Methodist Homes

Harwood Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Harwood Court is a large two storey residential care home based in Cramlington. The service is registered to provide accommodation, care and support to up to 35 people. At the time of our inspection, 26 people were using the service.

This inspection took place on 24 and 27 May 2016 and was unannounced. This means the provider did not know we would be attending. At our last inspection of the service in November 2014 we rated the service as 'Requires Improvement' overall. This was because we identified four breaches of the Health and Social Care Act 2008 related to staffing, care and welfare of people who use services, records and assessing and monitoring the quality of service provision.

At this inspection we found improvements had been made and the provider had achieved compliance with each of the regulations that had previously been breached. The service has a new registered manager 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.

People living at Harwood Court told us they felt safe and comfortable with the support they received. Relatives we spoke with confirmed this. Policies and procedures were in place, such as those about safeguarding and whistle blowing, to protect people from harm and to ensure staff understood their responsibilities.

Risks associated with the health, safety and wellbeing of the people who lived at the home were well managed and included the provider carrying out checks of the premises in line with their legal responsibilities. People's care needs had been assessed and we saw evidence in records that new care planning documentation had been drafted. These were evaluated and reviewed regularly. Accidents and incidents were investigated in a timely manner and where appropriate the manager had informed the local authority and the Care Quality Commission (CQC) of significant incidents. These records were analysed and used to review people's care needs, risk assessments and implement preventative measures. All other records related to the management of the service were well maintained.

Medicines were managed safely and medicine administration records were completed and accurate. Medicine was stored safely and in line with best practice guidelines. Senior staff followed policies and procedures with regards to receiving, storing and disposing of medicines safely.

People and relatives told us there was enough staff deployed by the service to operate safely and to meet people's needs. The manager used a 'needs dependency' tool to monitor staffing levels. The recruitment process was safe and staff had been appropriately vetted. Training was up to date, and staff had a variety of experience, skills and knowledge. Competency checks were undertaken to ensure staff remained suitable

for their roles. Staff had been given the opportunity to progress their career through access to qualifications.

Evidence showed the manager and staff had an understanding of the Mental Capacity Act (MCA) and their own responsibilities to apply this act in their work. The provider had assessed people's mental capacity and reviewed it. Care records showed that wherever possible people had been involved in making decisions, but significant decisions regarding people's care were made in people's best interests and had been appropriately taken with the involvement of other professionals and relatives.

Records showed that supervision and appraisals were held regularly and staff confirmed this. Staff and relatives' meetings were held and notes were taken. This demonstrated that everybody involved with the service had an opportunity to speak with the manager.

Staff encouraged people to maintain a healthy, balanced diet. We observed people in the dining room at lunchtime and teatime; staff ensured this was a positive experience and they interacted well with people. People made choices around their meals and selected options from the planned menu. We saw some people choose an alternative meal or snack which the chef prepared.

People's general healthcare needs were met by staff and external healthcare professionals were involved when necessary. We reviewed care records which demonstrated people had input into their care from GP's, district nurses, diabetic screening nurses and dentists. Staff worked closely with healthcare professionals and followed their instructions to care for people appropriately.

Staff showed caring and kind attitudes and people told us staff were nice and friendly. We observed people's privacy being respected and their dignity was maintained. Staff told us they were happy working at the service and it had improved a lot in the last 12 months. They said they felt "valued and appreciated."

People engaged with activities on a one to one basis and in groups. A programme of activities had been developed which included day trips and bringing local services into the home.

During the inspection, people and their relatives told us they had nothing to complain about but they knew to tell staff or the manager if something was wrong. We reviewed complaints records and saw they were promptly investigated and resolved.

Quality monitoring took place which involved people, relatives and staff being asked for their opinions via surveys and meetings. The manager had undertaken audits to ensure the quality and safety of the service. There was evidence of provider oversight as they also audited the service. The manager drafted action plans to improve the service following audits and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding and whistle blowing procedures were followed to protect people from harm or improper treatment.

Risk assessments were in place to manage the risks people faced. Accidents and incidents were recorded and monitored.

There were sufficient numbers of staff to care for people safely and medicines were well managed.

The premises were well maintained and the provider carried out appropriate checks to ensure safety.

Is the service effective?

Good

The service was effective.

The manager and staff had a good understanding of the Mental Capacity Act (2008) and applied its principals in their work.

