Helen McArdle Care Limited

Sutherland Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 17 and 18 February 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Sutherland Court in May 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Sutherland Court provides personal care for up to 74 older people, including people with dementia- related conditions. Nursing care is not provided at the home. At the time of our inspection there were 65 people living at the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was on leave of absence and an acting manager was in post.

We found that people's care was provided in a safe, comfortable and hygienic environment. Risks to personal safety were suitably assessed and managed to keep people safe from harm. There were robust safeguarding procedures which protected people against the risk of abuse. Enough staff were employed at the home, enabling people to be safely supported and have continuity of care.

The service had made appropriate arrangements for meeting health care needs and assisting people to take their medicines safely. A varied menu with choices of meals was offered and any special dietary needs were met. Nutrition was closely monitored and dietetic support was requested when needed.

Staff were provided with training relevant to their roles and responsibilities to ensure people received care that was effective in meeting their needs. Systems were in place to supervise staff and support them in their personal development.

People had been consulted about and agreed to their care and treatment. Where people were unable to give consent, formal processes to uphold their rights were undertaken.

The staff knew people well and understood their diverse needs. They were kind and caring in their interactions and promoted people's privacy and dignity. Staff treated people as individuals and supported them to make choices and decisions about their care.

Care needs were regularly assessed and people had individualised care plans which took into account how they preferred to be supported. People could pursue their leisure interests and had access to a programme of social activities for stimulation.

The acting manager provided leadership within the home and was supported by the provider's

management team. They promoted an inclusive atmosphere and encouraged people, their representatives and staff to be involved in the way the home was run.

There was a clear complaints procedure and any concerns received were taken seriously and managed in a timely way. A variety of methods were used to monitor the quality of the service and make sure any necessary improvements were implemented.

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.

Appropriate steps were taken to prevent people from being harmed and abused.

Systems were in place to identify and prevent risks to people's safety and welfare.

There were sufficient staff to provide people's care and support the running of the service.

People's medicines were safely administered by staff who were trained and assessed as being competent.

Is the service effective?

Good

The service was effective.

Staff received regular training and supervision that enabled them to carry out their roles effectively.

Care was provided with people's consent. The implications of the Mental Capacity Act 2005 were understood and implemented in practice.

People were assisted to stay healthy and access a range of health care professionals.

People were supported to have a nutritious diet and told us they enjoyed the food offered.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful in their approach.

People were cared for in ways that protected their privacy and dignity.

People were supported to make decisions and direct the care

they received.

Is the service responsive?

Good

The service was responsive.

Individuals' needs and preferences were assessed and care planned, ensuring staff had written guidance about the care each person required.

People were able to participate in a range of activities and events to support them in meeting their social needs.

Any concerns or complaints were properly investigated and acted upon.

Is the service well-led?

Good

The service was well led.

Suitable arrangements had been made for managing the home during the absence of the registered manager.

There was commitment to an open culture and the management routinely sought feedback about people's experiences of the service.

The quality of the service was continuously monitored to check people were satisfied with their care and that standards were maintained.

Sutherland Court

Detailed findings

Background to this inspection

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

The inspection took place on 17 and 18 February 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a specialist advisor.

Before the inspection, the provider had completed 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 reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted local authority commissioners who told us they had no concerns about the service.

During the inspection we talked with 21 people living at the home and eight relatives and visitors. We observed how staff interacted with and supported people, including during a mealtime. We spoke with the head of elderly care, an operations manager, the acting manager, the assistant manager, 14 care and ancillary staff and a visiting professional. We met the provider's representatives including the project manager, marketing manager, office manager, catering development manager and the head of housekeeping. We looked at eight people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People described feeling safe living at the home. Their comments included, "It's lovely and we're treated very well"; "I'm very safe, they (staff) are gentle with me"; and, "I feel secure at night. The staff come straight away if I need them." A relative told us, "My mother is safe here", and, "The staff are very good at assisting with moving and handling. My mother always gets the assistance she needs." Another visitor told us, "We visit the home regularly and have no concerns about the safety or care."

People were provided with a guide to the service that explained how they would be kept safe from abuse and about the measures in place for ensuring their safety and security. Safeguarding issues had been discussed at a 'resident and relative' meeting to help raise awareness of people's rights to be protected from harm and abuse. A poster from the local authority on how to report abuse was also displayed for information.

