T.L. Care Limited

Queens Meadow Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The last inspection of this home was carried out on 14 January 2014. The service met the regulations we inspected against at that time.

This inspection took place over two days. The first visit on 7 July 2016 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 8 July 2016 which was announced.

Queens Meadow is a purpose-built care home which provides personal care for older people, some of whom are living with dementia. It is registered for 59 places. At the time of this visit there were 54 people living at the home, including two people on short breaks.

The home had a registered manager who had been in this role for several years. 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.

During this inspection we found the service did not always make sure that risks were managed. For example, safety checks had not always been carried out and some areas of bathrooms could not be kept fully clean because they had surfaces that were not sealed.

Care records were not always sufficiently detailed to make sure people received personalised and consistent care.

The provider's quality monitoring processes were not fully effective in making sure people received a safe or quality service. This was because shortfalls had been identified but action had not always been taken to address them.

You can see what action we told the provider to take at the back of the full version of the report.

The people and relatives we spoke with felt the home provided a safe and comfortable place for people to live. One person commented, "I'd rather be in my own home, but I know I'm safer here." A relative commented, "I can leave without worrying about her because I know they look after her."

Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. The provider made sure only suitable staff were employed, although there were no regular renewals of checks for long-term staff.

There were enough staff to support people with their needs. One relative said, "There always seems to be enough staff." Another visitor commented, "There are always staff around when we visit." People were assisted with their medicines in the right way.

People and relatives felt staff were well trained and experienced. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision.

Health and social care professionals said the staff cared for people in a competent, effective way and responded appropriately to any changes in people's well-being. People were supported to eat and drink enough and they had choices about their meals.

People felt the staff were "caring" and "friendly". For example one person said, "The lasses are lovely." Another person told us, "It's a nice home and the girls are smashing."

Relatives said the home was "caring" and "supportive". One relative commented, "My [family member] says she's well looked after and they are lovely to her. They need medals for the job they do." Another relative told us, "We really like it and my [family member] is happy here. They've been settled since the day they moved in and staff are really good with my [family member]. They are as happy here as they have ever been."

Staff were knowledgeable about people's history as well as their likes and dislikes. A relative told us, "It's a very stable staff team so they know people's needs, and people are familiar with staffs' faces and voices which is really important for people with dementia." A care professional said, "The staff in the home tend to know the residents very well."

It was good practice that the home had links with the North Tees Dementia Collaborative to make sure its service was informed, involved and up to date with best practices in relation to the care of people living with dementia. In discussions all the staff we spoke with were enthusiastic about finding fresh ways of supporting people living with dementia. For example, for the past nine months the home had kept hens in one of the gardens so that people could be involved in looking after them. Hen therapy can successfully help people with depression and loneliness.

People had opportunities to join in activities or go out with staff from time to time. The activities co-ordinator planned activities on each floor each day. There was a diary of events displayed in communal areas for people.

People had information about how to make a complaint and they were confident these would be acted upon. People, relatives and staff felt the registered manager was approachable.

People and relatives felt the home was well-run. One relative said, "It's well-managed. I would recommend it." Health and social care professionals told us they thought the home seemed "well run" and that the registered manager was "very competent".

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Routine safety checks had not always been carried out. Some premises issues and practices did not meet infection control guidelines.

People said they felt safe living at the home and were comfortable with the staff who supported them.

There were enough staff to support people with their needs. People's medicines were managed in the right way.

Is the service effective?

Good

The service was effective.

Staff had access to training in care and health and safety.

People were supported with their meals in a way that met their preferences and well-being.

The service applied Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily unless it was in their best interests.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were caring and friendly.

People were given time to go at their own pace and were not rushed when being assisted.

People's dignity was promoted. They were encouraged to make their own choices and these were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always detailed enough to make sure people got consistent support.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they would be comfortable about making a complaint if necessary, and there was information about how to do this in the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider carried out regular monitoring of the service but some identified shortfalls had not always been addressed so improvements had not been made.

People and visitors felt there was an open and approachable culture within the home.

There was a registered manager in place who had been managing the home for several years.

Queens Meadow 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 was carried out on 7 and 8 July 2016. The first day was unannounced which meant the provider did not know we would be visiting. The inspection team was made up of two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also 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 what improvements they plan to make.

