Gainford Care Homes Limited

Lindisfarne Crawcrook

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

This was an unannounced inspection which we carried out on 28 July 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

Lindisfarne Crawcrook provides personal and nursing care to a maximum of 60 older people, including people who live with dementia or dementia related conditions.

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

We last inspected Lindisfarne Crawcrook in August 2015. At that inspection we found the service was in breach of its legal requirements with regard to person centred care, premises and equipment, good governance and staffing. This was because records did not contain all the information needed to ensure people received appropriate care that met their needs. The auditing arrangements were not effective to ensure people received appropriate care. Arrangements were not in place to ensure people enjoyed a pleasant dining experience to support their nutrition and hydration. Standards of hygiene were not always satisfactory and the home was not well maintained and designed for the needs of people who lived there.

Due to their health conditions and complex needs not all people were able to share their views about the service they received. Those that could speak with us told us that care was provided with kindness and we observed that people's privacy and dignity were respected. Staff knew the people they were supporting well.

We found improvements had been made to ensure the safe care and treatment of people. People told us they felt safe and there were enough staff on duty. Staffing had been reviewed and increased so staff now had more time to interact and spend time with people and not just when they carried out tasks.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff received opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal and there were robust recruitment processes being used when staff were employed.

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. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

A complaints procedure was available. People told us they felt confident to speak to staff about any concerns if they needed to. Staff and people who used the service said the registered manager was supportive and approachable. People had the opportunity to give their views about the service. Feedback was acted upon in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided. Records had been updated and they were regularly reviewed to reflect peoples' care and support requirements.

Changes had been made to the environment. It was cleaner and brighter and areas had been refurbished. 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. Some activities and entertainment were available for people and people were being consulted to increase the variety of activities and outings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Improvements had been made to ensure the service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

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

Is the service effective?

Good

Improvements had been made to ensure the service was effective.

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

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

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Improvements had been made to the environment so it was well maintained. It was designed to promote the orientation of people who lived with dementia.

Is the service caring?

Good

Improvements had been made to ensure the service was caring.

Staff were caring and respectful. People and their relatives said

the staff team were kind and patient.

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

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

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

Improvements had been made to ensure the service was responsive.

Improvements had been made to record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with some activities and entertainment.

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

Is the service well-led?

Good

Improvements had been made to ensure the service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were complimentary about the changes that had been made in the home.

Improvements had been made by the provider and were being maintained by the registered manager and management team to promote the delivery of more person centred care for people.

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

Lindisfarne Crawcrook

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 28 July 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 service as part of 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 CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 14 people who lived at Lindisfarne Crawcrook, seven relatives, the registered manager, the area manager, two registered nurses, eight support workers including one senior support worker, the activities organiser, two members of catering staff and two visiting health care professionals. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting

minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

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

At this inspection we found improvements had been made to ensure people received safe care and treatment. Staffing levels had been increased. There was improved infection control and the environment was better maintained.

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. People's comments included, "There is always someone you can talk to," "Yes, I feel safe here," and, "I don't wait long if I buzz for help." A relative commented, "At nights and weekends there are staffing issues. I know they are addressing this as they were interviewing yesterday," and, "Staff are around if you need them."

The registered manager told us staffing levels were determined weekly using a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. At the time of inspection there were 59 people living at the home. They were supported by two registered nurses, one senior support worker and ten support workers who were allocated to different areas of the home. We saw staff were always available to supervise people and respond promptly to people's calls for assistance. We were told a twilight shift was in place between 6.00am and 8.00am to provide additional staff supervision and support to people as they were assisted to get up. After the inspection we were told the provider had taken other action to ensure staff were available to support people as staffing levels had further increased over the 24 hour period so 12 support staff and two nurses were on duty during the day and six support staff and a nurse were available overnight. A senior support worker had also been assigned to work with the nurse in charge of each shift and they both had the responsibility to ensure staff were appropriately deployed around the home. From our observations, people's feedback and looking at staffing rosters we considered there were sufficient staff to meet people's needs safely.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. 11 safeguarding alerts had been raised since the last inspection. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to

describe various types of abuse and 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 support worker told us, "I'd go straight to the nurse in charge if I was worried or had any concerns." Nursing staff spoken with showed a good understanding of peoples' individual needs and their vulnerabilities, and the need to provide a safe environment.