The staff we talked with had a good understanding of their roles in keeping people safe. They were able to access a range of policies and procedures in the home for guidance on safeguarding and related topics. All staff were provided with safeguarding training and we saw evidence that most had completed e-learning training on whistleblowing (exposing poor practice). The provider operated a confidential whistle-blower hotline and a poster about this was displayed in the staffroom. The provider had introduced a 'duty of candour' policy. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

Safeguarding incidents were reported to the relevant authorities and a log was kept with details of the outcomes. The acting manager told us appropriate action was always taken to ensure people's safety. For instance, staff carried out extra checks following incidents of potentially harmful behaviour between people living with dementia. Arrangements had been made for reassessments when there were concerns that people's needs could no longer be safely met at the home.

There were safe systems for the handling of personal finances. The service had established where people were supported with their finances by relatives or representatives, including whether they had legal status such as power of attorney. All cash deposited was checked in by the home's administrator and the acting manager. Records of expenditure were held electronically and transactions were suitably recorded and backed by receipts. A full financial audit had last been conducted six months ago. Weekly balance and cash checks were carried out and the office manager confirmed that monthly internal audits were being implemented to keep closer scrutiny on the safekeeping of people's money.

Recruitment information demonstrated that all necessary pre-employment checks were completed before new staff started working at the home. These included obtaining application forms, proof of identity, criminal records checks and interviewing applicants to determine their suitability. Two references were sought, including one from the last employer. We brought to the attention of the management that reference requests had not always been made directly to the previous employer and this was followed up during the inspection.

The numbers of care staff on duty were based on the numbers of people living at the home and their levels of dependency. At the time of the inspection there were 11 care staff on duty during the day and 6-7 at night, including seniors across all shifts. The operations manager and acting manager kept the staffing levels under review at monthly meetings to ensure sufficient care staff were being deployed to meet people's needs.

During our visits we observed that staff worked at a steady pace and had time to converse and socialise with people. Records were kept confirming that care staff carried out at least hourly 'comfort checks' to check on each person's welfare. External agency staff were not used at the home. The staff team and, at times, staff from the provider's other care services covered absence to enable people to receive continuity of care. The home's management and senior managers operated a tiered on-call system outside of office hours. This meant that staff were able to get advice and support when needed and could escalate any emergencies.

Assessments were completed which identified any risks involved in people's care delivery, such as moving and handling, falls, nutrition and skin integrity. Measures to reduce risks were specified and built into care plans according to the individual's vulnerabilities. For instance, where a person was frail and cared for in bed, appropriate steps had been taken to protect their personal safety. These included provision of a pressure-relieving mattress and bed-rails, a pureed diet due to risk of choking and routine checks by staff to prevent social isolation. Staff completed additional records of the support they had given with personal hygiene, positional changes, fluid intake and the application of topical medicines. We observed the person looked comfortable and well cared for and it was evident that potential risks to their safety and welfare were being well managed.

Suitable aids and equipment were provided including profiling beds, specialist mattresses, crash mats and hoists, slings and slide sheets for safe moving and handling. People told us they were happy with their accommodation and the facilities within the home. A relative told us their family member had brought their own made to measure furnishings which were essential for their safety.

We saw accidents that had occurred were properly reported and followed up. For example, referring a person who was at higher risk of falling to a specialist falls team for support. Accidents reports were reviewed by the operations manager and analysed on a monthly basis to check for any trends.

There was a calm and welcoming environment and all areas of the home were bright, clean and comfortable, with no odours present. A relative told us, "The home is always clean and attractive." We saw that staff wore clean uniforms and used personal protective equipment when necessary, which was available around the home. Cleaning schedules were worked to and products were kept in their original containers, clearly labelled and locked away when not in use. Housekeeping staff were mindful of keeping their trolleys with them as they worked and used wet floor signs to prevent potential hazards. The home was supported by a dedicated estates team and maintenance personnel. Regular audits were undertaken to ensure the environment was well maintained and to check standards of hygiene, safety and infection control.

The external doors, stairwells and the lift were protected by electronic keypads to ensure people were kept safe within the building. Those people who had capacity were made aware of the codes that were needed to access the protected areas or doors. Any rooms or storage areas that contained equipment or items that could cause harm or injury to people were kept locked. All fire doors were closed and fire fighting equipment was placed around the home. Individual plans in the event of people needing to be evacuated from the home and a business continuity plan covering the failure of key services and utilities were in place.

