Gainford Care Homes Limited

Lindisfarne 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?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 19 and 23 October 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Lindisfarne Care Home provides care and accommodation for up to 61 elderly people with residential and nursing care needs. On the day of our inspection there were 60 people using the service, some of whom had a dementia type illness.

The home had a registered manager in place. 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.

Lindisfarne Care Home was last inspected by CQC on 13 November 2013 and was compliant.

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

Summary of findings

Accidents and incidents had been fully recorded and analysis carried out to identify any trends.

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

Staff training was up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The home was clean, spacious and suitable for the people who used the service.

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 interests 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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the registered manager and looked at records. We found the provider was working within the principles of the MCA.

All of the care records we looked at contained evidence of consent.

People who used the service, and family members, were complimentary about the standard of care at Lindisfarne Care Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

We saw that the home had a programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Lindisfarne Care Home and care plans were written in a person centred way.

Risk assessments were in place where required and were regularly reviewed.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

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

The service had good links with the local community.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents had been fully recorded and analysis carried out to identify any trends.

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

Good

Is the service effective?
The service was effective.

Staff training was up to date and staff received regular supervisions and appraisals.

The provider was working within the principles of the MCA.

All of the care records we looked at contained evidence of consent.

Good

Is the service caring?
The service was caring.

Staff treated people with dignity and respect and people were encouraged to be independent and care for themselves where possible.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Good

Is the service responsive?
The service was responsive.

Risk assessments were in place where required and were regularly reviewed.

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

The provider had a complaints policy and complaints were fully investigated. People who used the service knew how to make a complaint.

Good

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

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

Staff told us they felt supported in their role.

The service had good links with the local community.

Good

Lindisfarne Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 23 October 2013 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector, a specialist advisor in nursing and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. Some concerns were raised, particularly about staffing levels at the home. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. Some concerns were raised by these professionals which we looked into during our inspection.

Before the inspection, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the registered manager about what was good about their service and any improvements they intended to make.

During our inspection we spoke with four people who used the service and four family members. We also spoke with the registered manager, deputy manager, two nurses, two care workers, the activities co-ordinator and a visiting health care professional.

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

Good

Is the service safe?

Our findings

People who used the service and family members we spoke with told us they thought people were safe at Lindisfarne Care Home. They told us, "Yes I think that she is safe", "He is safe apart from one man who doesn't like him and there was an altercation last week", "I am safe enough in here, oh yes I feel comfortable" and "He is safe, he does wander around and they can't keep him down all the time but he always has since he came in. If he does have a little fall they inform me".

The home is a three storey building set in its own grounds. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service.

All the floors of the home comprised of people with residential or nursing needs and people with a dementia type illness, however the majority of people with more challenging needs were located on the first floor. The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and the temperature of the building was at a suitable level. People's bedrooms were en-suite and personalised with people's own furniture and personal items. For safety purposes, window restrictors, which looked to be in good condition, were fitted in the rooms we looked in and wardrobes were secured to walls.

When we first arrived at the home we noticed a strong odour on the first floor however the odour had gone a few hours later and we did not notice any other odours during the two days of our visit.

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. We also saw records of disciplinary issues, including copies of letters sent to staff members regarding the outcome of disciplinary meetings. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We asked staff whether there were plenty of staff on duty. They told us, "It's the nature of the unit, we have five carers and one nurse, we need six carers as there are two areas to look after", "Staffing is ok" and "Staffing levels are rubbish". We also asked people who used the service and family members about staffing levels. They told us, "Sometimes they are rushed on a morning but that's understandable when getting everyone up", "I don't think that there is enough staff but if I was to have a word with the nurse then she would say that it is adequate", "They are busy but if there is anything I want they will do it, albeit not immediately but they will do it when they get time", "I think that there are enough staff but you have to wait a few minutes before you get one though" and "I accept that they keep insisting that they are fully staffed but it just doesn't seem that there are enough. It's maybe the right number of staff but can they really cover? They do a really good job they're just run into the ground". A visiting healthcare professional told us, "It's a very busy home, it's very well run. They've had lots of issues with staff shortages and this is managed well."

We discussed staffing levels with the registered manager and looked at the rotas. The registered manager told us rotas were prepared six weeks in advance and care staffing levels comprised of at least 13 members of staff on during the day, including at least one nurse, two senior care staff and 10 care staff, and seven members of staff on at night, including two senior care staff and five care staff. Staff were deployed depending on the needs of the people on each floor. The registered manager told us any absences were covered by their own permanent and bank staff and the home did not use agency staff.