Staff were well trained, knowledgeable and experienced. They were supported through supervision, appraisal and team meetings.

We observed a positive dining experience. Healthy, well-balanced meals were on offer and people chose what they wanted.

The premises were adapted to meet the needs of the people who lived there. There was access to ample outdoor space.

Is the service caring?

Good

The service was caring.

Staff displayed kind and caring attitudes and they knew people well.

Records contained information about people's life history, wishes and preferences.

Relevant information and advice was on display around the home.

People were treated with dignity and respect. People's privacy was maintained.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and explored individual needs.

Keyworkers ensured care records were up to date and regularly reviewed.

A wide range of activities took place including one to one sessions and day trips.

The service had received a low number of complaints. People knew how to complain and felt confident to do so.

Is the service well-led?

Good

The service was well-led.

People and relatives told us there had been a lot of improvements in the past few months. They spoke highly of the new manager.

Staff were happy to work at the service and told us they felt valued and appreciated.

The manager carried out audits to ensure there was good governance of the service. The provider had oversight through internal audits and reports.

Regular 'Resident/Relative' meetings took place to gather feedback from people who used the service and their relations.

Harwood Court

Detailed findings

Background to this inspection

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

This inspection took place on 24 and 27 May 2016 and was unannounced. This means the provider did not know we would be visiting.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information we held about Harwood Court including the action plan they submitted following the previous inspection and any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their registration obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted the local authority contract monitoring teams and safeguarding adult's teams, to obtain their feedback about the service. We asked the national independent consumer champion, Healthwatch, for any information they held about the service. We used the information that they provided us with to inform the planning of our inspection.

During our inspection we spoke with six people who lived at Harwood Court. We spoke with nine members of staff including the registered manager, the administrator, one senior carer, two care workers, the chef and the maintenance worker, who were all on duty during the inspection. We also spoke with five relatives of people who used the service, who were visiting at the time. Two provider representatives were present for part of the inspection and we were able to speak with them about their management oversight of the service.

We spent time observing care delivery at various times throughout the day, including the lunchtime

experience in the dining room. We also shadowed two care workers as they visited people in their rooms at teatime. We observed people engaging with activities.

We examined three people's care records in depth. We looked at other elements of people's care, including medicines management , food and fluid intake charts and generic risk assessments.

We looked at three staff files, including a mix of staff who carried out care and non-care related roles. Additionally, we examined a range of other management records which related to monitoring the safety and quality of the service.

Good

Is the service safe?

Our findings

At our last inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 with staffing levels in that there were not always enough staff on duty to support people with the care they needed, including during the night shift period. At this inspection we found staffing levels had been increased and this was no longer a concern. Four staff were now regularly on duty overnight. We examined the staff rota and reviewed the dependency tool which the manager used to determine staffing levels. A dependency tool measures the level of needs people have who live in the home and calculates how many staff are needed to care for those people safely. We observed staff delivered care in a relaxed manner. They were not rushed with their duties. One person told us, "There is plenty of them (staff), they are never in a hurry". Other people told us if they press their 'call buzzer' the staff responded promptly.

We also identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 with regards to the safe delivery of care. Previously we had observed people being assisted to move with equipment which had not been safety checked. At this inspection we reviewed all the records related to the safety and management of the premises, utilities and equipment used at the home. We found these to be comprehensive and up to date. Approved contractors had been used to check the safety of gas, electric and water. These were carried out periodically and updated as legally required. People's individual rooms and equipment were routinely checked for hazards. For example, safety checks of the water temperature, window restrictors,nurse call system and equipment used to move people were carried out. The maintenance worker told us he felt supported by the manager and the provider's estates management team, who ensured he had the budget and equipment to carry out his role safely. He said, "There was one time we realised a resident had just opened the door and let people in they didn't know, they (provider) sent security fitters here immediately – by 2am they were fitting a keypad to the front door".

There were no issues identified with infection control. We observed the home to be clean and comfortable. Domestic and laundry staff were on duty daily and we observed they cleaned to a high standard. The cleaning schedule showed routine deep cleaning of equipment and communal areas took place.

People told us they felt safe living at Harwood Court. One person said, "I feel safe and secure here – I'm well looked after", another person said, "I feel safe here" and a third person said, "It saved my life coming here." Relatives confirmed their family members were safe. When asked if they thought their parents were safe here, relatives said, "Yes, definitely – everything is fine" and "She is very safe here – we are very happy with her care".

