SLW Limited

Sycamore Care Centre

Inspection report

Sycamore Care Centre
Nookside
Sunderland
Tyne and Wear
SR4 8PQ
Tel: 0191 525 0181
Website: www.sycamorecarecentre.co.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 19 and 20 November 2015 and was unannounced. At the previous inspection in October 2014 the service was given an overall rating of 'good'.

Sycamore Care Centre is registered to provide personal and nursing care for up to 113 older people with general care and mental health needs. At the time of this visit 106 people were using the service. The service is set in its own grounds and consists of four units (the Lodge, the Mews, the Villa and the Cottage).

At the time of our inspection the registered manager had been absent since the end of July 2015. An acting manager was appointed at the beginning of August 2015. 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

Summary of findings

and associated Regulations about how the service is run. The service had notified us about this and an acting manager had been in post since the beginning of August 2015.

We found the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not have accurate records to support and evidence the safe administration of medicines. Medicine records were not always completed correctly or in a timely manner, which placed people at risk of medicine errors.

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

People told us they felt safe because they were well looked after. The provider made sure only suitable staff were employed. Thorough background checks were carried out before staff started to work with people who used the service.

Staff completed safeguarding training as part of their induction and then at regular intervals. Staff we spoke with said they would raise any concerns immediately. This meant they knew how to deal with any concerns about people's safety.

Accidents and incidents were recorded accurately and analysed by the manager. Measures were put in place which significantly reduced the number of falls people had. Risks to people's health and safety were assessed and reviewed regularly.

Staff received appropriate training and regular supervisions and appraisals. Staff understood the Mental Capacity Act 2005 for those people who lacked capacity to make a decision, and Deprivation of Liberty Safeguards to make sure people were not restricted unnecessarily.

People's health needs were assessed and monitored. People were supported to maintain a balanced diet. Staff knew people's likes and dislikes well. Care records were personalised to each individual and were reviewed regularly.

People and relatives spoke positively about the caring and friendly attitude of staff. One person told us, "The best thing about the place is the staff – they're lovely. You can't help but bond with them because they are so nice."

The people, relatives and staff members we spoke with felt the service was well-run. The provider had an effective quality assurance system and people's views about the service were frequently sought to check where any improvements could be made. People and their relatives had several opportunities to raise suggestions and comments about the service.

People felt the atmosphere in the home was very good. Staff members we spoke with said staff morale was good and they felt valued.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. This was because medicine records were not always completed correctly or in a timely manner. Also, guidance for 'when required' medicines was not up to date which placed people at risk of medicine errors. People who used the service and their relatives said the service was safe. People spoke positively about the staff and people felt they were well looked after. Thorough checks were carried out on all staff before they started to work at the service, to check they were suitable to care for and support vulnerable adults. The accommodation was clean, well maintained and decorated to a high standard.	**Requires improvement**
Is the service effective? The service was effective. People were supported to meet their nutritional needs. People's healthcare needs were monitored and the service liaised with other healthcare professionals where appropriate. The registered provider had developed a comprehensive induction programme for new staff. This training was updated regularly for all staff. Staff received regular supervisions and appraisals.	**Good**
Is the service caring? The service was caring. People said staff were kind, caring and compassionate. Staff understood and acted on people's preferences. People's privacy and independence were promoted.	**Good**
Is the service responsive? The service was responsive. Care plans were well written and reflected the needs of individuals. They were reviewed and updated regularly. Staff were knowledgeable about people's support needs, interests and preferences in order to provide personalised care. When people's needs changed staff were quick to respond accordingly.	**Good**

Summary of findings

People and their relatives knew how to make a complaint. Complaints were recorded and acted upon.	
Is the service well-led? The service was well-led. People, relatives and staff felt the service was well run. The provider had an effective quality assurance system to check the safety and quality of the service. The manager sought frequent feedback about the service from people who used the service, their relatives and staff members.	**Good**

Sycamore Care Centre

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 over two days. The first visit on 19 November 2015 was unannounced which meant the provider and staff did not know we were coming. A second visit on 20 November 2015 was announced.

The inspection was carried out by two adult social care inspectors, two pharmacy inspectors, two specialist advisors, and an expert by experience on the first day. An expert by experience is a person who personal experience of using or caring for someone who uses this type of service. Two adult social care inspectors visited on the second day.

Before our inspection we reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). This inspection was brought forward due to safeguarding concerns that had been reported to us regarding people's medicines.

During the visit we observed care and support and looked around the premises. We spoke with 22 people who used the service, 16 relatives, the acting manager, a representative of the provider, a unit manager, a care plan co-ordinator, the activities manager and 12 members of care staff. We looked at a range of records which included the care records for 12 people who used the service, medicine records for 18 people, recruitment records for seven staff, and other documents related to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

Medicines were not always managed in the right way. The service did not have accurate records to support and evidence the safe administration of medicines. Medicine records were not always completed correctly or in a timely manner, and people did not always receive their medicines at the times they needed them. On one unit care staff had administered both the 'dinner time' and 'evening' medicines to seven people on one day, but none of the medicines administration records (MAR) had been signed at the time of administration. This meant people were placed at risk of medicine errors.