Arrangements had been made to ensure people received their medicines safely. Senior care staff ordered medicines on a monthly cycle and any new prescriptions sent to the supplying pharmacy were usually delivered the same day. The treatment room, cupboards and medicines trolleys were clean and secure and the separate unit for controlled drugs was kept locked at all times. A sharps box was available for used needles and other items which needed to be safely disposed of. Information was available in the treatment room including a current British National Formulary (a publication with information about the use of medicines), contact details for the pharmacy and a file with details of commonly prescribed medicines.

All medicines were administered by senior staff who had been trained in the safe handling of medicines and their competency to do so was thoroughly assessed every six months. Any new staff were observed for three complete drug rounds to check they were competent and confident before taking responsibility. We observed senior staff administering medicines prior to lunch so as not to intrude on the mealtime and saw they followed the correct procedures and best practice guidelines.

Each person's Medicine Administration Record (MAR) had a cover sheet with their name, date of birth, GP and a photograph for identification purposes. A summary of the individual's preferences for taking medicines were included. Any allergies and specific directions, such as medicines authorised to be given covertly (disguised in food or drink) were highlighted and details were also documented in the person's care plan. We found the MARs were completed accurately including any 'as required' medicines that had been administered. Controlled drugs (medicines liable to misuse) were correctly recorded in a separate book and signed for by two members of staff upon administration. A robust regime of auditing was conducted to assure people their medicines were safely managed.

Good

Is the service effective?

Our findings

Staff told us training opportunities were facilitated and said they felt supported in their roles with regular supervisions, staff meetings and annual appraisals. Their comments included, "You do extra training to become a senior"; "I'm on a phased return to work and the manager has been very supportive"; and, "There's plenty of training and we're encouraged to do NVQ's (care qualifications)."

New staff completed a company induction, were assigned a mentor and spent time shadowing experienced staff when they started working at the home. They completed the Care Certificate, which was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

The provider had established their own training academy in 2015 which was overseen by a training manager. A training programme had been developed, with 57% of courses provided at the academy and other training mostly through e-learning. Training records demonstrated the majority of staff had completed mandatory training in safe working practices including moving and handling, fire safety, health and safety and infection control. Records showed that staff were booked onto courses where they needed to undertake or update training in these areas. Staff had completed a range of further training relevant to the needs of people living at the home. This included caring for people with dementia and challenging behaviours, person centred care, equality and diversity, and mental capacity law.

A delegated system was in place for providing staff with individual supervision. The acting manager allocated supervisions each week and kept checks on the schedule to make sure all staff were supervised at the required frequency. The supervisions were at times themed to particular topics such as teamwork and Deprivation of Liberty Safeguards, to ensure staff were aware of and understood their responsibilities.

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 found that the service worked within the principles of the MCA. Staff received training in the MCA and DoLS and had access to associated policies and procedures. People living at the home were asked to give their consent to their care and treatment and had signed to confirm they agreed to their care plans. Where people were living with dementia, mental capacity assessments and any best interests decisions were clearly identified in their care record, along with a guidance document for staff to refer to. The staff we talked with had a good understanding of the implications of DoLS and senior staff monitored referrals, authorisations and expiry dates. This showed us that formal processes were followed to uphold people's rights.

Staff were provided with training on nutrition and diet and written guidance was made available to them. People's nutritional needs were assessed on a monthly basis and dietitians were requested for further assessment when concerns were noted. An information file was kept on each unit with nutrition care plans and ongoing details of weight monitoring. The care plans addressed needs including support with eating and drinking and provision of special diets for medical or religious reasons.

Seven people currently received a smooth diet that was supplemented with a product that had been sourced by the provider's head of catering. This allowed pureed food to be fortified, given texture and moulded to resemble the original shapes so it could be eaten with a knife and fork. We were told that this had benefitted two people in particular by helping them to maintain stable weights. The catering development manager informed us that new snacks made using the product were being trialled and introduced.

A new four week menu was in place that offered a balanced diet and choices of food. Each day people were asked to choose their meals and preferred portion sizes and alternatives could be requested. A variety of snacks and drinks were served between meals. The kitchen staff told us they were kept informed about people's dietary requirements and likes/dislikes and were able to cater for individuals' needs and preferences. The people we talked with said they enjoyed their meals and many praised the efforts of the new chef.

People told us they were happy with the arrangements for meeting their health care needs. One person said they had been admitted to the home from hospital after an accident when they had sustained an injury. They commented, "I've had no falls since and manage well with my walking stick." A relative told us their family member's had many health problems which they felt were met at the home. They described their family member as being prone to infections and said, "The senior is proactive about taking urine samples." Another relative told us, "They (staff) know what they are doing."

