Staff had received face to face training about infection control. A programme of work had been carried out by the estates department of the company to replace flooring and toilet plinths in some en-suite and communal lavatories to ensure effective

infection control.

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 other checks were available and up to date. They included the Nursing and Midwifery Council to check nurses' registration status and a form was completed by all applicants to check people's right to work in the United Kingdom. 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 were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "There are opportunities for training," "We get plenty of training, some of it is face to face but most of it is e learning," "I was doing training yesterday," and, "I'm doing a National Vocational Qualification (NVQ) at level 2.(Now known as a diploma in health and social care).

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face to face and practical training. One staff member told us, "I shadowed another member of staff for two days and read people's care plans on the third day."

The staff training records showed and staff told us they had received other training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as end of life care, nutrition awareness, mental capacity, distressed behaviour, dementia care, vision awareness, effective communication, catheter care, record keeping, diabetes and person centred care. Several staff had obtained or were studying for a diploma in health and social care.

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "We have supervision every two-three months," "[Name], the manager does my supervision," and, "I'm asked what needs improving and what works well." Staff told us they were well supported to carry out their caring role. All staff said they had regular supervision to discuss the running of the service and their training needs. They said they could approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal with a six month meeting to review their progress and work performance. Staff comments' included, "I love it here," and, "The manager is approachable and always has an open door."

People were supported to maintain their healthcare needs. 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.

A weekly clinic took place at the home. The clinic was run by the General Practitioner from a local surgery, a specialist nurse and supported by a nurse from the home. The clinic was held to review people's health needs and their medicines and make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. We were told relatives also had the opportunity to attend the clinic to support their family member. We spoke with two visiting health care professionals during the inspection. They told us people were referred straight away if there were any concerns about their health and that staff

followed their advice and guidance. They also said staff were caring and communication had improved. They were very positive about the improvements to people's care. Their comments included, "The manager is very pro-active, passionate and committed," "The management is fantastic, they're much more confident," "The deputy comes up with ideas," "Communication is much better," and, "There have been lots of improvements."

At the last inspection we had concerns that communication was not effective to ensure people's needs were met. At this inspection staff told us communication was much more effective. Staff members' comments included, "Communication is fine," "There have been big improvements with communication," and, "Communication has improved." We were told a handover session took place with all staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. 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. Written information was also referred to with regard to any concerns with people's dietary needs and any personal care issues. We were told the registered manager was involved and attended some daily handovers. Staff told us the diary and communication book also provided them with information. Relatives we spoke with told us they thought communication was good and they were kept informed by the staff about their family member's health and the care they received. A relative told us, ""Staff will let me know if anything changes."

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. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed when 'best interest' decisions may need to be made. For example, one person's care plan included, "[Name] can make non-complex decisions on what to wear and what to eat and drink. Staff will make 'best interest' decisions if [Name] doesn't make simple choices, depending upon mood will determine if [Name] will make a choice."

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). Staff were aware of and had received training in the MCA and the related DoLS. 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. The registered manager told us 29 applications had been authorised, seven applications were being processed and one person did not require one.

Systems were in place to ensure people received drinks and varied meals at regular times. We looked

around the kitchen and saw it was stocked with fresh, frozen and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and told us special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The cook told us they received information from nursing staff when people required a specialised diet such as diabetic, soft or pureed food.

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 eat. For example, information in one care plan included, "[Name] likes porridge," and, "[Name] needs a high calorie diet because of their constant walking around, with high calorie snacks in between meals." We observed when the drinks trolley came around in the morning and afternoon the person was served yoghurt and other snacks.

We were told menus had been reviewed and people were offered a cooked breakfast, light lunch and their main meal in the evening. People told us they had a choice at meal times and on the day of inspection we saw the lunchtime meal was soup and sandwiches or spaghetti on toast. The evening meal was sausage casserole or egg and chips. Peoples' comments included, "Menus are better," "There's plenty to eat, you can have more, and, "The food is fine."

At the last inspection we had concerns the environment was not well maintained for the comfort of people who lived in the home. We observed a programme of redecoration had taken place around the home. Bedrooms we looked at were personalised and bright and bedding had been replaced as necessary to ensure people were warm and comfortable whilst in bed.

Good

Is the service caring?

Our findings

People who could comment were all positive about the care and support provided by staff. Their comments included, "I get looked after really well," "The carers are really nice," "The staff are very kind and patient," "You just ask, you're well looked after," If you want anything the staff would be only too pleased to get it for you," "It's better than living alone," "We have a good rapport between us," and, "I'm pleased there's somebody looking after me." Relatives' comments included, "They [staff] are stars, all of them," "I'm full of admiration for them [staff]," "The care is good," "[Name] is very happy here," "[Name] is kept clean and tidy," "Staff are very caring and with the families. I'm in visiting nearly every day and I missed a visit and they phoned me to check I was alright," and, "Staff get on great with people."