Corporate safeguarding and whistle blowing policies and procedures were in place. The registered manager told us she also adhered to local authority guidelines and followed their procedures in addition to the provider's own procedures. We reviewed records and saw that there were no on-going safeguarding investigations, and that previous incidents were well documented and accompanied by investigation notes, action plans, outcome letters and supporting information from the local authority. The provider had an internal process in place whereby a dedicated team provided advice and guidance to the manager depending on the nature of the incident, to ensure they have oversight of the management of safeguarding

incidents. Staff were trained in safeguarding and when we spoke with them they displayed a thorough understanding of their responsibilities and had confidence in the manager and the processes in place. The provider had a confidential telephone line set up and managed by a neutral third party, to handle any whistle blowing concerns from staff.

Accidents and other incidents were also well recorded. We reviewed 11 records from March 2016, which included near misses. These were analysed by the manager to identify trends and implement preventative measures. Falls in particular were monitored closely to ensure appropriate action was taken which included intervention from external professionals, putting safety equipment in place and increased observations by staff. Information about each incident was transferred into care files to enable staff to review their assessments of risk.

Risk assessments were in place to manage the individual risks people faced. The records we reviewed had all been recently reviewed. Care needs were assessed and any area considered to be a risk was documented with instructions for staff to follow. For example, a clinical risk assessment was in place for a person with diabetes. This included actions to minimise the side effects and instructions for staff to take in the event of a 'hypo', such as seeking emergency medical attention, offering sweets or applying jam or honey inside the cheek if the person is incapable of helping themselves. A 'hypo' is when blood glucose levels go too low. Hypo, in diabetes, is short for hypoglycaemia.

Procedures were in place to deal with emergencies such as fire. We reviewed all the records which related to assessing and monitoring the risks of a fire. Personal Emergency Evacuation Plans (PEEP's) were drafted for each individual that documented the level of support a person required in the event of an emergency. PEEP's included a 'traffic light' system to easily identify priorities. They also described the number of staff each person would require the assistance of and the best method by which they should be supported to evacuate the building. The maintenance worker carried out periodic checks on the fire alarm call points, extinguishers, lighting and exits. Practice evacuation drills had been carried out with day and night staff to ensure they were prepared. The staff we spoke with were confident that they would respond well in an emergency.

Staff recruitment remained robust. We reviewed three personnel files, which evidenced that a thorough application, interview and selection process was followed. Pre-employment vetting checks had taken place, including references and an enhanced DBS check. The Disclosure and Barring Service (DBS) check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed. The staff we spoke with confirmed these checks had taken place.

Best practice and national guidelines were followed in respect of the management of medicines. We spoke with a senior care worker about medicines, including ordering, administering and disposal. We inspected the treatment room and carried out a number of random checks on the medicine supplies. We found the arrangements were safe and hygienic. Senior staff were responsible for administering medicines and were trained to do so. We saw senior care workers had also completed a level three qualification in health and social care. The senior carer we spoke with was knowledgeable about medicines which needed to be administered in a set way. Competency checks were carried out by the manager to ensure staff remained competent to administer medicines safely. People told us they received their medicines on time and they knew why they needed it. One relative said, "They are very serious when dealing with the meds, we know not to interrupt them". Records which related to the safe management of medicines were well maintained, accurate and up to date. Audits were carried out to ensure medicine administration and record keeping was safe.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we recommended the provider considered the Supreme Court ruling on Deprivation of Liberty Safeguards and consulted with the Northumberland
safeguarding adults team. At this inspection we checked whether the provider was working within the principles of the MCA. Care records showed, and the manager confirmed that some people living at the home may require a DoLS. Nine applications had been made to the local authority and the manager was awaiting an outcome. One application had recently been granted. These decisions had been made in the person's best interests and other relevant people such as relatives, GP's and social workers had been involved in the decision-making process. Best interest decisions were reviewed regularly and the manager monitored when further applications for extending these authorisations were required. The manager had also notified the Care Quality Commission of these applications in line with their legal obligations to do so.

The staff we spoke with were knowledgeable in topics such as safeguarding, medication and the moving and handling of people and they had received training from a range of internal and external training providers. Staff had received training specifically related to the needs of the people who lived at the home such as dementia and end of life care. We also saw evidence that external healthcare professionals provided instructions and awareness for staff on topics such as continence care and nutrition. A relative told us, "They (staff) are confident and seem to know what they are doing".