We contacted the local authority commissioning team and a range of health and social care professionals. We also contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the service, eight relatives and a visitor. We spoke with the registered manager, the deputy manager, two supervisors, three care staff, two catering staff, an activity co-ordinator and a member of housekeeping staff.

We reviewed five people's care records and 12 people's medicines records. We viewed nine staff files for recruitment, supervision and training. We looked at other records relating to the management of the service.

We looked around the building and spent time in the communal areas. We joined people for a lunchtime meal. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During this inspection we looked at how the provider managed the potential health and safety risks to the premises. The provider planned a range of checks to be carried out to the premises on a daily, weekly and monthly basis. Daily checks included internal temperatures, boiler control, fire safety checks, disarming of door sensors on doors used during the day, escape route checks, carbon monoxide checks and fire break doors. We found these had not always been carried out. For example there was no evidence that these checks had been carried out during February and March 2016. This was because the home had no maintenance staff during that period. Since April 2016 the checks had been completed three days a week by a relief maintenance staff. No other staff in the home were carrying out the daily checks on the remaining four days.

The registered manager told us a new maintenance staff member had been appointed and was due to start when their recruitment checks were completed. We asked if there was a contingency in place to ensure the checks were completed in the absence of the maintenance staff, for example at holiday time. The registered manager confirmed there wasn't but told us they would put one in place.

We saw a fire risk assessment dated 24 April 2014 with actions to be completed. The fire risk assessment had noted that 30 minute fire-resistant glazing was needed in in the reception area. A review of actions had been completed in September 2015. The registered manager said, "Everything has been done apart from the glazing in the reception area." This meant here was an outstanding shortfall from the fire risk assessment which had not yet been completed.

During this inspection the accommodation for people was clean but there were some premises shortfalls and staff practices that could compromise the control of infection. For example, in most bathrooms there were gaps in the boxing to pipework and exposed areas of hardboard which were not impervious. There was a gap in the flooring around the base of a toilet. The frame of a bath chair, which would be immersed into the bath water, was rusting. These items could not be kept hygienically clean. On both days of the inspection we also saw staff were using a hand-operated bin for clinical waste instead of a pedal bin. In another bathroom, an unlidded bin had been used to dispose of used personal protective gloves, which could have been picked up by a person living with dementia. In some bathrooms and shared toilets there were loose continence aids on display near or on top of toilets. In two shower rooms there were unnamed toiletries in cupboards. These practices were contrary to the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections (Department of Health). The code of practice states homes should provide and maintain a clean and appropriate environment that facilitates the prevention and control of infections.

These matters were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. One person commented, "I'd rather be in my own home, but I know I'm safer here." Another person told us, "It's safe and comfortable." Relatives also felt people were safe

at the home. A relative commented, "I can leave without worrying about her because I know they look after her." Another told us, "It's safe and caring. We wouldn't have left her if it wasn't safe." Other relatives' comments included, "My [family member] is safe here" and "I've no concerns at all, it's very caring, it's lovely".

Staff told us and records confirmed that they had training in safeguarding people. They were able to describe the reporting systems for concerns about people's safety. Staff had access to a range of policies and procedures in the offices on both floors, including safeguarding and whistleblowing policies. The registered manager told us supervisions were used to discuss policies and procedures. Staff told us they felt confident about raising any concerns and felt these were dealt with appropriately. One staff member told us, "We've had the safeguarding training and I know I could go to either my supervisor, the manager or the area manager at any time."

The service had a safeguarding log to record any safeguarding concerns. The record included the date, the reason for the safeguarding, the outcome and any lessons learnt or action taken. There were 24 incidents logged, which mainly related to altercations between people living with dementia, a small number of medicines errors and potential abuse.

Safeguarding concerns were appropriately notified to Hartlepool Borough Council. Any lessons learnt were recorded such as a new induction process for agency staff, a change in the medicine round and re-training.

Risk assessments were in place for health and safety hazards such as cooking, slips and trips, waste disposal, lifts and manual handling of deliveries. Key risks to people were identified, such as eating and drinking, mobility, allergies and entrapment such as the use of bed rails.