During our inspection visit, there were 20 people living on the ground floor of the home, 27 on the first floor and 14 on the second floor. We observed staffing levels on each of these floors and found them to be sufficient for the number of people who used the service and to care for their individual needs. We saw call bells were answered promptly. On the first day of our inspection visit we found staff were very busy due to two people who used the

Good

Is the service safe?

service being very ill. However, on the second day of our inspection visit, we found a much calmer atmosphere and saw staff had time to sit with people and a lot more interaction took place.

We saw hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs, wheelchairs and pressure cushions. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, the fire alarm was tested weekly and regular fire extinguisher and emergency lighting checks were carried out.

We saw the service had a contingency plan and evacuation procedure and saw copies of 'Residents' fire check lists'. These were colour coded to and included the person's name, room number and their level of mobility. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We looked at safeguarding, accident and incident records and saw copies of individual accident reports and copies of monthly accident reports, which included the location, time and whether the incident was as a result of a fall, altercation or other accident. We also saw copies of monthly accident/incident graphs which were used to identify any trends. We saw the registered manager had noted that although the number of accidents had remained level throughout the year, there had been an increase overnight and "staff need to be more vigilant and ensure regular checks are maintained." We asked a visiting healthcare professional whether they had seen anything that concerned them. They told us, "Nothing at all, I made a safeguarding and reported it, however it was related to something which had occurred to a person in a previous care home."

We saw copies of risk monitor reports, which were completed and submitted to the regional manager on a weekly basis to provide an overview of any risks or incidents that had occurred in the home. These included pressure damage, serious changes in health, weight loss and variance, infection control, safeguarding, complaints, serious accidents and incidents, deaths and deprivation of liberty.

We looked at the management of 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. Systems were in place to ensure that the medicines had been ordered, stored, administered, audited and reviewed appropriately.

We observed a medicines round and saw the staff member check people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. Medicines were given from the container they were supplied in and we saw staff explain to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate. We saw the MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. The registered manager was responsible for conducting monthly medicines audits, including the MARs, to check that medicines were being administered safely and appropriately.

Medicines requiring cool storage were kept in a fridge which was within a locked room. Medicines with a short life once opened had the date of opening noted, this meant they remained safe and effective to use. We saw that temperatures for the treatment room and refrigerator were recorded daily and were within recommended levels. This meant medicines were stored safely and securely.

Good

Is the service effective?

Our findings

People who lived at Lindisfarne Care Home received effective care and support from well trained and well supported staff. Family members told us, "I really do feel that he is looked after well. Honestly, I have never had to complain about his care", "On the whole he is well looked after. I am here most days" and "On the whole yes it's ok, it's not as good as it used to be".

We discussed training with the registered manager who told us mandatory training for staff included fire safety, moving and handling, safeguarding, health and safety, food hygiene, nutrition, mental capacity and deprivation of liberty and dementia. We saw records of training certificates and workbooks in staff files. Where training was due, we saw dates for planned training on the notice board in the registered manager's office, which included mental capacity, safeguarding and food hygiene. We saw staff had completed an induction when they started working at the home and the registered manager told us all new staff were enrolled on the Care Certificate programme, which is a set of standards designed to provide new care staff with the necessary skills and training for their role.

We looked at supervision and appraisal records. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We saw staff received regular supervisions, which included discussions on moving and handling, policies and procedures, dementia awareness, documentation and whistleblowing. Two of the staff whose records we looked at had received an annual appraisal in the previous 12 months and the registered manager told us the other two were due and planned for November 2015. Staff we spoke with told us they received regular supervisions and appraisals. This meant staff were fully supported in their role and were up to date with their training.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). An example for one person stated, "[Person] is having very poor diet and on thickened fluids, providing mouth care for [Person] and giving small amounts of fluids to maintain hydration." We also saw choking risk assessments were in place for two people to identify specific risks associated with eating and drinking. The registered manager told us that they were currently implementing the choking risk assessment for all people living at the home.

Where people were identified as being at risk of poor nutrition staff completed daily food charts and fluid balance charts. The food charts were used to record the amount of food a person was taking each day. Fluid intake charts recorded the fluid intake goals and we saw there was consistent completion of the totals recorded. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals, such as GPs, dietitians and speech and language therapists (SALT), for advice and guidance to help identify the cause. We saw there were weekly menu lists for each person who used the service in the kitchen and copies of diet notification sheets. We saw SALT guidelines and recommendations for some of the people who used the service and included pureed or mashable diets and fortified drinks. This meant there was good communication between care and catering staff to support people's nutritional well-being.