Staff told us and records showed that they completed refresher courses. A staff member said, "This was my first job in care and now I have a level three diploma. There is loads of training, anything you want really". There was evidence in staff files which showed all new staff had received an induction which was specific to their role, and they had been supervised throughout a probationary period. Supervision and appraisal took place regularly. Supervisions reviewed work performance, made plans with objectives to work towards and monitored progression with training. Appraisals were carried out annually to summarise the overall training and development of the staff member and set targets for them to achieve in the coming year. This ensured staff continued to learn and develop in their role and made sure their competence was maintained.

Communication was good between staff and the manager. The manager demonstrated she was fully aware of what was going on within the service. Staff used handover sessions at the start of each shift to a pass on information to their colleagues and the manager. We reviewed handover notes which showed information about people and their needs was discussed amongst the team and any actions which had been taken. Issues to be actioned were shared and delegated appropriately. Staff also maintained daily notes about

each individual to ensure other staff knew what had occurred prior to them coming on duty. The manager kept herself abreast of all this information. Effective communication meant that all staff could carry out their role responsibly.

During the inspection we observed the lunchtime and teatime experience. We also spoke with the chef in detail about managing the kitchen and providing a service to the people who lived at the home. The chef told us how they met people's individual needs. She said, "We have a board in here (the kitchen) where we write special requirements on such as, pureed food, allergies and dislikes". She added, "We rang the GP for advice about insulin diabetics because that was new to us". On admission of a new person, kitchen staff were provided with a 'dietary advice' sheet linked to that person's needs. The chef also meets with the person and notes their food and dietary preferences. This information is then used to update the board in the kitchen area. 'Dietary advice' sheets were also used to share information between the departments when people's needs changed.

The kitchen had received a 5* hygiene rating from the local authority. The dining room was invitingly set out. Tables had contrasting tablecloths, condiments and there was cutlery, cups and saucers set out ready for people to arrive. We saw afternoon tea, cakes and scones were being served which were all home-made. Cake stands were used to display the choices available. People were able to see what they preferred before they made a choice. Staff also went around each table to offer sandwiches and toasted teacakes with butter, jam or marmalade. We observed people in the dining room enjoyed the food they ate. There was lots of chatter and positive interaction between everyone. Staff sat with people and encouraged them to eat where required. Some people required assistance and we saw staff offered this discreetly and only as necessary.

Staff told us a bigger meal had been served at lunchtime and we saw this on a menu board on display outside the dining room. Menu cards were also on each table to remind people of the choices. The chef told us people chose in the morning what they would like for lunch however it was not a problem if they changed their mind. Alternatives were always available such as soup, omelette, jacket potato and beans on toast – anything the chef had the ingredients to make. The chef said, "Chicken and pepper sauce went down well today – it's new to the menu", and "(Name of Person) requested a bacon sandwich and thoroughly enjoyed it." The chef also told us she left some snacks prepared in the fridge so the evening staff could provide supper. She said, "All the carers have had food hygiene training so they can all make food if anybody wants something when I'm not here".

Relatives told us, "The food is great here – credit where it's due. We came and joined in for Christmas dinner – it was great." We heard comments from people such as, "These (scones) are lovely" and "The food is very nice here – very acceptable!" A comments book was left in the dining area for anyone to pass comments to the chef. We reviewed mostly positive comments such as, "(Name of person) enjoyed the burgers in buns tonight", "Pork casserole went down well but only five people chose the lasagne" and "I had my lunch with my mother for the first time in Harwood Court, I really enjoyed it and so did Mam. We had a good meal and Mam enjoyed eating downstairs with others around. The staff are excellent."

Care records showed people had access to external healthcare professionals in order to support their health and well-being. A record of healthcare visits was maintained within each file. Of the records we reviewed, we saw a GP, optician, care manager, dentist, chiropodist, district nurse and paramedics had all visited one person in the months following their admission. There was also evidence that a diabetic screening appointment and other hospital appointments had been attended.