Personal emergency evacuation plans (PEEPs) were in place and detailed people's room number, the zone of the building plan they lived in, whether support was needed to evacuate and if so what support was needed. Some of the PEEPs were dated 2013. We spoke to the registered manager about this who said, "They are reviewed when we do the care plans, so if there's no need for a change they aren't changed. The overall list is reviewed monthly and that includes a review of the PEEP." An overall evacuation list was in place which detailed the name of the person, their room, the number of staff they needed support from to evacuate and any equipment needed.

Fire safety management risk assessments were in place for the whole of the building and were also completed by each zone of the building. The overall risk assessment stated there were a minimum of ten staff during the day whilst eight risk assessments for the zone said there were fourteen staff working in each zone during the day. We spoke to the registered manager who acknowledged this was incorrect. The registered manager amended the risk assessments to reflect the actual staffing on the day of the inspection.

We found that gas safety certificates, electrical installation condition report and appropriate servicing of fire alarms and nurse calls were all completed. A business contingency plan was in place which included information on what to do in the event of an emergency. This included policies for notifying next of kin, missing person procedures, fire procedure, gas emergency and lift failure. There was also a contingency plan for dealing with mass staff absence either through sickness or winter weather.

Any accidents or incidents were dealt with appropriately and recorded. The reports included the nature of the accident or incident, any witnesses and any action taken. Accident reports were also completed and analysed on a monthly basis to check for any trends. Any falls were also analysed for trends. The records included information on the potential cause of the fall, such as an infection, and the actions taken. Actions

included referrals to the falls team, attendance at A & E, and in one case a full assessment of the person's needs.

All the people and visitors we spoke with said they felt there were sufficient staff on duty to meet their needs. One relative said, "There always seems to be enough staff." Another visitor commented, "There are always staff around when we visit."

Staff told us staffing levels were safe and that there were enough staff on duty to support people. One staff member commented, "We have enough staff to help people. Some days are more rushed than others but it's enough to meet their needs." Another staff member told us, "We have enough staff to keep people safe."

We observed that call alarms were answered promptly. There was a visible staff presence throughout the home. This meant staff provided support and supervision to people when needed. The registered manager used a dependency tool to calculate the staffing levels needed to meet people's needs. Rotas showed the staffing levels met the level identified on the dependency tool. We saw there were five care staff on the dementia unit and three staff on the residential unit. This included a senior member of staff on each floor. Overnight there were five staff on site, including a senior member of staff.

Staff files showed the recruitment process included an application form and interview. Two satisfactory references were required and a Disclosure and Barring Service check (DBS) before anyone started in post. DBS checks are used to support providers to make safe recruitment decisions about staff who will be working with vulnerable adults. The staff team was well established and some staff had been in post for several years. Currently the provider did not routinely renew DBS checks nor did they ask staff to complete an annual disclosure. The registered manager said, "We are looking at a renewal timeframe."

We checked how people's medicines were managed. We looked at the medicines administration records (MARs) for 12 people using the service. There were photographs attached to people's MARs so staff were able to identify the person before they administered their medicines. There was also information about any allergies and the person's GP, date of birth and room number. The MARs we looked at were completed correctly, up to date and in good order.

Staff assisted people with their medicines in an encouraging way. Staff on the dementia unit said that occasionally people might refuse their medicines, for example if they were agitated. Staff described how they would then return shortly after when the person was calmer and offer the medicine again until it was accepted. The medicines file included guidance for supporting individual people with 'as and when required' (PRN) medicines. For example, some people were prescribed 'as and when required' pain relief such as paracetamol. The guidance provided sufficient detail about how people would express if and when the medicine was needed.

Staff who were responsible for administering medicines had training in this and an annual competency check. The security of medicines storage was appropriate. Medicines were stored in lockable medicine trolleys so these could be transported to people wherever they were. The lockable trolleys were stored in locked offices. Staff checked the ambient temperature of the offices each day to make sure this was satisfactory for the safe storage of medicines. We saw the records of temperatures were within safe levels.

Good

Is the service effective?

Our findings

People who were able to express a view told us they felt well cared for by the staff. For example, one person told us, "I get looked after properly."