Consent to care and treatment records were signed by people where they were able. If they were unable to sign a relative or representative had signed for them. Records confirmed that, where necessary, assessment had been undertaken of people's capacity to make particular decisions. In some of the records we looked at it had been deemed that people did not have capacity. We saw the mental capacity assessments were decision specific and we saw also records that best interest decisions had been made for people. However, in some of the records it was unclear whether people's family and staff at the home had been involved in the decision making process when the person lacked capacity to make certain decisions as this had not been recorded.

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 interests and as least restrictive as possible.

Good

Is the service effective?

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the registered manager, who told us applications had been submitted to the local authority for those people who required DoLS but no authorisations had been received yet. Records we looked at confirmed this. We found the provider was working within the principles of the MCA.

We saw records of when people had made advanced decisions on receiving care and treatment. The care records held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. However, for one person we saw that the person's home address was recorded on the form rather than Lindisfarne Care Home. We discussed this with the registered manager who told us they would discuss it with the person's GP.

Care records showed details of appointments with, and visits by, healthcare professionals and we saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GPs, community nurse practitioners, district nurses, social workers, safeguarding team, dietitian, speech and language therapy team (SALT), community mental health, tissue viability nurses, occupational therapists, chiropodists and podiatrists. Care plans reflected the advice and guidance provided by external health and social care professionals. A family member told us, "I have just told the nurse he has a pain and they have phoned straight away for the doctor."

We discussed the design of the home with the registered manager, particularly for people with a dementia type illness, as there was little visual stimulation on the walls of the home. We discussed what improvements could be made to provide more visual stimulation for people with dementia. The registered manager told us the sensory room, which wasn't being used at the time of our inspection, was going to be turned into a memorabilia room, which would contain old furniture, photographs and other items. We saw carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. Doors were clearly marked and bathroom and toilet doors were painted a different colour to people's bedroom doors. People's names and photographs were on individual bedroom doors. This meant the service incorporated some environmental aspects that were dementia friendly and the registered manager had plans in place to make improvements.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Lindisfarne Care Home. They told us, "It's alright living here ", "They are lovely with him" and "Some of the staff are lovely". One family member told us, "I think that she gets left because she can look after herself. I don't know what else they can do. She is left to her own devices and other people take up more of their time".

On the first day of our inspection we observed very little interaction between staff and the people who used the service. Although there were sufficient numbers of staff on duty, staff appeared to be busy with daily tasks rather than spending time with people. We observed lunch on two floors of the home and both mealtimes appeared hurried, with little interaction between the staff and the people who used the service. However, on the second day of the inspection we observed a significant increase in interactions between staff and the people who used the service. We observed staff sat with people for long periods of time, talking to them and holding their hands. We saw and heard how people had a good rapport with staff. We saw a member of care staff painting a person's nails, together with the hairdresser proactively interacting with people living at the home. We also observed more people sat in groups or at tables, talking to each other.

We observed the lunch time experience on the ground floor during the second day of our visit and saw a noticeable increase in interactions between staff and the people who used the service. We saw there weren't any menus on the tables and there was no menu board displayed. Pictorial menus were also not available to help people visualise the planned meals if people no longer understood the written word. The registered manager told us that the they would look into putting a 'today's menu meal board' in each dining room, together with menu cards for all dining room areas.

We observed people who required assistance being helped to the dining room. One care staff member assisted a person by putting their arm under the person's arm and provided encouragement and reassurance throughout. People were offered a choice of drink and care staff knew which people had hearing problems and approached them separately and spoke in their ears. People chose where to sit and unlike the first day of our visit we observed no-one was sat on their own. There was a lot of interaction at the tables, with people having conversations among themselves or with staff members. We observed one member of staff sit with a person who required assistance and provided encouragement throughout. The care staff member noticed a person at another table hadn't started eating so went over to assist and encouraged the person to eat. The same staff member noticed later that the person was still struggling with their meal so suggested using a spoon instead and assisted. One person did not want anything to eat so was escorted back to her room and staff offered to get her a sandwich later.

We saw staff asked people if they had finished before removing plates. Other people pushed their plates to one side so staff knew they were finished. People were offered drinks throughout the meal and one person asked for a second dessert, which staff provided. One person asked for a cup of tea in their room and staff told them they would bring one along once everyone else had finished.