Risk assessments and their evaluations were up to date. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for losing weight, choking, falls and pressure area care. A relative commented, "A support worker sits with [Name] at mealtime to prevent [Name] choking." Records contained information for staff on how to reduce identified risks, whilst avoiding undue restrictions. For example, a falls risk assessment included measures to minimise the risk of falls

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

People were supported with their medicines safely. We observed a medicines round. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

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

At the last inspection we had concerns about the standards of hygiene and cleanliness around the building. We looked around the building and saw improvements had been made. Domestic hours had been increased to ensure the building was kept clean. There was effective odour control in most areas apart from two lounges that were identified at inspection. We saw the carpets in these areas were stained and malodorous. The main staircase carpet was also stained. The registered manager told us they were regularly 'deep cleaned' but we saw that that this was not effective. We were told after the inspection arrangements had been made to replace these carpets. All other areas of the building looked clean. The registered manager carried out a daily walk around to check the building met expected standards of safety and hygiene. Records showed cleaning schedules were in place that were checked and signed off by the registered manager. A monthly environmental audit was also carried out by the regional manager, who visited the home regularly, this included signing off these internal checks to ensure the environment was clean with a good standard of infection control. Staff received training about infection control.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job.

Records of other checks were available and up to date. They included the Nursing and Midwifery Council to check nurses' registration status and a form was completed by all applicants to check people's right to work in the United Kingdom. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

At the previous inspection we had concerns not all areas of the home were well-maintained and appropriately designed for the orientation and comfort of people who lived in the home. At this inspection we saw improvements had been made. A programme of refurbishment had taken place. A number of bedrooms, corridors and the dining room had been decorated and flooring and curtains had been replaced. The environment was better designed to ensure it was stimulating and therapeutic for the benefit of people who lived there. We saw there were areas of visual and sensory stimulation to help maintain the involvement and orientation of people with dementia. The communal areas and hallways had decorations and pictures of interest, including memorabilia to help people reminisce. There were displays and themed areas around the home to stimulate and remind people as they sat or walked around. The registered manager and staff had several other ideas to put in to place to help people with dementia remain engaged for example, tactile boards and rummage boxes. There was appropriate signage around the building to help maintain people's orientation. Lavatories, bathrooms and bedrooms had pictures and signs for people to easily identify the room to help maintain their independence.

The gardens were secure and well maintained. They were overlooked by some bedrooms and lounges. They were ornate and well planted and provided seating areas for people to sit outside. They were colourful and attractive and provided interest and stimulation for people who lived in the home.

The registered manager told us catering hours had increased to help the running of the kitchen. Systems were in place to ensure people received drinks and varied meals at regular times. We looked around the kitchen and saw it was stocked with fresh, frozen and tinned produce. We were told menus had been reviewed and people were offered a choice at meal times and on the day of inspection we saw the meals looked appetising. Pureed meals were well presented and each portion was clearly separate on each plate. The lunchtime meal was gammon or meatballs served with vegetables. The evening meal was curry or cheese on toast. Peoples' comments included, "Menus are better," "I can't fault the food, too much sometimes," "I can have any amount of food and drinks," "We like the food," and, "If I wanted a drink, they (staff) would get me one." Relatives' comments included, "She is well-fed and watered," "There are opportunities for second helpings," and, "[Name] loves the food."

We spoke with the cook who was aware of people's different nutritional needs and told us special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The cook told us they received information from nursing staff when people required a specialised diet such as diabetic, soft or pureed food. We saw written information was available in the kitchen, for when the regular cook was not available, to show people's nutritional needs and capture any changes that had been communicated about people's dietary requirements.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to

help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and district nurses. We spoke with a visiting health care professional. They told us, "People are appropriately referred and staff follow the advice and guidance we provide." A relative told us, "[Name]'s wheelchair was too small, the nurse suggested we get a more comfortable one and they arranged it for [Name] very quickly." Records were kept of visits. Care plans reflected the advice and guidance provided by external 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed when 'best interest' decisions may have needed to be made.

People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 25 applications had been authorised and seven applications were being processed.

Staff told us communication was effective to keep them up to date with people's changing needs. Staff members comments included, "Communication is very good," "We're given information when we come on duty, if anyone is ill or has an appointment," and, "[Name] went into hospital during the night but I didn't find out until after 9:30am." We were told a handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. The nurses then cascaded the information to support workers. This was to ensure staff were made aware of the current state of health and wellbeing of each person. We saw handover records contained information about the care provision and the state of well-being for each person over the previous 12 hours. Written information was also referred to with regard to any concerns with people's dietary needs and any personal care issues. Staff told us the diary and communication book also provided them with information. Relatives we spoke with told us they thought communication was good and they were kept informed by the staff about their family member's

health and the care they received. A relative told us, "Staff inform us if the doctor comes to see [Name]."

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "There are opportunities for training," "We get plenty of training," "I've done eye training," "We do face to face practical training and e-learning."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face to face and practical training. One staff member told us, "I started recently and shadowed another member of staff."

The staff training records showed and staff told us they had received other training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. The training matrix showed training was role specific so staff received training according to their role. The training helped staff to understand people's needs and this included a range of courses such as end of life care, equality and diversity, dementia care, managing risk, dignity and respect, pressure ulcer prevention, tissue viability, mental capacity, distressed behaviour, dementia care, vision awareness, record keeping, mentoring and mentors and nutrition awareness.