During the inspection there was a relaxed and pleasant atmosphere in the home. It was noticeable since the last inspection that the lounges were more tranquil and calm. Throughout the home staff interacted well with people. We observed the improvements to people's care and mood because staff were enthusiastic and had time to spend talking with them about things that interested them, interacting with them on an individual basis. They were kind and caring and they sat amongst people engaging with them and not only supervising them.

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 explained what they were doing as they assisted people and they met their needs in a sensitive and compassionate manner.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two drinks or two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. A communication care plan for a person recorded, "[Name] is not able to indicate any signs of pain therefore an 'Abbey Pain scale' needs to be completed every month."

Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. For example, we heard a staff member ask, "[Name] are you going to sit up and have a drink?," and, "Shall I get you a table to put your biscuits on?." Peoples' care plans contained detail of how staff were to support them. Examples in care plans included, "Staff to come in front of [Name] when approaching them and not to the side," and, "It is important to talk [Name] through the task so they understand what is happening."

We observed the lunch time meal on the two floors of the home. We were told mealtimes were 'protected' (so people were not disturbed) and measures were in place such as two meal time 'sittings' for each meal to create a relaxed atmosphere so people were not distracted from eating. People sat at tables set with tablecloths, napkins and menus. Specialist equipment such as cutlery and plate guards were available to

help people. People sat at tables set for three or four. Staff did not assume people's preferences and offered people a choice of food verbally or showed two plates of food that contained the two options. The meal experience was relaxed and staff were unhurried as they supported people. For people who required total assistance we observed staff were seated with people and interacted with them individually. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a clear and respectful way. Staff talked to people as they helped them and as lunch was served.

Staff treated people with dignity and respect. We saw they knocked on people's doors before entering their rooms and ensured any personal care was discussed discretely with people. We observed that people looked clean, tidy and well presented. Most people sat in communal areas but some preferred to stay in their own room.

Measures were in place to protect people's privacy. Resident and relative meeting minutes recorded that any individual comments or concerns about a person's care would be discussed individually with the registered manager. This was so personal details about people were not discussed in an open forum in order to protect people's privacy.

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 this was discussed and signed for some people at the weekly clinic to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required and one person was supported by an Independent Mental Health Advocate (IMHA) because they lacked the mental capacity to make decisions with regard to their well-being. Advocates can represent the views for people who are not able to express their wishes. Information was displayed that advertised what advocacy was and how the service could be accessed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed.

We saw that improvements had been made to ensure that records accurately reflected peoples' care and support needs so staff had guidance to provide appropriate care and support.

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, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

The registered manager told us new care plan documentation had been introduced which allowed for more detail. This helped to ensure staff had information and guidance about people's care and support needs and these also detailed how care was to be delivered.

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 people's needs. For example, a referral had been made to the speech and language team because of a person's difficulty with swallowing. Staff had then received dysphagia (swallowing) training to give them more insight into the needs of the person who had swallowing problems. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly.

Charts were also completed to record any staff intervention with a person. For example, 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. 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. Care plans alerted support staff when a person may be at risk of developing pressure areas on their body.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed and provided information for staff about how people liked to be supported. A relative told us, "I was asked about [Name]'s likes, dislikes and ways to keep [Name] calm and staff have responded to that. They seem to take note of how [Name] is feeling."

We found improvements had been made to assist staff with the management of distressed behaviour which some people displayed. Records were now in place for the management of this behaviour. 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. This guidance helped ensure staff worked in a consistent way with the person, to help reduce their anxiety and distressed behaviour. Care plans were in place to show peoples' care and support requirements when they became distressed or agitated and they were regularly updated to ensure they provided accurate information.

Records showed 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. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

An activities organiser was employed and they had been in post for four weeks. They had been employed in another capacity in the home for the previous three years so they knew the people they supported. They spoke with enthusiasm about their role, their affection for the people and could describe details of which person enjoyed each particular activity.

We observed an up-to-date programme of activities was not displayed around the home in an accessible format for people who may no longer recognise the written word. This would have helped keep people involved and be aware of the activities available each day. We were told magnetic activities boards had been purchased but the home had reverted back to the paper planner which recorded the month's programme and this was small and difficult to read.

Individual records showed the activities that people took part in supported by the activities person. These included pamper sessions, dancing, sing along, arts and crafts, pairing socks and baking. The activities programme advertised a daily breakfast club where the activities person helped staff with breakfast duties. There was also a newspaper club that involved the activities person taking someone to buy a newspaper or giving some people a newspaper to read followed by some discussion about current affairs. A mini bus was available and people had the opportunity to go to the coast, Ashington, Blyth, Woodhorn Colliery and other places of interest. People were supported individually by the activities person to follow their previous interests and hobbies. For example, a person was supported to go to the local pond for a nature watch.