The premises were adapted to suit the needs of the people who lived there. The décor in the communal areas was welcoming and homely. The service had considered best practice guidance around dementia

care when decorating the home. The walls were painted with a contrasting colour from the floors. Ornaments and other artefacts were on display such as framed pictures of local landmarks and historical photographs, comics and coins to stimulate memories and conversation. Easy chairs were situated through the corridors, next to small tables with vases of flowers. A large screen TV was on the wall in the communal lounge. DVD's, games and jigsaws were also available for people to enjoy at their leisure. People had personalised their bedrooms with furniture and pictures from their own home. Small individual post boxes were on the wall outside each bedroom door and a plaque with the person's name on it. There were handrails in place, shower rooms with walk-in facilities as well as bathroom's with bath lifts. These rooms had pictorial and word signage on the doors to make it more understandable for those who may suffer from dementia.

To the rear of the home, there was a large conservatory and an enclosed spacious garden with trees, plants, grassed and patio areas. The home kept pet chickens which sometimes wandered around the gardens. Staff and people told us they loved having the chickens there. There was also a dedicated area away from the doors and windows for people who wished to smoke. We observed care staff and the maintenance worker supporting people to access the outdoor areas. One person told us, "I like the garden and I go for a smoke. (Name of maintenance worker) pushes me around the garden for a walk sometimes." This demonstrated people had access to appropriate space and could access outdoor space whenever they liked.

Good

Is the service caring?

Our findings

The staff approached people in a caring, kind and friendly manner. We observed lots of positive interactions throughout the inspection. One person told us, "Its great here, the staff are so nice and well disciplined". Another said, "Its fab here, no cooking, housework or ironing – what more could I want!" A relative said, "They (staff) are so friendly here – we visited other homes and this one had the best feeling". Another relative said, "I get well looked after when I visit, they have cheery faces and big smiles. I wouldn't fault a thing – they are 120%." A third relative told us, "They made a big cake for her birthday – they made a real fuss. They have made her feel welcome and I can't ask for more."

The manager told us they tried to make special events memorable for people and they aimed to provide 'golden moments'. A 'golden moment' is a wish or a desire a person may have which the staff can help them achieve. For example, the relatives of one person who had stopped going out told staff about their love for St Mary's Lighthouse at Whitley Bay and how the person had spent a lot of time there with their spouse. Staff encouraged the person and they arranged a visit, which we were told was highly emotional and very precious to the person who experienced their 'golden moment'.

Staff had untaken training in equality and diversity and we saw how they had identified people's diverse needs in care records, such as medical, social and religious. Staff told us about how they treated people equally but recognised that everyone is different. One staff member told us, "Although this home is run by a Methodist organisation, people of all denominations can live here. We have a resident chaplain and she visits everyone if they want it. We support people to go to their own church if they want and we arrange for visitors from other faiths to visit." Records showed people had received visits from their local priest and Holy Communion had taken place with four people who were practising Catholics.

People and their relatives were encouraged to be involved in the service. Records showed people had been involved in their care planning and reviews. Wherever possible people had consented to the care and treatment they received or their relatives had confirmed it on their behalf. One relative told us, "I really enjoy coming here; I've planted some pansies. It's Grandma's house and as I would at home, I've done flower pots for the front doors." They added, "It's a big family, there are no restrictions for visitors, we get involved in all sorts. I spoke to (manager's name) about hosting some quizzes." People and relatives told us they were involved with 'resident and relatives' meetings. They said, "When things were worse before (manager's name) came, there were lots of relatives coming to the meetings, now hardly anyone comes. I presume that's because they are not worried anymore."

Notice boards were on display around the home which provided relevant information and guidance for people to study. The home had appointed 'champions' in topics such as safeguarding, infection control and nutrition. This meant specific staff members took on the responsibility of leading in these areas and shared advice and best practice guidance with their colleagues. Information about the provider's safeguarding and complaints policies were on display along with advice for people on falls prevention, local advocacy services and religious services. The activities coordinator and the chaplain had their own noticeboard to maintain. We saw these were up to date with a programme of activities and services available. The chaplain board

read, "Whatever your faith, we are here for you, your relatives and the staff."

We asked the staff about peoples use of advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. Staff were aware of how to access a formal advocate if people needed this type of support and they had leaflets and contacts of local services. Care records showed that most people had family who acted on their behalf informally. Some people had legal arrangements in place where their relative acted as a lasting power of attorney in respect of their financial or health matters, and this was evidenced in care records.