There were regular reviews of people's welfare by other professionals, including GP's and consultant psychiatrists, and evidence of continuing health care meetings. We saw clear records were kept of visits by professionals in response to requests or referrals from the home and any advice or changes in treatment were incorporated into the person's care plan. Future decisions of instructions not to be resuscitated and emergency health care plans were also clearly documented, identifying the actions staff needed to take in emergency situations.

Staff told us they were very well supported by the community nursing service. We spoke with one of the nurses who told us they received prompt referrals from the home and felt there was good communication. They said staff actively sought advice from the nurses and there were appropriate systems and aids that enabled people to be cared for effectively.

Good

Is the service caring?

Our findings

People living at the home were complimentary about the staff who cared for them and the way they were treated. They told us, "I love it here, all the staff are lovely. They treat me well and I'm very happy"; "They (staff) are all really good, they do anything I ask"; "The carers are kind and patient"; and, "It's great, I'm very happy here." One person pointed out a care assistant to us during lunch and said, "She's lovely."

Relatives and visitors were equally positive about the care and the attitude and approach of the staff. Their comments included, "Caring for a person with dementia is not easy, but the staff here are willing to try anything that makes life easier and more pleasant"; "It makes my day coming in here"; "The carers and domestics are great"; "Staff are exceptional, kind and caring"; and, "They are very caring and always try to be helpful." One relative said they were going away and had left details with the staff of how the family could be contacted. They told us, "I know my mother will be well looked after because she always is."

From our observations and conversations with the care staff it was evident they really knew and understood the people in their care. They used their knowledge to good effect, recognising people's individuality by talking with them about their family members and other things which were important to them. As other staff came onto the units we saw they greeted people warmly, spent time talking with them and interacted positively. Throughout our visits we heard staff spoke to and about people in a respectful manner. We noted one exception to this, where a staff member used a collective term to refer to people, which we brought to the attention of the acting manager. This was acknowledged as being inappropriate by the manager and was addressed during the inspection.

We found that staff took time to engage, participate in and encourage activity and involvement. For example, on the Grace unit we saw staff singing and dancing with people in one of the sitting areas and observed the people taking part were having great fun. Afterwards, one person told us, "That was lovely" and another said, "It makes me feel alive again." In another instance, after lunch we saw that two people were helping using feather dusters and were clearly enjoying this activity.

Staff were mindful of people's privacy and dignity and were sensitive in their interactions. They knocked on doors, checked before entering rooms and talked discreetly when offering support, such as guiding a person to go to the toilet. We saw that respecting dignity was built into people's care plans. For instance, instructing staff to use towels to minimise a person's body being exposed when they were receiving support with personal care.

The acting manager regularly carried out structured observations to monitor people's care experiences, care practices and the ways staff communicated and interacted. Two staff had signed up to undertake a training workshop with a view to becoming 'dignity champions' and promoting dignified care in the home.

Good standards of personal grooming were maintained to promote people's self-esteem and encourage them to continue to take pride in their appearance. People wore clean, well pressed and co-ordinated clothing. It was evident that, where necessary, support was given with hairdressing, shaving and manicures

and some of the women were wearing make-up, jewellery and accessories. We observed a person accidentally spilled juice and a staff member dealt with this in a caring way, helping them to their room to change into dry clothing.

People were supported to express their views about their care and the service in general. They were able to be involved in reviews of their care and gave feedback informally and through meetings and surveys. A range of information about the service was provided and displayed for people and their visitors to refer to. This included an informative guide to the home, details of menus and activities, the complaints procedure, a comments box, information about advocacy services and the role of the Care Quality Commission. The home's monthly newsletter, minutes from the latest resident and relative meeting and the provider's quarterly news magazine were also made available.

Routines in the home were flexible and people made every day decisions such as when to get up, which meals they wanted, and whether to take part in activities. We saw that staff encouraged people to make choices in their daily living. As an example, we heard a care assistant asking a person who was alone in a lounge if they wanted the television turned on. They then read out from the television guide, described the different programmes which were on at the time and asked the person what they liked to watch.

The care environment was spacious, bright and welcoming with tasteful décor and furnishings. There was a comfortable and welcoming reception area and plenty of small sitting areas in addition to the main lounges and dining rooms. The outside space had well-tended gardens with lawns, shrubs and seating and was easily accessible from the two lower floors.

The Grace unit in the home accommodated people living with dementia. We saw this unit provided lots of stimulating and themed areas for people to explore and enjoy. There was signage to help people find their way around and identify rooms and memory areas beside each bedroom, which we were told were being further developed.

