HC-One Limited

Bishopgate Lodge 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 30 November and 3 December 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Bishopgate Lodge Care Home provides care and accommodation for up to 46 people with personal and nursing care needs. On the day of our inspection there were 46 people using the service.

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.

Bishopgate Lodge Care Home was last inspected by CQC on 30 September 2013 and was compliant.

Summary of findings

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.

Thorough investigations had been carried out in response to accidents and incidents.

People were protected against the risks associated with the unsafe use and management of medicines however some records were inconsistent.

Staff training was up to date and staff received regular supervisions. Some appraisals were overdue but were planned.

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

People were protected from the risk of poor nutrition however some food and fluid charts were not consistently 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.

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. The provider was working within the principles of the MCA.

All of the care records we looked at contained evidence of consent being obtained from people or family members.

People who used the service, and family members, were complimentary about the standard of care at Bishopgate Lodge 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 full programme of activities in place for people who used the service.

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

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 who used the service and the provider had an effective recruitment and selection procedure in place.

Thorough investigations had been carried out in response to accidents and incidents.

People were protected against the risks associated with the unsafe use and management of medicines however some records were inconsistent.

Good

Is the service effective?
The service was effective.

Staff training was up to date and staff received regular supervisions. Some appraisals were overdue but were planned.

People were protected from the risk of poor nutrition however some records were inconsistent.

The provider was working within the principles of the Mental Capacity Act.

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

Good

Is the service caring?
The service was caring.

Staff treated people with dignity and respect.

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.

The home had a full 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 the registered manager was approachable and they felt supported in their role.

Good

Summary of findings

The service had good links with the local community.

Bishopgate Lodge 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 30 November and 3 December 2015 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. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and the infection control team. No concerns were raised by any of these professionals.

For this 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 eight people who used the service and seven family members. We also spoke with the registered manager, deputy manager, cook and five members of care staff.

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 and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at Bishopgate Lodge Care Home. They told us, “Yes, I feel safe here” and “Very safe”. Only one family had any concern about care and that related to a fall by their family member. They told us, “We have been told different accounts of what happened so we are going to see the manager shortly to discuss it. Otherwise care has been fine”. We saw the registered manager agreed to meet with the family to discuss their concerns.

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. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We observed staffing levels, looked at the ‘Rota planner file’ and discussed staffing with the registered manager and deputy manager. We observed sufficient numbers of staff on duty, care was not rushed and call bells were answered in a timely manner. Daytime staffing levels were a minimum of one nurse, two senior care staff and five care staff on duty. We saw that during the afternoon, when the workload was reduced, one senior care staff member was allocated to a floor to monitor effectiveness and ensure policies and procedures were followed correctly. Staff were able to request shifts by completing a ‘Shift preferences sheet’. The registered manager and deputy manager told us staff were allocated to a specific floor using knowledge and experience of which staff worked best together. Guidance on staffing and skill mix had been sought from publications such as the NHS England National Quality Board publication ‘A guide to nursing, midwifery and care staffing capacity and capability.’ We also saw the nurses and two senior care staff members rotated from day shift on to night shift to ensure continuity of quality of care.

We asked how staff absences and vacancies were covered. The registered manager told us agency staff had not been used at the home for a long time and the majority of staff absences were covered by the home’s permanent staff or staff from a nearby home, also owned by the same provider. The provider operated a ‘One extra shift’ system where staff could use the provider’s electronic system to say when they were available for additional work. We asked staff whether there were plenty of staff on duty. They told us, “Not bad, as long as people don't call in sick, we try and ring around and get it covered” and “We don’t use agencies, if we need staff we can call on the other homes. If we use agency nurses they only work night shift”. People we spoke with did not raise any concerns about staffing levels. This meant there were enough staff with the right experience, skills and knowledge to meet the needs of the people living at Bishopgate Lodge Care Home.

The home is a three storey building 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 and there were no unpleasant odours. We saw appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. This meant people were protected from the risk of acquired infections.

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.

We saw Portable Appliance Testing (PAT), gas servicing, Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 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, fire risk assessments were in place, a fire inspection and service had taken place recently and fire extinguisher checks were up to date.