The relatives we spoke with felt the staff were "professional" and "know their jobs". One relative commented, "All the staff seem trained and experienced." Another relative told us, "The staff do a good job of looking after my [family member]." Other visiting relatives told us, "The staff are competent" and "We come at all times of the day and it's always the same good standard of care".

Staff told us they had good opportunities for training. A detailed training programme was in place which included timeframes for refresher training. The training matrix showed that all staff, including ancillary staff, were required to attend training in moving and handling, safeguarding adults, health and safety, infection control, dementia awareness, fire safety and the Mental Capacity Act (MCA). All senior care staff who administered medicines had completed training and were assessed as competent. The cooks and kitchen staff had attended training in food hygiene and nutrition.

The registered manager explained training was delivered in a range of ways. They said, "We have some internal trainers, we use the virtual college through Hartlepool Borough council and have used DVDs on the Mental Capacity Act." We also asked if there was specific training for the activities co-ordinator in developing specific activities for people living with dementia. They said, "They go to an activities meeting with the group and have been to workshops."

New staff members completed a two day induction which was linked to the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

We spoke with the registered manager about the supervisions and appraisals. The service aimed for staff to have six supervision sessions each year and an annual appraisal. In the past six months 12 staff out of 46 had attended three supervisions, which meant they were on target to attend six supervisions in the year. Twelve care staff had only had one supervision meeting in the first half of the year. The registered manager told us that supervisors (senior care staff) were being trained to take on the role of supervisions and appraisals. Some senior staff were also working towards a national qualification which included supervisory management.

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 so that they can 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. Initial capacity assessments were completed for each person and reviewed on a monthly basis. These were not intended to be decision specific but covered basic care choices, food choices, communication and ability to leave the home without escort and awareness of danger. The registered manager said, "When people are admitted we do the initial capacity assessment and if people don't have capacity we do another checklist and a best interest decision for the DoLS." They added, "We then contact the DoLS team who do the assessment, if there's no family or representative we contact advocacy services." This meant the service was working within the principles of the MCA.

At the time of this inspection 31 people who lived there had DoLS authorisations. The home kept a DoLS referral log which was used to record the date an application had been made, the date it had been refused or authorised and the date it was due to expire. There were also notes to indicate if the person had moved elsewhere, or if they had passed away and if the coroner had been notified. Daily staff handover records were pre-printed with reference to whether each person had a DoLS authorisation in place. In this way staff were aware of the authorised restrictions in place for relevant people.

People were complimentary about the meals at the home. Their comments included "the food is lovely" and "it's nice, home-made food – it's never packet meals". Relatives also commented positively on the meals. Their comments included, "the food always looks good", "they're well-fed" and "they know what (food) people like and they always offer them choices".

People had the choice to eat in the dining room on each floor or eat in their room if they preferred. People were asked for their menu choices by catering staff a couple of hours before main meals. The two catering staff we spoke with were knowledgeable about people's dietary needs as well as their individual preferences. For example, they described how they made desserts that were suitable for people with diabetes and how one person liked potatoes but not if they were mashed. Care staff were also very familiar with people's specific likes and dislikes and served the meals to people according to their individual tastes. The home used coloured plates and dishes. This helped people living with dementia or with poor vision to see their meals more clearly.

We joined people for a lunchtime meal on the first floor unit. There was a sociable atmosphere in the main dining room. People were offered a choice of main meals, and these were served to individual preference which staff were clearly familiar with. Some people needed physical support at mealtimes and we saw this was provided. During the lunchtime meal we saw staff were supportive and engaged with people, encouraging them to enjoy their meal. One staff member told us, "It's good that we can sit with people at mealtimes so we have some time with them and can also check how they are."

Dietary requirement sheets were included in people's care records. Nutritional risk assessments were completed on a monthly basis and weights were recorded either weekly or monthly depending on people's individual nutritional risk. Nutritional care plans were in place and dieticians had been involved where necessary.

Relatives felt people were supported to access health services when needed. For instance, one relative commented, "If my [family member] seems poorly they get the doctor out straight away."

People's care records showed when other health professionals visited people, such as their GP, dentist, optician, and dietitian. A visiting nurse told us, "The staff refer to us appropriately. They call us out when needed and they respond to people's change in needs."