Staff told us and their personnel files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "[Name], does my supervision," "I get supervision regularly," "We have supervision every two-three months," and, "The manager does my supervision." Staff told us they were well supported to carry out their caring role. They said they could approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

Good

Is the service caring?

Our findings

People who could comment were all positive about the care and support provided by staff. Their comments included, "Staff are very kind and helpful," "I'm well looked after," "Carers are very kind and caring," "Staff listen to me," "I do like it here," "I like the company," "There is always someone you can to talk to," and, "I trust the staff." Relatives comments' included, "Staff are brilliant with my husband," "Staff are very attentive, "Fantastic, brilliant staff," "Staff are very kind and caring, one carer is my rock," "Visually [Name] seems much better," and, "Staff ask before doing things."

During the inspection there was a relaxed and pleasant atmosphere in the home. It was noticeable since the last inspection that the lounges were more tranquil and calm. Throughout the home staff interacted well with people. They were kind and caring and they spent more time engaging with people and not only supervising them. We observed the seating area on the downstairs corridor where some people sat together and talked and we heard the friendly conversation as staff acknowledged them as they passed by.

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. Staff asked people for permission before delivering any support. They explained what they were doing as they assisted people and they met their needs in a sensitive and compassionate manner. Examples included, "You look very nice in your checked shirt, do you want to go for lunch now?" "Yes, they ask before doing things," and, "We shall move you now okay."

People's privacy and dignity were respected. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. People told us staff were respectful. Their comments included, "I like to shower on my own, staff wait outside the door," "They (staff) knock on my door and only come in when I say so," and, "I always have a female carer." Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Pictorial menus and photographs about food were available to help people make a choice of food. We saw at lunch time people were verbally offered a choice of meal, if a person was undecided they were shown two plates of the available meal to help them make the choice by smell and visually.

People told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities, bathing and rising and retiring routine. Their comments included, "I've had a long lie as I've just got up," "I like a bath, the nurse will take me for one when I want it," and, "I can have a lie down in the day time." Peoples' care plans contained detail of how staff were to support them with their choice. For example, "[Name] is able to make a choice of when to go to bed," and, "[Name] often goes to sit on a shower chair and undresses and awaits the water being turned on. This empowers [Name] in their

choice and preference to take regular showers."

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Relative's told us staff seemed knowledgeable about people's care needs and knew how to look after them. Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Staff also gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care.

We observed the lunch time meal on the two floors of the home. We saw improvements had been made to the dining experience for people. We were told regular audits were also carried out by management of people's mealtime experience to ensure it was positive. A calm environment was created to help people relax so they were not distracted from eating. People sat at tables set with tablecloths and menus. Specialist equipment such as cutlery and coloured dishes were available. The meal experience was relaxed and staff were unhurried as they supported people. For people who required total assistance we observed staff were seated with people and interacted with them individually. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a clear and respectful way. Staff talked to people as they helped them and as lunch was served. They also checked that people had enjoyed their meal.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

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

Good

Is the service responsive?

Our findings

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

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

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

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

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the behavioural team were asked for advice with regard to people's distressed behaviour as required. For a person who had been losing weight, records showed a referral had been made to the dietician and their weight was being monitored weekly.

Charts were also completed to record any staff intervention with a person. For example, it was recorded when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. When personal hygiene was attended to and other interventions to ensure peoples' daily routines were also carried out, these were also recorded. This information was then transferred to people's support plans which were up-dated monthly. These records were used to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences. Care plans alerted support staff when a person may be at risk of developing pressure areas on their body.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed and provided information and guidance for staff about peoples' care needs and how they liked to be supported. For example, "I need my glasses on," and, a care plan for personal hygiene stated, "[Name] requires prompts and encouragement with personal care." A personalised, one page profile, that outlined people's needs and how they wanted their care to be delivered was also available in people's bedrooms so new staff were familiar with people's needs straight away.

People's care records and personal profiles were up to date and personal to the individual. They contained

information about people's history, likes, dislikes and preferred routines. Examples included, "I served with the Royal Auxiliary Corps as a driver, driving tanks and amphibious vehicles," "Things that upset me are noise and a busy environment," and, "[Name] prefers their pills to be taken from a spoon in one go followed by a beaker of mango juice."

We found improvements had been made to assist staff with the management of distressed behaviour which some people displayed. Records were more detailed to provide guidance to staff. They were devised using the National Institute for Clinical Excellence (NICE) guidance. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. Detailed guidance helped ensure staff worked in a consistent way with the person, to help reduce the anxiety and distressed behaviour. For example, "Staff to spend time to chat with [Name] as this has a calming effect on them most of the time as it diverts them from [Name]'s thoughts." Records were regularly updated to ensure they provided accurate information.