All of the people we met seemed relaxed and content in their surroundings and we saw they were free to spend time where they preferred. At mealtimes some people chose to eat in their rooms and this was facilitated. The dining rooms were well set out and tables were set with cloths, napkins and condiments and protective aprons were available to prevent spillage onto clothes. The atmosphere was calm and well organised and on one unit there was music playing softly in the background.

Staff ensured people were comfortably seated before serving food and drinks. They explained what was on offer and showed people the choices, which were attractively presented. Specialist crockery was used to help people eat independently and, where needed, staff prompted and assisted people with eating and drinking. The mealtime was unhurried and staff were attentive without being intrusive and ensured people's individual needs were met. For instance, we saw a person had difficulty concentrating, ate more quickly than their companions and left the table. Staff were caring in their approach, encouraging them to retake their seat and serving the next courses at the person's pace, allowing them to happily complete their meal. We observed that all interactions were respectful and dignified and the mealtime was a very pleasant experience.

Good

Is the service responsive?

Our findings

People and their relatives described the staff as being responsive to their needs and requests. They told us, "I can't fault them. They respond and rectify anything, no matter how minor"; "I only have to say Mum wants something and the staff quickly arrive to help her."

We observed that staff were readily available and able to assist, though allowed people to maintain their skills and independence as they went about their activities. Those people who required support were helped in a timely manner. Some people spent a lot of time in their bedrooms and staff popped in throughout the day to make sure they were comfortable, to assist with any personal care, or to see if they needed anything. The operations manager told us they were looking into keeping checks on the staff response times to the call system when people summoned assistance. We saw that staff responded well when a person suddenly became upset, angry and distressed. A care assistant quietly dealt with this by taking time to talk with the person and redirect their thoughts, which calmed the situation quickly.

People's needs were thoroughly assessed before they were admitted to the home and this provided a framework for their initial care planning. A range of assessments were then regularly completed and care plans had been developed according to people's needs and preferences. The care plans were clearly written, focussing on how best to meet the person's individual care requirements and maintain or improve their well-being. They addressed needs including physical and mental health, medicines, personal hygiene and communication and any identified risks such as nutrition, falls and skin integrity. The care plans were reviewed monthly and there was evidence they had been updated to reflect changes in people's care needs.

Care reviews were held on a six monthly basis with staff, the person and their family members. These meetings gave everyone concerned an opportunity to discuss and evaluate the care provided and ensure all involved were happy with the way the person was being cared for.

Care staff completed day and night reports on each person's well-being and verbal and written handovers took place between shifts. This ensured that all staff were made aware of people's welfare and any changes which had occurred.

Care records contained some life story work that had been compiled to give staff information about the person's history, background and interests. People had social care plans which were individualised to their interests and the activities they liked. The home was a member of a national association that promotes meaningful activities for older people. An activities co-ordinator was employed who took responsibility for arranging a programme of social activities and events. They kept records with a hobbies and leisure summary for each person and logs of the activities they had taken part in. Details of seasonal events and special days which had been celebrated or were being arranged were also logged, including Shrove Tuesday, St Patrick's day, Dignity Action day, and World Book day. The home had use of a mini-bus for taking people on outings to ensure they maintained contact with their local and wider community.

Four staff had been trained to deliver the HEARTS process, a combination of therapeutic approaches aimed at enhancing people's relaxation, peace and well-being. The trainer was visiting the home and spoke enthusiastically about the benefits which could be derived for older people. The activities co-ordinator was on leave and a care assistant confirmed to us that the staff continued to provide activities in their absence. Another care assistant we talked with told us an oven had recently been bought specifically for doing baking sessions with people.

Other staff told us people were involved in growing plants for the garden and a relative who helped maintain the grounds was intending to get people involved in growing sunflowers. There was a small cinema room in the home and people were looking forward to a film afternoon during our visit. One person told us, "There are plenty of activities here. I've been involved in doing crafts and am really enjoying it" and another person said, "I don't go to everything but there's plenty to do." A number of people told us they had formed friendships with other people living at the home and liked to spend time socialising with one another.

People and their relatives told us they understood how to make a complaint if they were ever unhappy with the service. Their comments included, "I've never needed to, but I'm sure the manager would take anything seriously", and, "I have absolutely no concerns." A relative described having previously raised a concern which they felt was handled well and had led to improving an aspect of their family member's care.