We saw risk assessments were in place and included lone working, use of electronic equipment, moving and handling, fire, kitchen and laundry equipment and use of oxygen. The service had an emergency and a contingency plan and emergency and evacuation instructions were in

Good

Is the service safe?

place for each person who used the service. These were colour coded based on low, medium and high risk. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We looked at the safeguarding file and saw a copy of the provider's safeguarding policy and procedure. We saw records of safeguarding incidents, which described the incident, level of risk using the local authority risk threshold tool, action taken and who the incident was reported to, for example, local authority safeguarding team, police or CQC. Staff we spoke with told us they had been trained in safeguarding and whistleblowing and would know what to do if needed.

We saw copies of incident and accident review forms, which were electronically recorded and analysed for any trends. We saw the home had a 'Falls champion' and looked at the falls prevention and management policy. A monthly falls prevention meeting took place, which analysed who had fallen and where and when the falls happened. An action plan was produced for each person at risk and we saw one person's action plan included, "Safety checks performed day and night" and "Ensure resident risk assessments/care plans accurately reflect current needs". We saw up to date copies of moving and handling and falls risk assessments in the care records.

We looked at the way medicines were managed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines that may be at risk of misuse. Systems were in place to ensure that the medicines had been ordered, stored, administered, audited and reviewed twice daily. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys for the treatment room. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines.

We saw staff explain to people what medicine they were taking and why. The nurse gave people the support and time they needed when taking their medicines. People were offered a drink of water and the nurse checked that all medicines were taken. 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. We saw written guidance kept with the MAR charts for the use of 'when required' (PRN) medicines, and when and how these medicines should be administered to people who needed them, such as for pain relief.

We saw refrigerator temperatures were monitored and recorded, together with the medicine room temperature. However, refrigerator and room temperatures had been inconsistently recorded during November 2015 and on 4 November and 5 November 2015 the 'actual' recording for the refrigerator temperature had been 11 degrees centigrade, which is above the recommended two to eight degrees centigrade. There were no reasons or actions recorded for these high temperatures. Refrigerator and treatment room temperatures need to be recorded to make sure medicines are stored within the recommended temperature ranges. There was limited stock in the refrigerator and the deputy manager assured us they would seek advice immediately from the pharmacist.

We also saw there was inconsistent completion of topical medicines application records. Topical medicines are applied to a particular place on or in the body, for example, creams, lotions or ointments. The deputy manager reassured us that they would address this immediately and would explore the delegation of the monitoring of the topical medicines application records to senior care staff, to ensure accurate and timely completion. We saw all other charts were completed accurately, including trans-dermal patch records, and as the previous medicines audit had taken place in October 2015 these discrepancies had not been identified.

Good

Is the service effective?

Our findings

People who lived at Bishopgate Lodge Care Home received effective care and support from well trained and well supported staff. People who used the service told us, "Staff are wonderful", "People say 'It's lovely here but…' Here there are no buts" and "The staff are really nice and do care for me". Family members told us, "The care here is very good and we know [Name] is well looked after" and "I always get an update on what has happened when I come into the home and that is comforting".

We saw copies of staff training records on the provider's electronic 'Touch' training system. The electronic system showed whether training was completed, in progress, not started yet or expired. We saw mandatory training included control of substances hazardous to health (COSHH), dignity, emergency procedures, food safety, health and safety, infection control, medicines, nutrition and hydration, dementia, person centred care, safeguarding, safe people handling, equality and diversity and mental capacity and Deprivation of Liberty Safeguards (DoLS). We also saw all staff were trained at either level 2 or level 3 in health and social care and all new staff completed an induction programme. We saw mandatory training was up to date for the staff members' training records we looked at. Staff we spoke with told us they had received all the training necessary for their role. We discussed training with the registered manager who told us the deputy manager and a senior care staff member were training ambassadors, with the role of monitoring training, allocating courses and carrying out introductory training to the electronic system.

We checked to see whether staff received regular supervisions and annual appraisals. 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. Records for the staff members we looked at showed they had received regular supervisions. Subjects discussed at supervisions included training, focus on under nutrition and intentional rounding. Intentional rounding is a structured approach where care staff conduct checks on people at set times to assess and manage their fundamental care needs.