The first floor unit provided accommodation for people living with dementia. The staff team had worked hard to create an environment that supported the needs and orientation of people living with dementia. There were visual signs for different rooms and coloured doors to bathrooms and toilets for people to find their way around. Most bedrooms had different coloured doors with knockers and letterboxes to resemble a front door and to help the person identify their room.

There were lots of items of visual and tactile interest for people around this unit, such as themed areas and reminiscence artefacts. A new 'tea-room' had been designed by staff, which was set out with old fashioned furniture and tea sets. This was a pleasant and interesting place for people to go to meet with relatives or to 'go out' from the remainder of the home.

Good

Is the service caring?

Our findings

People told us they were "well cared for" and praised the staff. For example one person said, "The lasses are lovely." Another person told us, "It's a nice home and the girls are smashing."

Relatives said the home was "caring" and "supportive". One relative commented, "My [family member] says she's well looked after and they are lovely to her. They need medals for the job they do." Another relative told us, "We really like it and my [family member] is happy here. They've been settled since the day they moved in and staff are really good with my [family member]. They are as happy here as they have ever been."

Relatives felt staff were "warm and friendly" towards the people who lived there and with visitors. One relative told us, "They are very supportive of families as well as residents. They treat you like a friend." Another relative said, "It's home from home – we feel we can treat it like it's my [family member's] own home. We've had family parties here and the staff have been really supportive of that."

One relative described how they chose the home based on the caring attitude of staff. They said, "I met with [registered manager] and staff. They then visited [family member] and did an assessment. They were lovely and understood (my family member's needs). It was such a relief. My [family member] has a lovely room, is always clean, there's no smell, it's great. The staff are lovely. I don't how they do it."

Relatives felt people were treated with dignity and respect. One relative commented, "Staff look after them really well. They're always clean and well-cared for." Staff members described how they treated people as individuals. One staff member said, "We're careful about addressing people in the way they want to be addressed."

We saw that people's personal appearance was very good. People were appropriately dressed and gentlemen were clean-shaven. Relatives told us people's dignity was promoted and staff supported people to maintain their preferred routines with personal care. We saw people were offered tabards to wear at meal times to protect their clothes but most people declined these and their choice was respected.

Staff explained that a team of care staff worked together on each 'wing' (there were four wings in the home). Each team of staff paid specific attention to the preferred personal hygiene routines of the people who lived there. One staff member commented, "We each work in a wing and we make sure that each person has a bath or shower as many times as they want and we do their care plans. It means we become very familiar with how they are and what they like."

People were encouraged to make their own decisions about day to day matters, such as menus, clothing and how and where to spend their day. At lunchtime we saw people were offered a choice of main meal and this was offered in a way that met people's individual communication needs. People's choices were respected. For example, one person had initially chosen one option for lunch but changed their mind at the table and was offered a variety of choices of their known preferences instead.

We saw staff were patient and sensitive towards people's needs. For example, one person needed physical support at mealtimes and we saw this was carried out in an encouraging but unrushed way that met the person's own pace.

Relatives felt there was good contact between them and the staff. One relative commented, "Communication is good. They ring if they are contacting the doctor or dentist." Health and social care professionals described the service as "caring" and "welcoming". One care professional said they found staff to be "attentive to the needs of the residents".

There was useful information for people and relatives in the entrance hallway. This included information about the service provided at the home, the aims and values of the provider and details of local advocacy services.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records for five people. Care plans identified people's needs such as mobility, nutrition and personal hygiene. The care plans were up to date and reviewed at least monthly and more often if people's needs were changing. We saw new care plans were put into place if needs changed. For example, there was a short term care plan if people had an infection.

Although the plans identified people's needs they did not always provide sufficient guidance for staff about how to meet those needs. For example, one person had mobility needs and required staff to support them with the use of a hoist and sling for transfers. The care plan did not detail how staff should use the hoist and sling. There was no detail about whether the person needed to use a shower chair and or shower/hoist for personal care.

Some care plans were not personalised. For example, one person's care plan stated the person had a 'toileting regime' to support them with continence care. However there was no description of the 'toileting regime' in the care records. This meant there was no plan for staff to follow.