The acting manager recognised the importance of good, clear communication with people and their representatives. They showed us that three complaints had been made over the past year and no trends were indicated. Each complaint was managed appropriately with detailed investigations and responses and all had been satisfactorily resolved. Numerous compliments about the service had also been received, including cards praising and thanking the management and staff for the care given to individuals in the home.

Good

Is the service well-led?

Our findings

At the time of the inspection the registered manager was on leave of absence and interim management arrangements had been made. An acting manager was managing the home and they were being supported in their role by an operations manager and other members of the provider's head office team.

A clearly defined management and staffing structure supported the smooth running of the service. The hours worked by the acting manager and assistant manager were in addition to the numbers of care staff rostered and administrative support was provided in the home. 'Heads of department' were accountable for different areas of the service, such as catering and housekeeping. Senior care staff were designated to lead all shifts and allocation sheets were used stating who was responsible for ensuring that certain tasks were completed. The acting manager was provided with daily reports from the seniors to make sure they were kept fully appraised about the welfare of people using the service.

The acting manager had regular meetings with all grades of staff to discuss issues related to their responsibilities and the standards expected of them. For example, recent meetings had included discussion about health and safety matters, teamwork, training and mentoring, the staffing levels and skills mix, and completion of care documentation. A robust range of policies and procedures were in place that gave the management and staff clear guidelines for their practice.

We observed there was a good team spirit and senior care assistants led staff in a positive and supportive manner. The staff we spoke with told us they felt their views were listened to and that they were valued and supported by the management and the provider. Their comments included, "(Acting manager) has been very supportive towards me"; "The manager has an open door policy and I'd feel able to go and talk to her if I needed to"; and, "I love it here, it's a good company to work for." Two staff commented that requested changes in their working conditions had been readily facilitated.

The provider operated an employee assistance programme, arranged rewards and discounts for staff and held recognition award events. A monthly newsletter was produced for staff that shared good practice between the provider's care services and informed them of news and developments within the company. The marketing manager informed us that the provider supported charities which benefitted people using their services and their employees. These included sponsoring the water supplied during an annual charitable walk for the Alzheimer's Society, which employees were planning to take part in, and being a 'business friend' of Beamish Museum. The home was currently organising for people to visit a cottage within the open air museum that offered a 1940's themed interactive experience.

The people and relatives we talked with were happy with the way the home was run and said the management were approachable. A relative told us, "They listen to me and take on board what I have to say. I'm interested in what's going on and go to the meetings", and another commented, "I really liked and respected the manager who is off at the moment and would dearly like her to return. I had every confidence in her."

Monthly resident and relative meetings were held and we saw from the minutes that involvement in the home was actively encouraged. For instance, recruitment had been discussed and people were asked if they wished to take part in staff interviews. A person and a relative had volunteered to become responsible for running the home's 'shop trolley' and taking it around the home a couple of times each week. Another relative confirmed to us that they had agreed to give a talk on their family member's life history at a forthcoming staff meeting. At each meeting there was a recap of the discussion from the previous meeting and people were given updates and informed about the action taken in response to their comments.

The home had established links with the community. The acting manager had organised with local clergy for young people from the church to visit people living at the home in a voluntary capacity. They had arranged for a GP practice to start visiting people on a weekly basis and staff told us they felt this was a beneficial arrangement. Some people had consented to take part in a rheumatoid arthritis research programme with a local university, focused on training for care staff, which had recently been completed. We were told links were also being forged with a local creative arts charity. A visiting professional told us, "There's a lovely, calm feel to the home. I would put someone here or recommend it."

The project manager showed us details of electronic care planning and medicines management which were being developed. These systems were being trialled and it was planned that they would be rolled out across the provider's care homes in the future.

A structured range of audits were carried out that checked health and safety in the home, the kitchen, food and food service, housekeeping, infection control, medicines and care documentation. The management visited the home unannounced during the night to check that people were being cared for safely. Monthly reports of care and staffing issues were submitted to the operations manager who met with the acting manager monthly and visited the home regularly to conduct their own audits. We saw these covered aspects of the service including the environment, recruitment and training, care records, management and leadership and innovation within the service. Observations and feedback from people living at the home and staff were incorporated into the audits. The views of people and their representatives about the quality of the service were also sought through internal surveys and surveys conducted by a market research organisation. The findings of the audits and checks were fed into a live action plan that was monitored to ensure improvements were being addressed and completed within specified timescales. We concluded that thorough quality assurance measures were in place to maintain and improve the standards at the service.