We saw that not all members of staff had received an annual appraisal in the previous 12 months. We discussed this with the registered manager who told us appraisals for the remainder of the staff were planned for early 2016. The registered manager also told us a 'Reflection record' system had been recently introduced, in addition to supervisions and appraisals. This was in response to feedback from staff and involved a less formal chat with staff. Staff we spoke with told us they received a supervision every three months and an annual appraisal. This meant staff were fully supported in their role.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People we spoke said they liked the food. They told us, "The food here is spot on" and "The food is very nice and choice is given".

We saw there was a menu on display and a pictorial menu also available. We saw people were offered juice and/or a hot drink with their meal. We saw three people needed assistance with eating their meals. One member of staff sat with one person to assist and the other two people were assisted occasionally by a care staff member who was standing next to them. We saw mid-morning and mid-afternoon drinks and cake were also available. The cook told us when someone new comes into the home a diet assessment sheet was completed of their likes and dislikes and any special dietary needs. This was reviewed every six months and shared with staff.

We saw people were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. We saw care plans were up to date with people's dietary needs and where people were at risk of choking, a separate choking risk care plan was in place. We also saw speech and language therapy (SALT) swallowing guidelines, choking treatment emergency guidelines and individual choking risk assessments as supportive information contained within care files.

Where people were identified as being at risk of poor nutrition staff completed daily 'Food and fluid balance' charts. The food charts were used to record the amount of food a person was taking each day however there was inconsistent information documented regarding the amount of food a person consumed, for example portion sizes. Fluid intake charts were completed for a person, however the fluid intakes were not consistently recorded.

Good

Is the service effective?

The deputy manager reassured us that they would address this immediately and would explore the delegation of the monitoring of the nutritional charts to senior care staff, to ensure accurate and timely completion.

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

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 looked at the MCA/DoLS file and saw a 'DoLS application process flow chart', a copy of the provider's DoLS procedure and copies of applications submitted to the local authority, which had not yet been approved. We discussed DoLS with the registered manager, who was aware of their responsibility with regard to DoLS. This meant the provider was following the requirements in the DoLS.

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. For one person who had recently been admitted to the service, the deputy manager told us they were undertaking the assessment on the day of the inspection. We saw people had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. We were told that one person self-administered one of their medicines and we saw a 'medicine capacity' assessment in place, which was reviewed on a monthly basis. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files 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 original home address was entered on the form and the deputy manager reassured us that they would contact the GP immediately to address this.

People's care records showed details of appointments with and visits by health and social care 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. These included GPs, social workers, dietitian, speech and language therapists (SALT), tissue viability nurses, chiropodist and podiatrist. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various healthcare and social care agencies to ensure that the individual needs of the people were being met and to maintain their health and wellbeing.

We discussed the design of the home with the registered manager. Recent improvements had been made to the building to make it more dementia friendly. Accommodation was provided over three floors. All the bedrooms included a hand basin and some also included en-suite bathrooms. Although the corridors were quite narrow, there was sufficient room for people to mobilise safely. Carpets were clean, not patterned and contrasted clearly with walls. Communal spaces and bathrooms were spacious and free from clutter. People's bedroom doors had a room number and photograph of the person who lived there on them. Some also had other photographs to help the person identify their room, such as a photograph of a pet dog. Bathroom and toilet doors were painted

Good

Is the service effective?

yellow so they contrasted with bedroom doors. We saw photographs of local landmarks on corridor walls. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Bishopgate Lodge Care Home. They told us, "I am very happy with the care and the staff are so helpful", "We can talk to staff and raise things we may not be happy with. Everything about this home is good" and "This home feels good. People are always clean and tidy and I know my relative is happy".

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. We saw people were assisted by staff in a patient and friendly way.

The home had adopted the NHS 'Culture of compassionate care' or '6 C's' model (care, compassion, competence, communication, courage, commitment) and we saw and heard how staff and people who used the service had a good rapport and exchanged jokes and comments. We heard one staff member say to a person who had just been to the hairdressers, "You look beautiful. It has taken years off you." We observed while a care staff member was serving afternoon tea and cakes and they said to a female resident, "Would you like me to paint your nails when I have done this?" The person readily accepted. We observed another member of staff talking to a person who used to be in the armed forces and was hard of hearing. The staff member sat close to the person and talked loudly and clearly to try to identify activities the person would like to do. The staff member asked the person if they wanted to go to a war museum. The person said yes and then told the staff member they had written their memoirs. The staff member said, "I know, I've read them." This meant the staff member had taken the time to find out about the person they were caring for.