Some people and relatives told us they would like more activities. One person said they just sat in their bedroom. They told us, "It's lovely when they [staff] sit and chat with you but it's not often as they are busy all the time." Another person said, "I don't do much, I usually like to stay in my bedroom." A relative commented, "My [Name] sits in the lounge most of the time and I do think it would be good if they could go outside into the garden for some fresh air," and another relative commented, "There could be more activities in the lounge area such as dominoes or card games."

We observed in the morning most people were asleep after breakfast in the first floor lounge. The television was on and out of nine people two people were awake. A chat show was on and no one was interested in the programme. We were told many people slept throughout the day. A number of people were also asleep in the ground floor lounge. However, we did observe later in the day that more people were awake and the atmosphere was relaxed. However, the general environment was quiet and sleepy and lacking in stimulation. We did not observe any staff, although sitting with people, engage in activities with people who lived with more severe dementia when the activities person was elsewhere in the home or out in the community with an individual.

We recommend the home expands the programme of activities to ensure people who live with more severe dementia are kept stimulated and engaged and that staff continue with activities provision with all people when the activities person is not available.

We were told resident and relative meetings were held every three months. Meeting minutes showed people had been consulted about the frequency and when they should be held to accommodate people and to encourage more participation. We saw they were to be held in the evening as it was a more convenient time for some people to attend. People who use the service and relatives told us the manager was approachable and they knew they could approach them at any time to discuss any issues.

People said they knew how to complain. A person commented, "I'd tell the staff." A relative commented, "I'd speak to the manager and I know I'd be listened to." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure in the information pack they received when they moved into the home. A record of complaints was maintained and we saw those received had been investigated and resolved appropriately.

Good

Is the service well-led?

Our findings

A registered manager was in place who had become registered with the Care Quality Commission (CQC) in February 2016.

We found that the breaches of regulation and areas for improvement identified at the last inspection had been acted upon and rectified by the provider's management team. One person who used the service told us, "A new regime came in to make things better-I do see a difference." After the last inspection CQC received regular action plans that detailed the action that had been taken to improve outcomes for people who used the service.

The registered manager had maintained the improvements to the home to benefit people who lived there. These included improvements to communication, record keeping and people's experience of living at the home to ensure their health and support needs were met safely and appropriately.

All relatives spoke highly of the changes in management in the home and were aware of how things had improved. Their comments included, "It's improved greatly," "Things have improved, we've seen such an improvement here." and, "Things have got better over time." Three relatives said they would now recommend the home to others.

The atmosphere in the home was relaxed. Staff were busy but they said they felt well-supported by the management team. They said they could approach them to discuss any issues. A staff member commented, "The registered manager is 100% supportive." Relatives told us the manager and staff were approachable. One relative told us, "I feel I can talk to staff and they listen." Relative meeting minutes showed the manager was responsive and took action to respond to any concerns that were raised. One relative commented, "Whenever I've mentioned anything it's taken on board."

Staff meeting minutes were available to show the staff meetings that took place monthly to assist with communication and ensure the smooth running of the home. These included quality and clinical governance meetings, health and safety meetings and general staff meetings. Staff members told us staff meetings took place and minutes were made available for staff who were unable to attend. Minutes from general staff meetings showed areas discussed included training, staff performance, record keeping, audits and communication.

Regular monthly analysis of incidents and accidents took place. The registered 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. For example, we noted the health and safety meeting minutes in March 2016 had discussed the increase in the number of falls for that period. The following month's health and safety meeting minutes showed action that had been taken to reduce the number of incidents. The person who had had repeated falls was referred to a falls clinic.

Monthly newsletters were distributed to keep people and their relatives up to date with what was happening

in the home. For example, social events, deaths, birthdays, new people who were coming to live at the home and new staff starters.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The registered manager told us a daily audit took place which involved them doing a daily walk around. It was completed electronically with an iPad and all responses and outcomes were received directly by head office each day. The responses were escalated electronically, and depending upon the category of severity, were triggered to senior management within the organisation to make them aware of any issues identified. The iPad was also used to collect feedback from people who used the service, relatives and staff, with at least six people being encouraged to comment daily.

Monthly audits included checks on people's dining experience, staff supervision, medicines management, care documentation, training, kitchen audits, accidents and incidents, clinical governance and nutrition. 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 registered manager to ensure they had acted upon the results of their audits. All audits were available electronically and we saw the information was filtered to ensure any identified deficits were actioned. Other audits included checking a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files. A weekly internal financial audit of the petty cash, amenities fund and monies held on behalf of people who lived in the home was carried out. A six monthly audit of finances held in the home was also carried out by a representative from head office. All audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.