We discussed the different atmosphere in the home on the two days of our visit with the registered manager. They told us that on the first day there where two very ill people in the home. Staff were concerned and were spending additional time with these two people.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and when we spoke with them were able to describe people's care preferences and routines. People we saw were generally well presented and looked comfortable. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. We saw people's bedroom doors were closed unless people asked for them to be left open and people were also offered a key for their bedroom door if they wished to lock their door for added privacy. This meant that staff treated people with dignity and respect.

One person told us his wife also used to live at the home and she was a very clean and tidy person. The person looked after his own bedroom, cleaning it himself, and helped in the garden. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

We saw care plans were in place for people's individual daily needs such as mobility, personal hygiene, nutrition

Good

Is the service caring?

and health needs. Staff knew the individual care and support needs of people, and this was reflected in people's care plans. The care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They also detailed what the person was able to do to help maintain the person's independence and we saw these plans were regularly reviewed.

We saw care plans were person-centred and helped staff plan all aspects of people's life and support, focusing on what was important to the person. We found that care records reflected personal preferences and wishes, for example, "[Person] likes to spend the day downstairs, they take their meals in the main dining room and spends the day either watching the TV or beside the fish tank." We observed the person enjoying watching the fish in the fish tank on the day of the inspection. This meant that care and support was delivered in the way the person wanted it to be.

Good

Is the service responsive?

Our findings

We found that risk assessments were in place as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or ensured people were eating and drinking. This meant that risks could be identified and action taken to reduce the risks and keep people safe. Standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

We noted that there were some gaps in risk assessments and care plan reviews from December 2014 to May 2015. However, from the end of May 2015 risk assessments and care plans were reviewed on a monthly basis, or more frequently as required, and were up to date. The registered manager told us that this was due to nursing staff shortages earlier in the year.

We saw pre-admission assessments were carried out and people's needs were assessed before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure people's safety and comfort. Following an initial assessment, care plans were developed detailing the care needs and support, actions and responsibilities, to ensure personalised care was provided to all people. The care plans guided the work of care team members and were used as a basis for quality, continuity of care and risk management.

Daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility, nutrition, activities and interests. The daily notes were written in black ink, dated and were signed and completed by the staff providing care and support. This was necessary to ensure staff had information that was accurate so people could be supported in line with their daily needs and preferences. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift. Information about people's health, moods, behaviour, appetites and the activities they had been engaged in were shared, which meant that staff were aware of the current state of health and well-being of people.

The home employed a full time activities coordinator who arranged the activities at the home and coordinated staff to carry out activities. We saw the activities schedule included movies, trips, pamper sessions, church services, quizzes and bingo. We also saw forthcoming events advertised, which included a Halloween party, a singer visiting the home and activities with local school children who visited the home on a Friday afternoon. We also saw photographs of previous activities and events, which included a visit by Zoolab, a trip to the Sealife centre and visits to a local garden centre.

During our inspection we saw approximately 20 people who used the service, visitors and members of staff enjoying the entertainment provided by a visiting singer and also observed people taking part in arts and crafts activities with local school children. These activities took place in the large downstairs lounge however on the first day of our inspection we did not observe much interaction between staff and people who used the service on the other two floors of the home. People were predominantly sat in rows of chairs in the lounges, with little stimulation. However, on the second day of the inspection we observed staff sitting with people, making conversation and carrying out individual activities.

We asked people if there was much to do at the home. One person told us he was a keen gardener and we observed him helping to maintain the garden at the rear of the home. We also observed a member of staff taking a person who used the service out to the shops in a wheelchair. Family members told us, "In terms of activities, we struggle to see any evidence of it. They have said that there have been singers on but not chair exercises. I think that they have a new activities co-ordinator; there have been some trips out", "I think they have had the children coming in to sing. I don't join in, it's not my cup of tea. As long as I have the TV I am quite happy" and "There was a trip the other day. They have had singers. There is a Halloween party coming up. The girl has just taken over, she seems to be getting it together".

Good

Is the service responsive?

We looked at how the provider managed complaints. We saw a copy of the provider's complaints policy on the wall in the foyer. We looked at the complaints file and saw there had been 12 complaints recorded since 1 January 2015. We saw copies of complaints forms, which included the date the complaint was received, who it was received by, details of the complainant, details of the complaint, what the complainant's desired outcome was, immediate steps to be taken, steps taken to investigate the complaint, findings and conclusions, whether the complainant was happy with the outcome, steps taken to prevent a reoccurrence and who else was notified. We looked at complaints records and saw copies of meetings, letters and emails sent to complainants and copies of safeguarding referrals where appropriate. All the complaints we looked at had been dealt with appropriately. This meant the provider had an effective complaints process in place.