The activities coordinator had previously been a care staff member at the home and was also the dignity champion. They were able to describe what this involved. For example, twice per week they went around with staff discussing what they were doing in relation to a person's dignity such as how they were dressing people and keeping them clean and tidy. We observed staff asking permission before carrying out a care task such as moving and handling or bathing. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. People told us, "The staff are very nice, they respect my privacy and the care is spot on" and "Staff always knock on my door before coming into my room so I know I have some privacy". This meant that staff treated people with dignity and respect.

We saw advocacy information was made available to people and their family members via a file in the foyer. This included information on organisations such as Help the Aged, Age Concern, MIND, Mencap and Diabetes UK, and provided contact details for local advocates.

We looked at care records and saw that care plans were in place and included mobility, personal hygiene, communication, nutrition, medicines and health needs. The care plans gave staff specific information about how the person's care needs were to be met and also detailed what the person was able to do to take part in their care and to maintain some independence.

We saw some people who used the service were in one of the ground floor lounges without any staff present. We discussed this with the registered manager and deputy manager who told us it was people's choice to be in this 'quiet' lounge. They told us staff checked the room regularly but each person wore a pendant alarm around their neck, which meant they could call for assistance at any time but allowed them to maintain their independence. We observed the activities coordinator ask people if they wanted to help decorate the Christmas tree. One person said, "Yes, I enjoy helping". This meant that staff supported people to be independent.

Each care record contained evidence that people had been involved in writing their care records and their wishes were taken into consideration. For example, we saw an entry in one person's care record which stated, "For staff to respect their religious beliefs, for example to respect that they do not celebrate Christmas or any other holidays or their own birthday." We saw an entry in another person's care record which stated, "[Name] likes to have their hair styled every week and likes to have their hair permed twice a year. Enjoys listening to music and singing along to it and likes a joke with staff" and "[Name] does not like their curtains to be closed and likes their window to be left slightly open but all lights in room off". People also told us they could get up and go to bed when they wanted and that it was their decision as to whether they got involved in activities.

Family members told us they could visit the home any time and were always made to feel welcome. Records showed

Good

Is the service caring?

that people and family members had been involved in care planning and the care plan documentation was signed by the person or family member. This meant people and family members were involved in planning their care and treatment.

We saw end of life care plans in place for people and included specific details about people's funeral arrangements and wishes. This meant that information was available to inform staff of the person's wishes at this important time and to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

Records confirmed that 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 initial assessment was also signed by the person, or if they were unable to sign a relative or representative had signed for them. The care plans guided the work of care staff and were used as a basis for quality, continuity of care and risk management.

During the initial assessment for a new person at the home, it was identified that the person was a Jehovah's Witness. The deputy manager told us that guidance had been provided to staff and staff had been briefed on alternative religious needs. In addition, a lounge on the first floor had been left undecorated for Christmas so people who did not celebrate Christmas, and their family members could use it during the Christmas period.

We found that risk assessments were in place, where appropriate. 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 to ensure 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 Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

Assessments had been carried out that showed which people were at risk of developing pressure ulcers. We found people's care plans were up to date to inform staff about people's care and support needs. We noted that moving and turning charts and body maps were in use to monitor people's care in this area. We saw the Tissue Viability Nurse had been involved to assess people's skin condition and what was needed in terms of care and pressure relieving equipment, to minimise the risk involved. We also saw hourly intentional rounding checks were in place, which covered the 5Ps (pain, personal, position, proximity and promise). This helped to ensure that care was safe and consistent.

We reviewed the daily handover records, which were fully completed and signed by each member of staff on duty. The daily handover sheet contained a photograph of the person, their brief medical history, their level of mobility/ support needs, together with their nutritional and support needs and any key information that needed to be handed over. This meant that staff were kept up to date with the changing needs of people who lived at the home.

We saw the activities board included a list of weekly activities. These included a hairdresser visiting twice per week, arts and crafts, mobility exercises, board games, movies, bingo and karaoke. The home had its own bar as part of the ground floor lounge. We also saw other Christmas activities were planned, such as a Christmas party on 21 December, a staff carol concert on 23 December and a visit from the local nursery school to perform a nativity play.

