Care Quality Commission

Gainford Care Homes Limited

Lindisfarne Birtley

Inspection report

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Birtley
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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

Overall summary

This was an unannounced inspection which we carried out on 24 June 2015.

We last inspected Lindisfarne Birtley in October 2014. At that inspection we found the service was not meeting all its legal requirements with regard to staffing levels, respect and involvement, staff training, record keeping and monitoring the quality of service. At this inspection we found that action had been taken to meet the relevant requirements.

Lindisfarne Birtley provides accommodation over three floors for up to 66 people who need support with their personal and health care. The home mainly provides support for older people many who are living with dementia. The home also provides support to some younger people with an acquired brain injury and/or mental health needs.

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

Summary of findings

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.

Several changes had taken place since the last inspection to improve the outcomes for people who lived at the home especially for people who live with dementia.

Staffing levels had been increased to the top floor of the home and two units had been created on this floor from the one larger communal area to provide care and support to smaller groups of people. This also improved the dining experience for people who lived with dementia on this floor. This model of care was planned to be provided to the middle floor of the home to promote individual care.

People received their medicines in a safe and timely way. However we have made a recommendation about the management of some medicines.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff had other opportunities for training to give them some insight into the specialist needs of some people.

Lindisfarne Birtley was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). 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 themselves.

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

The environment was better designed to encourage and maintain peoples' independence and orientation.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for.

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 treatment they needed.

Staff were caring and patient and had time to spend talking with people. People who lived with dementia were more involved in daily decision making.

Record keeping had improved to reflect the care and support provided by staff and to ensure people's needs were safely met.

Activities and entertainment were available for people.

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.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People said the registered manager was supportive and approachable.

The quality assurance system had improved and the provider undertook a range of audits to check on the quality of care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Regular checks were carried out to ensure the building was safe and fit for purpose.

Staffing levels were sufficient to meet people's needs safely and flexibly.

People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as 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.

Appropriate checks were carried out before staff began work with people.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

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

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.

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

The environment was designed and adapted to help people who lived with dementia to be aware of their surroundings and to receive more individual care.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Staff spent time interacting and talking to people and they were all were encouraged and supported to be involved in daily decision making.

Summary of findings

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

Is the service responsive?

Requires improvement

The service was responsive.

Staff were knowledgeable about people's needs and wishes. People received support in the way they wanted because record keeping had improved. However all changes in people's care needs were not always detailed in care plan reviews to ensure they reflected people's current needs.

There were activities and entertainment available for people.

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 for the benefit of people lived in the home.

A registered manager was in place. Staff and relatives told us the registered manager was approachable.

Staff and relatives were enthusiastic about the changes that had taken place to ensure the service provided more individual care to people.

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

Lindisfarne Birtley

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 24 June 2015 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist nursing advisor. 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. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

During the 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.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. During the inspection we spoke with 20 people who lived at Lindisfarne Birtley, seven relatives, the regional director, the deputy manager, two nurses, 13 support workers, two visiting professionals, the maintenance person and two members of catering staff. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for 14 people, the recruitment, training and induction records for four staff, ten people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We also contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We had received information of concern from the health authority and saw the action that had been taken to address these concerns at the inspection.

Good

Is the service safe?

Our findings

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. Comments included, "I feel safe here," and "Staff are around when I need them." "I don't wait long if I buzz for help." Relatives commented, "The staff are always around," and "The home is lovely, there are always enough staff to care for people."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found five concerns had been logged appropriately. Safeguarding alerts had been raised by the home and investigated and resolved to ensure people were protected.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and were able to tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. One staff member said, "I'd report any concerns to the manager or senior on duty." Another told us they had raised a concern with regard to a person's finances and this had been reported to safeguarding and the police and had been investigated and resolved. Staff were aware of the provider's whistle blowing procedure and knew how to report any worries they had. Staff members confirmed they had received local authority safeguarding training in November and could describe the role of the different agencies if a safeguarding alert was raised.