Another care plan in relation to epilepsy did not include any detail on the triggers for epilepsy, what a seizure might look like or what action staff were to take to support the person, such as timing the seizure, removing obstacles, contacting emergency services if the seizure lasted over a specific period of time.

In this way people may receive inconsistent or inappropriate care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care files for people included an 'all about me' document which detailed their likes and dislikes and personal history. The files also had a social history document which included information about their family, hobbies, employment, skills and who they would like to keep in touch with.

We saw people had been involved in assessments and decisions about their care where they had capacity to do so, for example consent for staff to manage their medicines. Relatives also felt involved in people's care where this was appropriate. For example one relative told us, "I was involved in planning and sharing preferences. They always let me know about updates or any incidents." Another relative told us, "They always involve me in any reviews and we've had meetings about my [family member's] care."

Relatives felt staff were knowledgeable about people's individual needs. One relative commented, "All the staff know the people here." Another relative told us, "It's a very stable staff so they know people's needs, and people are familiar with staffs' faces and voices which is really important for people with dementia."

Health and social care professionals felt people received individualised support that was adapted to meet any changes in needs. For example one care professional told us, "The staff in the home tend to know the residents very well."

Since October 2015 the home had been involved in an innovative hen therapy project supported by the Equal Arts HenPower Project. Hen therapy can successfully help people with depression and loneliness. There were currently three hens living in a coop in one of the home's garden areas. People had enjoyed watching and talking about the hens, as well as feeding and petting them. There were photographs throughout the home of people from both floors enjoying time with the hens.

The home also had plans to use some grant-aid money to buy 10 iPad tablets for use by people living in the home. The staff were enthusiastic about supporting people to use the iPads to keep in contact with family members, for example by using 'Skype'. They also described the various activities and pictures that could be used on the iPads for example to help people communicate choices, reminisce about old times, and engage in puzzles and arts.

The home employed two members of staff to arrange and co-ordinate activities. People described various activities, entertainment and trips out into the local community. One relative said, "There's plenty to do, activities, things to do, reminiscence, singing, films, bowling, and the hairdresser who is lovely."

The activities co-ordinator planned activities on each floor each day. There was a diary of events displayed on the hallways for people. The in-house activities included musical and quiz bingo, reminiscence sessions, chair exercises, floor games and musical sessions. Entertainers had included singers, puppets and a pantomime.

The home supported people to keep in contact with their local community. There were monthly lunches at a local pub and trips to the nearby seafront, tea dances and parks. A local library carried out twice-yearly reminiscence sessions, children came to visit from a local school and a local pet shop brought pets to visit from time to time. The home held events for people, relatives and the local community including cream teas, barbeques and summer fetes.

There was information for people and visitors in the hallway about how to make a complaint. The information was clear and directed people to make their initial complaint to staff or management in the home. If people felt unable to do so, or were dissatisfied with the response, the information pack included the contact details of senior managers of the service and other agencies such as the local council and advocacy services.

One relative commented, "If I had any concerns I would feel able to go to [registered manager], but I haven't. She's well looked after." Another relative commented, "We would tell the manager if we weren't happy and I know she would take our views on board."

The registered manager took any comments seriously and acted on them. They kept a log of complaints so that these could be checked each month for any trends. We saw there had been two complaints this year. The registered manager had carried out an in-depth investigation into a recent complaint and the outcomes, actions and resolution were recorded. For another, minor complaint the report only included the actions but not whether the complaint was resolved to the satisfaction of the complainant. The registered manager told us this would be added to the report.

Requires Improvement

Is the service well-led?

Our findings

We looked at the way the provider monitored the quality and safety of the service. Health and safety audits had been completed on 5 October 2015 and 26 April 2016. Both audits had action plans which detailed the action required, who the responsible person was, a date for completion and space to record the date completed. Neither of the action plans was recorded as completed. Some actions were the same on both audits, such as complete training for fire drills, provide records of competence, review action plans to ensure all actions are completed and risk register to be up to date.

We spoke with the registered manager about whether the actions had been completed or not. They looked at the October 2015 audit and said, "It's because I haven't completed them." They then looked at the 2016 audit and said, "They are done or mostly done." There was no documentary confirmation on the audits that the actions had been completed. In this way it was not possible to confirm that identified shortfalls had been addressed.