During the first day of our visit, the hairdresser was at the home getting people ready to go to a local pantomime in the afternoon. Whilst the activities coordinator and some of the people who used the service were at the pantomime in the afternoon, we did not observe any activities taking place for the other people who remained at the home.

We looked at the activities file and saw photographs of activities that people had been involved in. These included visits by local police officers and police dogs, a line dancing group, the nursery children and pet therapy. Wi-Fi has been installed in the home for the use of people who used the service, family members and visitors. We were told some of the people used Skype to contact family members. We asked people if there was much to do at the home. They told us, "We go out in the minibus to the seaside and Barnard Castle" and "There are bus outings every week". A family member told us they struggled to get their relative out of the home because "She's always doing so much in here, sewing, games and decorating Christmas trees."

We saw a copy of the provider's 'Compliments, concerns and complaints' policy in the entrance foyer. We looked at

Good

Is the service responsive?

the complaints file and saw only one complaint had been made to the service in the previous 12 months. We looked at the complaint form and saw details of the complaint recorded, correspondence between the home and the complainant, details of what action had been taken and evidence that the complainant was happy with the outcome. People, and their family members, we spoke with told us they did not have any complaints but were aware of the complaints procedure. This meant the provider had an effective complaints procedure in place.

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.

The service had a positive culture that was person-centred, open and inclusive. People who used the service, and their family members, told us they regularly saw the registered manager who would talk to them and was "Nice."

Staff we spoke with felt supported by the management at the home and told us they were comfortable raising any concerns. They told us, "They [Management] are very supportive, we get on really well", "They're a star and they're very knowledgeable", "They [Management] always listen and respect my opinion" and "We have a really, really, good staff retention, they're loyal, dedicated and caring staff".

We saw staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff and senior staff meetings. We saw the agenda for a senior staff meeting on 2 December 2015, which included care file audits, residents' reviews, medication, named nurse/senior ownership, return from hospital documentation and any other business.

The service had links with the local community. There were regular visits made to the home by local groups and organisations including dance groups, police, church and the local nursery school.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw the audit calendar, which included a list of monthly, quarterly and twice yearly audits to be carried out, such as medicines, catering, care records, infection control, falls and health and safety. We saw copies of recent audits for health and safety, falls, medicines and infection control. Care records were audited monthly and highlighted areas for improvement, the details of the actions to be taken, the date they were to be completed by, together with the signature of the person completing the action. This ensured that the records contained accurate and detailed information, so people received care in the way they wanted and needed.

We saw records of the provider's monthly quality assurance audit visit, which included the purpose of the visit, a walk around to check the quality of care, infection control and general observations of safe people handling, the dining experience, medicines management, staffing and maintenance. Each audit also included an action plan. The actions we saw included stairwells to be cleared and care plan corrections to be made.

We saw the registered manager completed an annual 'Care home self-assessment tool', the most recent took place in June 2015. This self-assessment was an audit of the CQC five key areas and included management, resident wellbeing, environment, eating and drinking and medicines management. Each area was scored and an action plan produced as a result. The registered manager also completed a daily audit. We saw these audits were up to date and included a check of communal areas, bedrooms, equipment and laundry.

We saw records of residents' and family meetings, which had taken place. We looked at the minutes for a meeting on 29 October 2015, which was attended by 16 people including the registered manager. The agenda included new appointments, activities, plans for a gentleman's clothes sale, estates, catering, resident/relative feedback and any other business. The registered manager told us they also held a dementia forum where people and family members could discuss, comment on and ask questions about initiatives and activities that had been put in place at the home.

We saw the provider's 'Participation and strategy policy' with the aim of increasing involvement in the planning and delivery of services by people who used the service, family members and visitors. We saw people who used the service, family members and visitors were able to provide feedback via the provider's 'Have your say' interactive touch screen system in the foyer. This automatically generated an email to the provider with the feedback so it could be responded to quickly if needed. www.carehome.co.uk review cards were also available throughout the home for people and family members to provide a review of the home and answer questions on the quality of care, staff, management, facilities, food and drink and activities.

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