We spoke to a visiting professional who told us a person who required supervision and support knew the door entry code to leave the unit and on occasion left the building without staff knowledge. The regional manager told us the door entry codes would be changed so the person would not be able to leave the unit unsupervised thus reducing the risk to the person. We checked after the inspection to ensure that the necessary action had been taken to keep the person safe.

People received their medicines in a safe way. We observed medicines rounds on two floors. Medicines were administered by the nurse for people with nursing needs and the senior support worker, who was responsible for administering medicines to people with non-nursing needs. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. We saw omissions were recorded but no reason for the omission was recorded on the reverse of the MAR sheet as recommended in the home's medicine policy. The nurse told us this would be addressed.

Medicines were given as prescribed and at the correct time. Both staff members told us medicines would be given outside of the normal medicines round time if the medicine was required for example, for pain relief.

All medicines were appropriately stored and secured. Staff were trained in handling medicines and a process had been put 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.

We saw two people who were prescribed covert medicines refused their medicines. Covert medicine refers to medicine which is hidden in food or drink in their best interests. We saw the two staff responsible for the medicines used other ways to encourage the people to take their medicine rather than give it covertly. Both staff members left the people without trying to force them to take the medicine. They returned at the end of the drug round, one person took the medicine and the other was reluctant until the senior support worker suggested a "Rolo" afterwards and the medicine was then taken. The senior support worker told us, "I would try anything rather than use covert medicines and generally the person will take them, you just have to be patient." This was echoed by the nurse who said, "Usually a person takes the medicine with persuasion."

Documentation for three people who required covert medicines showed the GP had authorised the decisions for the use of covert medicines, where people did not have mental capacity. However, the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people that included the

Good

Is the service safe?

pharmacist. A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, moving and assisting and nutrition.

Regular analysis of incidents and accidents took place. The deputy manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls, a person who had fallen more than twice was referred to the falls clinic.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs and it was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

There were enough staff to meet people's needs. The deputy manager and regional manager told us staffing levels were determined by the number of people using the service and their needs. At the time of our inspection there were 61 people who lived at the home who were supported by two nurses and 12 support workers including two team leaders and two senior support workers. Relatives commented, "The days I visit there are always enough staff around," and "The staff are always around and they are going up and chatting to people all the time." "You never have a problem finding a member of staff they are just there."

Changes had taken place on the top floor to help make care to people more individual. The deputy manager told us two units had been created on the top floor and staffing levels had been increased to provide care and support to people on each unit. We observed care was more relaxed and personal on the top floor whereas to the middle floor it was more hurried and less individual. The registered manager told us after the inspection two units on the middle floor had been created and staffing had been increased because of adopting this model of care. There was an existing smaller unit on the lower ground floor which accommodated younger people some whom had a high degree of physical dependency and some distressed behaviour. Staffing levels were adequate at the time of inspection but we were told they would be kept under review because of the changing needs of people on this unit.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four 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 they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes were also available.

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 for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, 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 promptly. 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 had opportunities for training to understand people's care and support needs. They told us they thought training was appropriate and they were able to access training and could make suggestions for training. Comments included, "There's plenty of training." "I've completed my safeguarding training," "I've done dementia care training," and "I've done Mental Capacity training."

Staff told us when they began work at the service they completed a twelve week induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One new staff member who had recently changed their role commented, "I have had good support from the staff and to start with I just watched what was happening on the first day and then I assisted another member of staff until I felt confident about what I was doing. I have learned a lot." A team leader commented, "If you feel specific training is appropriate you can request it and the management will often support and sometimes incorporate it in the induction training."

The staff training records showed staff were kept up-to-date with safe working practices. The regional manager told us 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 dementia care, catheter care, end of life care, distressed reaction, syringe driver, nutrition, mental capacity, confidentiality, mental health awareness and equality and diversity. Staff told us they had completed National Vocational Qualifications (NVQ) at levels two and three, now called the diploma in health and social care.