During the inspection we shadowed two care staff whilst they carried out their duties. We observed that they knocked on people's doors and waited to be called in before entering the room. They knew people well and spoke to them with kindness and compassion. The care staff told us they respected people's privacy and sometimes people wanted to stay in their rooms. They also told us they protected dignity by drawing the curtains and ensuring doors were closed when they attended to personal care. We saw care staff were discreet when they escorted people to use the bathroom. A relative told us, "They respect her choices and independence." People lived as independent a life as possible. Records showed that people who were still active visited the shops by themselves and often went out for a walk in the community. One relative said, "Mam often pops out, as long as she signs out and they know where she is going, she is absolutely fine."

There was nobody receiving end of life care at the time of our inspection but staff records showed that carers were trained in this area to enable the home to offer this level of support if anyone wished to remain at the home during this time. A chaplaincy service was also available if people wished to have this type of comfort and support. Care records showed that end of life wishes were discussed on admission and during reviews to ensure the home was up to date with people's choices and preferences.

Good

Is the service responsive?

Our findings

At our last inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to the care that people received, in that care records were not up to date and the management of some people's health conditions was not appropriate. At this inspection our concerns had been addressed. The care people received was appropriate to their needs and records reflected their current conditions.

Care records contained individual health and social needs assessments which had been compiled between the service, people and their relatives (where necessary). These assessments contained information about the person's life history, abilities, needs and outcomes to be achieved. They were centred on the person and staff had documented people's personal choices, wishes and preferences around how their care and support was to be delivered. Keyworkers had been allocated to each person and it was their responsibility to review and update the care plans as necessary.

Pre-admission documents were thorough. Keyworkers had met with people and their relatives (if appropriate) to assess all of their health and social care needs prior to an admission. This enabled the home to ensure they could meet these needs fully and for all parties to decide whether Harwood Court was a suitable place for the person to reside.

People's records had been re-written since our last inspection and new care planning documentation was in place. They were regularly reviewed and updated. Risk assessments, daily notes and other care monitoring tools such as food and fluid intake charts, weight charts and body maps were in place to support the care planning process and monitor progress towards outcomes. One relative said, "Mam was on pureed food when she first came here, but they've helped her build back up and now she eats normal food again". Another relative told us, "Mam has put on two stones since moving in…which was needed." This demonstrated that the service had put individual care and support packages in place to meet the needs of these people.

A long established activities organiser was in post at the home. The activities programme had been developed since our last inspection with the support of the new manager; more emphasis had been placed on individual preferences, one to one sessions and trips out. The activities board on display showed an array of activities scheduled for the week ahead which included, armchair exercises, garden walks, one to one sessions, hand massage, bingo, dominoes, and quizzes. A recent day trip to Blyth beach had been enjoyed by several people who were supported by staff to attend a World War II re-enactment. One person we spoke with told us, "I went to Blyth beach last week, it was great. We have a 'Dads Army' event coming up and panto. I prefer the trips out." A relative told us, "Mam loves the garden; the staff take her for a walk around it to look at how the plants and flowers are coming on." All the people and relatives we spoke with confirmed that one to one time is scheduled for them with the activities coordinator or a staff member. This showed that the service supported people to follow their own interests and take part in social activities. Relatives told us they could visit at any time. "There are no restrictions at all on visiting" one relative told us. This meant people could maintain the relationships they had with the people who matter to them.

People and relatives told us they knew how to complain, although nobody we spoke with had any complaints to raise. Two people raised the same minor issue and we passed this information on to the manager to deal with. We heard comments such as, "Everything is fine", "I've got nothing to complain about" and "There's no complaints now, (manager) seems to be on top of things." A copy of the provider's complaints policy was on display around the home and on admission people received this information individually. The provider aimed to resolve any issues raised within 15 days. We reviewed six complaints raised during 2015 and 2016. We saw that these were responded to and resolved in a timely manner. The manager had used a variety of communication methods such as, telephone calls, meetings and written letters to liaise with complainants throughout the investigations. We saw one anonymous complaint which had been received by the service was thoroughly investigated and the manager had addressed each point raised in her records. A meeting had been held with staff, statements were taken and actions were shared during staff meetings and one to one supervisions, in order to address the general concerns which had been raised.

Information about who to escalate a concern to if the person wasn't satisfied with the manager's response was also on display. This included contact details of the local authority and CQC. Complaints were recorded on a complaints form and these were analysed on a monthly basis. The manager passed on this information to the provider to enable them to have oversight.

Good

Is the service well-led?