The registered manager carried out daily 'walkaround' visual checks in the home and annual infection control audits. These checks had not identified the shortfalls relating to the bathrooms and staff practices around continence aids and toiletries in communal areas. Where shortfalls were identified these were not always addressed. For example the infection control audit of September 2015 had identified that not all clinical waste bins were pedal-operated. During this inspection we found clinical waste was still being disposed of in a bin that was not pedal-operated.

The regional manager carried out in-depth monthly audits of the service at the home. The audits included any identified shortfalls with actions and timescales for completion. For example, the audit in May 2016 reported that care plans were not person-centred and had insufficient detail. Although this shortfall had been identified at each of the monthly audits since January 2016 it had still not been addressed. This matter was also identified during this inspection. This indicated the auditing process was not effective at addressing shortfalls or improving the quality of the service.

These matters are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's safeguarding log included 21 concerns in relation to physical altercations between people living with dementia. None of these concerns had been notified to the Care Quality Commission (CQC). We saw a safeguarding investigation report into missing medicines in January 2016. This had been reported to the safeguarding team and to the police. However it had not been notified to the CQC. The failure to notify is being dealt with outside of the inspection process.

The registered manager carried out a number of observations of staff practices to check people's experience of the service. These included monthly mealtime observations, moving and assisting observations, checks of the medicine administration, and observations of night staff providing assistance with personal care. It was good practice that the reports of these checks included reference to people's choice, dignity, involvement

and staff interaction.

People and relatives felt the home was well-run. One relative said, "It's well-managed. I would recommend it." Health and social care professionals told us they thought the home seemed "well run" and that the registered manager was "very competent".

People and relatives said the registered manager was approachable and informative. Their comments included "she's really lovely", "I could talk to her about anything if I needed to" and "she's always been really amenable if I asked about anything". One relative commented, "The [registered manager] keeps us informed about any plans for the future, like new furnishings for the home. And there are relatives' meetings."

Residents/relatives' meetings were promoted and held every two months. The meetings were intended to offer people an opportunity to get information about the running of the home and to make suggestions and comments about the service. For example at the most recent residents/relatives meeting in May 2016 people had discussed activities, new menus, voting at the referendum and the running of the home.

The home scored 9.4 out of 10 on a national care homes review site. This was based on a number of positive comments posted by relatives about the service, including the activities, staff and catering.

Staff described the manager as "very approachable" and "supportive". One staff member commented, "I always feel she listens to us." Staff said they had opportunities to attend staff meetings and felt these were an open forum. One staff member said, "We can all speak honestly and openly at the meetings and try to resolve any issues."

The registered manager held a number of regular meetings with different staff groups, for example, care staff, activities staff and maintenance staff. At the time of this inspection there was little collaboration between different departments within the home. For example, there were no general staff meetings and no opportunity for staff from different teams to jointly discuss suggestions about the service. The registered manager agreed this was an area for development.

Recently some staff had taken responsibility for creating new rooms in the home, for example the reminiscence tea room on the first floor and the pub room on the ground floor. Staff felt proud of their involvement in these and were enthusiastic about future improvements to the home. Some staff had additional roles such as infection control lead and dementia care champion. It was intended that these staff members took responsibility for keeping up to date in relation to current best practice or initiatives relating to those areas.

It was good practice that the home had links with the North Tees Dementia Collaborative to make sure its service was informed, involved and up to date with best practices in relation to the care of people living with dementia. In discussions all the staff we spoke with were enthusiastic about finding fresh ways of supporting people living with dementia.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not protected from the risk of inconsistent care because care records were not sufficiently detailed to provide clear guidance for staff. Regulation 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from potential risks because daily health and safety checks had not always been carried out. Regulation 12(2)(d) People were not protected against the risks associated with unsafe infection control and prevention practices. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system was not effective in addressing required improvements to the quality and safety of the service. Regulation 17(2)(a) & (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider has failed to notify the Commission, without delay, incidents of alleged abuse and an incident which was reported to the police. Regulation 18(2)(e) and(f)

The enforcement action we took:

We have dealt with this matter outside of the inspection process.