Staff told us they were well supported to carry out their caring role. They told us they received regular supervision every two months from senior staff and nurses received supervision every two months from the registered manager. Staff also commented they received an annual appraisal to review their work performance. They told us they could approach the management team at any time to discuss any issues. Comments included, "The manager and senior staff support us and we can speak to them any time about any issues or concerns," "It's a good place to work," and "We are fine with staffing and we all work well together and support each other."

CQC monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and Deprivation of Liberty Safeguards(DoLS). DoLS are part of the MCA. They are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that three applications were being considered and seven people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused to bath or to receive assistance with personal care.

We saw people were encouraged to make choices about their food. A menu on dining room walls advertised a choice of two hot meals and two puddings, for the main meal served at lunch time. Food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received nice food. One person commented and we observed that portion sizes were large for some people. Another person commented, "The meals are good every day. I ask for a salad and that is what I get. There's always plenty of choice." Hot and cold drinks were available throughout the day and arrangements were in place so people could also get their own from the drinks dispensers in the dining rooms.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against

Good

Is the service effective?

the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. Referrals were also made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause. Special diets were catered for and the cook on duty could tell us about people's dietary requirements and who required a special diet. However, we did not see a formal system to inform the kitchen if a person's nutritional needs changed. This was important if there was a different cook who did not know people's dietary needs as well as the regular cook.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Comments from people included, "The home have arranged for an optician to call, my new glasses have made a big difference, I can read again," and "I see a chiropodist and hairdresser and I'm quite happy." Staff received advice and guidance when needed from specialists such as, the dietician, optician, speech and language teams, behavioural team and GP. Records were kept of visits and any changes and advice was reflected in people's care plans.

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. A staff member commented, "Communication is really good."

Relatives told us they were kept informed by the staff about their family member's health and the care they received. Some commented, "They always let me know about appointments," and "I'm always kept informed."

Improvements had been made to the environment to help people who lived with dementia to maintain some independence. People were able to identify different areas of the home. There was appropriate signage and doors such as lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence. Memory boxes had been completed for some people that contained items and information about people's previous interests and they were available outside some people's rooms to help them identify their room. They also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

We saw pictorial aids and orientation aids were available to help people relax or remain involved and be aware of their surroundings.

The top floor two units were themed and the corridors were also themed to provide some stimulation for people as they sat in one area or moved about. Walls were decorated with pictures and themes included eggs, plants and the sea. Some people who used the service and their relatives had been involved in the painting. We were told the units on the top floor were decorated monthly and adopted a different theme each month. We saw a summer theme was being used which involved staff and people making origami butterflies which were hanging from the ceilings.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were positive about the care provided by staff. Comments included, "The staff are marvellous, I am quite content here," "I am very happy here," and "I'm happy with the care and the staff are nice and friendly." "Some of the staff are good others aren't so good." Relatives commented, "Staff are welcoming when we come to visit and nothing is too much trouble for them," "We have been really happy with the care (name) receives and with the support staff have offered us." "We saw people who live here come first and that's the way it should be," and "I think the care is outstanding." A visiting professional also commented, "Staff are friendly, approachable and caring with people."

We observed the improvements to people's care and mood because of the motivation and enthusiasm of staff and changes to the environment on the top floor. Staff had time to spend talking with people about things that interested them and 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 on the top floor told us they were very excited and enthusiastic about the changes to create smaller group living units. They commented, "It's so much better than it used to be, I love coming to work." And "We've more time for people, it's more personal and individual," and "We have time for everything, it's lovely." We observed there was a camaraderie and friendly competiveness amongst staff on the two units. Staff were eager and took a pride in telling us how they were improving people's care on the units. A newly appointed team leader commented, "The team work is amazing on this floor." We heard staff were motivated and more than one staff member said it was a "Pleasure to come to work." The team leader described plans to recreate a 1950's diner on the unit with the involvement of relatives to help decorate the walls and make some props such as a juke box.