Our findings

At our last inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to assessing and monitoring the quality of the service. Ineffective governance systems had not protected people from inappropriate or unsafe care. The current manager had been in post for 16 months and became the registered manager of the service in December 2015. This meant she had accepted legal responsibilities for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service was run. Following our last inspection in November 2014 where we identified four breaches, and rated the service as 'requires improvement' the current manager had taken on the lead role and worked with the staff and the provider to devise an action plan which was submitted to CQC. The manager told us she felt like she had been given the time to make an impact on the service since she joined the company. Our inspection on 24 and 27 May 2016 showed significant improvements had been made throughout the service.

Prior to our inspection we checked our records to ascertain whether statutory notifications were being submitted and we found that they were. The manager had sent regular notifications to us about applications for DoLS and notifications of deaths or other incidents which had occurred within the service as she is legally responsible to do.

The culture at the service was open and transparent. Both the manager and administrator worked with us and provided everything we requested to inspect. The manager held comprehensive records to ensure her and the provider had oversight of the service. We reviewed audits related to monitoring and the safety and quality of the service. Monthly audits took place to review information kept relating to accidents analysis and falls analysis. We cross referenced these records with people's care records and found the information was recorded in individual records as well as the audit records. Other audits ensured information about people's care plans, weights and pressure damage was accurate.

We saw the manager had taken action to deal with issues which were highlighted during her audit. For example, one person's weight charts showed a steady weight loss; this had amounted to five kilos over six months so the manager made a referral to a dietician. An electronic audit which covered all aspects of the service was completed which provided a 'compliance' score. This was monitored by the provider. A provider representative also visited the home to audit the administration and financial records. The administrator told us, "I have a buddy at another home – they support me if I need anything."

Other monitoring took place such as absence of staff, training, supervision and people's dependency needs. Dependency needs were monitored by evaluating people's capabilities each month to ascertain how much support they required. This enabled the manager to deploy appropriate staff to each shift. All of the monitoring demonstrated there was good governance of the service.

Relatives told us their suggestions were "taken on board". All the relatives we spoke with knew about the relatives meetings and had attended many. One relative said, "Since (manager) was appointed she has slowly changed things." Another relative told us, "The meetings are productive now and they listen." A third

relative said, "We have been involved in the meetings, they tell you what's happening and we are always invited to join in the activities." They added, "They could use technology a bit more to communicate – we don't always need a meeting, we could just have an email or a text."

The service had recently tasked a neutral third party organisation to conduct a survey on their behalf. We reviewed the 20 responses which had been received. The service had scored an above average rating for satisfaction. For example, 100% of people who responded were satisfied with the home, 100% of people agreed they were treated well and 100% of people said staff understood them as an individual. Other scores included 90% of people were happy living at the home and 95% of people staff said were available when they needed them. The manager had not yet compiled an action plan to address the minor issues raised but told us she intended to draft an action plan as soon as possible. This demonstrated that the service actively encouraged people and their relatives to provide feedback and intended to investigate the information received to improve the quality of care being delivered.

Staff meetings took place and staff told us they felt "fully involved in the running of the home." A staff member told us, "We have staff meetings but also health and safety meetings too – If I can't go I always get the minutes." They added, "The management change made the difference, she's (the manager) made gradual changes and it's worked."

People and relatives spoke highly of the new manager. They commented, "This place has turned around amazingly since (manager) was appointed", "What (manager) has done for this place in a year is unbelievable" and "(manager) is easy to approach, there have been a lot of improvements in the last few months". Staff were also positive with what they said, "We have a great time now, it's a lovely place to work", "Everyone gets on, we are like a family", "There's been a lot of improvements, we feel appreciated now… (manager) does everything she can" and "We laugh, we sing, residents are happy and that makes us happy – we get everything we can to look after people and residents are getting out now, (manager) makes sure it happens."

Staff appeared happy at work as we observed them during the inspection. Staff with non-care related roles were integrated into the home and we saw them interact with people positively. We also saw the manager conduct daily walk around inspections and observed her joining in with activities at times. Relatives and staff told us the manager was very approachable and always had time to speak with them. A member of staff said, "(Manager) gives us so much potential…she wants us to progress." Staff spoke with delight about a recent pay rise. We were told, "Consultations took place, there were clear messages from the management, we had a staff representative and we were involved in the discussions and the proposals." Staff told us this made them feel valued.

The manager had encouraged community links which benefitted people who lived in the home. People engaged in activities outside of the home environment. The manager ensured local services, including dog-petting, entertainers and religious figures visited the home to enable people to remain included within their community.