We asked people who used the service and family members whether they had ever made a complaint. A family member told us, "I have never had to complain. He has been looked after really well." Another family member told us, "The laundry and lack of clothes was an issue but I think that it is now being addressed."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

We looked at what the provider and registered manager did to check the quality of the service, and to seek people's views about it. We saw records of daily walkabouts and flash meetings. We discussed these with the registered manager and looked at records. The daily walkarounds included a 10 point checklist for the premises, people who used the service, staff, records and charts. Daily flash meetings were held between the registered manager and department heads and discussed any specific issues. We saw these records were up to date. The registered manager told us that senior care staff were also tasked with a walkaround at 11am each day to check people's rooms and record any issues or observations.

We saw the registered manager held regular clinical governance meetings with the senior staff and discussed clinical effectiveness, audit processes and training.

We saw staff were regularly consulted and kept up to date with information about the home and the provider. Six monthly staff surveys took place and asked staff about their level of satisfaction, teamwork, communication, training, support received and supervisions and appraisals. Staff we spoke with felt supported in their role. They told us, "She [registered manager] does support us, she'll help to try and sort things out."

We saw three care records per week were audited by the registered manager or deputy manager. Monthly audits took place and included accidents and incidents, the dining experience, mattresses, infection control, complaints, activities and health and safety. We saw copies of these audits in the file, including the latest dining experience audit which took place in September 2015 and included checks that the meals were appropriate, mealtimes were enjoyable and sociable, alternative meals were available, food presentation and quality, environment, respect for dignity and refreshments. We saw the safeguarding audit included checks that staff were aware of safeguarding issues, any person deemed vulnerable or a risk to others had a care plan in place, the risk monitor report had been completed, referrals had been communicated appropriately and next of kin and relevant healthcare professionals had been notified of any incident.

We saw a copy of the most recent health and safety audit, which took place on 30 September 2015 and included fire safety, cleanliness, laundry, electrical equipment, bed rails and water temperatures. An action plan was put in place for any identified issues, for example, three nurse call bells were missing and two toilets were cracked. We saw these had been actioned.

The registered manager told us monthly management meetings were held with the provider, where the provider would discuss with home managers issues that were relevant to all the homes and issues specific to an individual home.

We saw records of residents' and family meetings, which took place regularly. Subjects discussed at these meetings included trips and activities, the garden, church services, staffing and the treasurer's report.

We saw a six monthly relatives' survey took place and looked at records from the most recent survey in June 2015. Topics included level of satisfaction, teamwork, care provided, activities, communication, staffing levels, leadership, manager availability and confidentiality. We also saw a 'Quality survey' had been sent to family members in February 2015. 16 responses were received and we saw most responses to questions were rated either excellent or good. For example, all 16 of the responses rated the manager's attitude as either excellent or good, 15 rated staff attitude either excellent or good and 14 rated the atmosphere in the home as either excellent or good. We also saw copies of questionnaires provided to people who used the service in May 2015. Questions included the quality of the home, staff, daily care, social activities, food and catering and democratic rights. We also saw a 'Questionnaire, suggestions and comments feedback' board in the foyer, which provided an update on what the home had done in response to feedback.

People who used the service and family members told us, "I must say that I have only been to one meeting but I don't like going to meetings. That's my fault, I don't like it. I think they are once a month. It's just not my thing", "Oh yes I have just done a survey from the company and one from the County Council", "Yes they have meetings. We have the

Good

Is the service well-led?

Friends of Lindisfarne and we meet on the first Saturday of every month it is just relatives and friends of relatives", "I have never been to any meetings. I am quite happy here" and "I used to go to the meetings but I stopped going as you go over the same things over and over again. I found them repetitive. They are not at the time I can go. They provide feedback printed from the meetings. We sometimes get surveys from the home, the last one we got was from head office".

This meant that the provider gathered information about the quality of their service from a variety of sources.

The service had good links with the local community. There was a church directly behind the home and the registered manager told us a 'dementia café' used to be held there but had now stopped. The registered manager had contacted the Alzheimer's Society to see if they would start up the café again and had offered to host the café at Lindisfarne Care Home on a monthly basis. The home also had a good relationship with the local primary school and children visited the home every Friday afternoon to carry out activities. The registered manager told us that two people who used the service attended a local day centre. The home also had links with a local college and university and offered placements at the home.