We observed the atmosphere was calm, relaxed and tranquil. We saw two people who previously spent time sleeping were more involved and aware of their surroundings. On previous inspections the environment was sometimes noisy and people who had distressed behaviour had reacted and become more distressed or agitated so upsetting other people. We saw staff engaged with people in a quiet and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, when they offered assistance to people as they moved to the dining table for lunch or when a staff member offered a person a choice of drink at coffee time.

We saw that care was provided in a flexible way to meet people's individual preferences. For instance, two people had a late breakfast as they had been having a long-lie in bed.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, 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.

We observed the lunch time meals on all floors of the home. The meal time was relaxed and unhurried. People sat at tables set for three or four and staff remained in the dining area to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served.

Staff treated people with dignity and respect. We saw they knocked on people's doors before entering their rooms and staff ensured any personal care was discussed discretely with people. We observed that people looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room. One or two had their doors open and we saw staff stopped and had a chat as they passed by.

Good

Is the service caring?

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at where these were in place showed the relevant people were involved in these decisions about a person's end of life care choices.

There was information displayed in the home about advocacy services and how to contact them. Advocates can represent the views for people who are not able to express their wishes. We were told one person had the involvement of an advocate.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Care plans were developed from the assessments that outlined how these needs were to be met. Care plans were individual and provided information so staff could provide support in the way the person wanted. For example a care plan for mobility detailed the type and size of sling, "Medium sling and green hooks," and for personal hygiene, "(Name) will wash face with a flannel and staff will assist with rest of body. (Name) uses Dove soap and never shower gel."

Staff were aware of people's care and support needs and most care plans reflected people's needs. However, the monthly review of care plans did not capture or accurately reflect people's needs if they had changed. For example, for some people we saw where people's needs had changed the care plan was not always reviewed more regularly and changes reflected in the care plan, although the information was available in the daily records. A person was being nursed in bed but this change was not detailed in the person's care plan. Another person's care plan for pressure area care did not detail the location of the reddened area or details of the need to be now nursed in bed. A review of a care plan for a person falling did not note the incidence of falls in the review and the progress that had been made due to the reduction in falls. A care plan evaluation for distressed behaviour for a person did not record the progress although the person's daily records showed the incidence of behaviour was less. This progress was not reflected so it could be accurately monitored and to show the continuous care provided.

Staff responded to people's changing needs and arranged care in line with people's current needs and choices. The service consulted with healthcare professionals as required about any changes in behaviour and medicines. A relative told us, "Since (name) came to live at the home, staff identified concerns with (Name's) health and they acted promptly to seek medical advice." Another person had a care plan for distressed behaviour as they became upset at raised noise levels. The plan provided detailed guidance about the actions to be taken when the person became distressed. This included giving them time on their own, going back frequently to check and to sit and chat with them as they became calmer. Staff confirmed this approach was working well as the person enjoyed individual time with staff but also "needed their own space."

Daily records were completed by support staff, we saw they were stored appropriately to protect people's confidentiality. The chart included for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. The turning charts however did not record the positional changes of the person as they were nursed in bed but rather included comments such as "asleep." Other charts completed included for distressed behaviour and personal hygiene. Food and fluid charts were also completed to monitor people's dietary and fluid intake each day where they had been identified there were possible issues with nutrition.

Detailed information was available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information about their life history, likes and dislikes which gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. Information was also available with regard to their wishes for care when they were physically ill and reaching the end of their life, or arrangements for after their death. For example, to record their spiritual wishes or funeral requirements.