The activities person spoke with enthusiasm about their role, their affection for the people and they could describe details of which person enjoyed each particular activity. For example, watching rugby, musicals and going out. We observed they sat with people and got them involved in the preparation for the fayre the following day folding tombola tickets. The activities organiser told us about the activities available and these included film afternoons, especially musicals and cowboy films. Other activities included baking, gardening, knitting, arts and crafts, music therapy, ball games, jigsaws and quizzes. Church services took place regularly and the hairdresser came in weekly. The home had a minibus and outings took place to the coast, parks and the church. People also had the opportunity to go out individually with staff. Forthcoming events and entertainment were advertised and these included coffee mornings and the summer fayre. Most people commented positively about the activities and entertainment. Their comments included, "I like to go out," "We were out in the bus last week." Relatives' comments included, "[Name] doesn't like to go out now, they like to do crafts," The sweet shop and post office decoration is very good upstairs," "The home recognises seasonal events and decorations are put up in corridors and they have parties," and, "They took [Name] to church on their ninetieth birthday."

We were told resident and relative meetings were held regularly. Meeting minutes showed people had been consulted about the frequency and when they should be held to accommodate people and to encourage more participation. We saw they were to be held at different times and be more of a social event. For example, afternoon teas, coffee mornings and wine and cheese events were to be arranged. This was to encourage more participation and included evening events as it was a more convenient time for some people to attend. People who used the service and relatives told us the manager was approachable and they knew they could approach them at any time to discuss any issues. They told us meetings were held regularly and they were generally kept up to date about what was happening in the service.

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

Good

Is the service well-led?

Our findings

A registered manager was in place who had become registered with the Care Quality Commission (CQC) in 2010. They had been pro-active in keeping us informed and submitted statutory notifications to the CQC. These included safeguarding notifications, applications for DoLS and serious injuries.

We found that the breaches of regulation and areas for improvement identified at the last inspection had been acted upon and rectified by the provider's management team.

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

The provider had strengthened the management team within the home to ensure consistent leadership when the registered manager was not on duty. An additional deputy manager's post had been created so there was management cover over seven days of the week. One of the deputies was responsible for night shift to provide leadership and support to night staff.

The registered manager was present and assisted us with the inspection. They appeared to know the people using the service and the staff well. Records we requested were produced for us promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and was open to working with us in a co-operative and transparent way. They told us about the underlying values they saw as important, including ensuring people were treated with dignity and respect. Care staff were also clear about expected standards of work and the registered manager's ethos.

The atmosphere in the home was relaxed. People told us they were happy at the home and with the leadership at the home. Staff said they felt well-supported by the management team. They said they could approach them to discuss any issues. Staff comments included, "I can go to the manager," "The manager is approachable." Relatives' comments included, "Without a shadow of a doubt I'm listened to, I rate the manager very highly," "I like the service," and, "I don't think I would change anything about the care provided."

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. They showed the action that had been taken as a result of previous audits where deficits were identified. A weekly risk monitoring report that included areas of care such as people's weight loss, pressure area care and serious changes in their health status was completed by the registered manager and submitted to head office for analysis. Regular monthly analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence.

The registered manager carried out a daily walk around each day. If an issue was identified at the initial walk around, the walk around would be repeated later in the day to check that the appropriate action had been

taken to improve in the identified area. Weekly checks included for the nurse call system, fire checks, medicines stock, care documentation and financial checks. Monthly audits included checks on staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Checks were carried out on personnel files and finances. The registered manager told us monthly visits were carried out by the provider or compliance manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, staff files and the manager's audits to check follow up action had been taken by staff. 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.

Staff meeting minutes were available to show the staff meetings that took place monthly to assist with communication and to ensure the smooth running of the home. These included night staff meetings, quality and clinical governance meetings and general staff meetings. Staff members told us staff meetings took place regularly and minutes were made available for staff who were unable to attend. Minutes from general staff meetings showed areas discussed included people's care, communication, staff conduct, record keeping, audits and communication. We noted that the same areas had been discussed in three consecutive staff meetings to obtain better outcomes for people who used the service. The results of the audits were communicated to staff at their meetings where areas of improvement were identified. This helped to ensure people experienced better outcomes in their care provision as it was more effectively monitored. 'Flash' meetings were called spontaneously by the registered manager if an issue was identified at the shift handover. Minutes showed areas that had been discussed included medicines, staff deployment and catering arrangements.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. Surveys had been completed by people who used the service in January 2016 and staff surveys had been completed in August 2015. 57 surveys were sent out to relatives and 26 were returned. Survey results were predominantly positive but also included areas for improvement such as staffing levels which had been addressed and requests for more activities.