People confirmed they had a choice about getting involved in activities. And an activities plan advertised what was available. An activities person was employed to organise activities across the home and we saw staff were more engaged in the provision of activities when the activities organiser was not on duty. For example, staff on the top units told us they were involved in helping people take part in arts and crafts. They also spoke of other ideas and plans to stimulate and engage with people who lived with dementia. They described a project to provide some sensory equipment so people may relax and be stimulated. Photographs showed regular entertainment and seasonal parties took place in the home. We saw there were a variety of board games and jigsaws available for people on the younger person's unit. Staff told us people were assisted to follow previous interests and hobbies. For example, a person attended a day service. Other people had been out for pub meals. A group of people had been to Beamish Museum. Some staff members said they came in on days

Requires improvement

Is the service responsive?

off to accompany people on the outings or to go out individually with people to the shops. A visiting professional however commented, "I don't think there's much in the way of activities," and another person commented, "There are never any activities going on." This was discussed with the deputy manager.

The complaints procedure was displayed in the entrance to the home. People said they knew how to complain. Comments included, "I know how to, but I haven't needed to." "The manager (Name) is very approachable and I just speak to them." One complaint had been received since the last inspection and investigated appropriately.

Good

Is the service well-led?

Our findings

A manager was in place who registered with the Care Quality Commission in 2014. The registered provider had submitted statutory notifications to the Care Quality Commission, such as safeguarding applications, applications for Deprivation of Liberty Safeguards and serious injuries.

Staff and relatives said they felt well-supported Comments included; "The manager is lovely-very approachable," and "I can speak to the manager any time." Staff told us that morale at the home was now good and people were enthusiastic about their role and they all worked as a part of a team.

People told us the atmosphere in the home was warm and friendly and relatives said they were always made welcome and they could visit at any time.

We saw improvements had been made to the running of the home since the last inspection. The management team had been increased to support the registered manager as a deputy manager, who was also clinical nurse lead had been appointed. An external management team had also been strengthened by the registered provider to support home managers. There was an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Physical changes had taken place in the environment, by changing room layout, which helped to promote a culture that promoted person centred care, for each individual. Experiences for people who lived with dementia were improved to increase their well-being. Record keeping had improved so information was available to help staff provide care in the way the person may want, if they could not verbally tell staff themselves. Staff were positive and enthusiastic about their work and they took a pride in what they achieved especially on the top floor units. Changes to the environment on the top floor units helped to keep people engaged and stimulated.

Regular meetings were held with residents and relatives. The deputy manager said relative's meetings provided feedback from people who used the service and their relatives about the running of the home. We saw areas of discussion included, menus and changes in the home. We saw any comments or suggestions that had been made by people were discussed with staff so any relevant action was taken.

Staff told us regular staff meetings took place and these included nurses and senior meetings and general staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues. Minutes showed meetings had discussed care planning, communication, risk assessments, medicines and record keeping. We saw a new template that had been introduced for clinical governance meetings. It listed areas to be discussed at each meeting with dates for any required action and who was responsible for the action included so actions required could be addressed in a timely way and progress fed back at future meetings.

Records showed audits were carried out regularly and updated as required. The regional manager told us a number of new audits had been introduced that were to start on 1 July 2015. These were to strengthen the quality assurance process carried out by the home and provide some external scrutiny of the care provided by the service, we saw they were extensive as they covered areas in more depth. New audits included monthly checks of mental capacity documentation, safeguarding, Do not Resuscitate (DNACPR) paperwork, people's dining experience and a monthly financial audit. Monthly audits currently in place included checks on, documentation, staff training, medicines management, infection control, accidents and incidents, finances, nutrition, falls and mobility and pressure area care. Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. Annual audits were carried out for fire risk and health and safety. A financial audit was carried out by a representative from head office annually. The regional manager told us monthly visits were carried out by a representative from head office to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and a range of survey questionnaires that were sent out annually to staff, people

Good

Is the service well-led?

who used the service and visiting professionals. We saw a letter dated April 2015 was sent out to people who completed the surveys to inform them of the action taken with regard to individual comments made. For example, with regard to the menu and décor. The survey results were also displayed in the hallway of the home.