We also found that prescribed creams were not always recorded as administered so it was unknown if this had taken place in the right way or at the right frequency. Stocks of medicines received into the service and existing stocks of medicines carried forward from the previous month were not properly recorded. This meant medicine stock records were not always accurate, so care staff could not properly monitor when further medicines needed to be ordered. For medicines with a choice of dose, the records did not always show what dose a person had been given. Medicines records for 10 people were incomplete which meant we could not be sure if people were having their medication administered correctly.

The arrangements for administering 'when required' (PRN) medicines were not always safe. Although there were arrangements for recording this, guidance was not kept up to date and information was missing for some medicines. For example, one person was prescribed a medicine that could be used to reduce agitation and anxiety. There was no care plan or guidance in place to assist senior care staff in their decision making about when it could be used. For another person, the prescribed dose had changed but the guidance had not been updated to reflect this. This meant we could not be sure people were given 'when required' medicines in a safe, consistent and appropriate way.

Medicines were not kept safely. On two units medicines were stored in a locked trolley secured to the wall, however no records were kept of the temperature of the area. In one of the treatment rooms where medicines were stored, the temperature was recorded above that recommended for safe storage on 27 out of 31 days in October and all of November 2015. On one unit (the Lodge) stocks of medicines were kept in a cupboard in an office, along with medicines which needed to be returned to the pharmacy. Unwanted medicines were last returned to the pharmacy on 2 August 2015, a significant amount of medicines had built up and needed to be returned. Proper records were not kept so it was not known what should have been in the cupboard. This meant stocks of medicines were not adequately accounted for. A medicines audit that had been completed recently was not thorough and did not identify any of the issues we found during our visit.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke to the acting manager about accurate medicines records and adequate procedures not being in place, they devised an action plan to address these issues. We also spoke to the acting manager about the temperature of one of the treatment rooms being too high. The maintenance team immediately installed a vent and the temperature of the room decreased to recommended limits during our inspection.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss, which meant the arrangements for controlled drugs were safe. The temperatures of fridges used for medicines such as insulin were checked daily and were within recommended limits. There was a detailed risk assessment in place for a person who manages their own medicines.

People who used the service told us they felt safe. One person said, "I am safe here because I don't need to worry. I am well looked after, and the staff are very good." A family member we spoke with told us, "[Relative] would not be here if it was not safe, staff look after them really well."

One staff member said, "Yes people are safe here. Staff observe and can defuse situations."

Staff told us, and records confirmed, they had completed training in safeguarding vulnerable adults as part of their induction training and then regular refresher training. Staff we spoke with said they would raise any concerns immediately. Staff were able to describe different types of abuse and what signs to look out for such as changes in a person's behaviour or appetite. A safeguarding file which contained the provider's up to date safeguarding policy and a list of useful contacts was accessible to staff. Safeguarding incidents were recorded and investigated appropriately.

Requires improvement

Is the service safe?

There were thorough recruitment and selection procedures in place to check new staff were suitable to care for and support vulnerable adults. Eligibility checks had been carried out, proof of identification had been provided and gaps in people's employment history were accounted for. The provider had requested and received references, including one from the most recent employer. A disclosure and barring service (DBS) check had also been carried out before staff started work. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Where issues with DBS checks or previous employment history were identified a thorough risk assessment process was in place.

Staff had mixed views whether there were enough staff on duty. Some staff felt more activities co-ordinators were needed, some felt more nurses were required, and some felt staffing levels were fine. Relatives also had mixed views whether there were enough staff on duty. When we asked the acting manager about this they said people who used the service were classed as low, medium or high dependency. They told us the service was over staffed according to the staffing tool they used. Call bells were answered and people did not have to wait for staff to attend to them.

The premises were clean, comfortable, well decorated and spacious. Regular planned and preventative maintenance checks and repairs were carried out by the three members of maintenance staff. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire safety, window restrictors and water temperatures. External contractors also carried out required inspections and services including legionella checks, and electrical and gas safety. The records of these checks were up to date.

The accommodation was safe and well maintained. However, on the first day of this inspection portable hoists and other equipment was cluttering the length of the first floor corridor of one unit. This could have presented a tripping hazard for people on this unit. We discussed this with the acting manager who agreed these items should be kept in the storage room on this floor. By the second day these items had been suitably stored away.

Accidents and incidents were recorded and overseen by the acting manager for any trends. Over the past few months the acting manager had been analysing falls and introducing improvements to try to reduce the number of falls experienced by people. The acting manager carried out a weekly audit of accidents which included any required actions and the outcomes. The falls reports included the time of day, the area it happened and any cause of fall (for example, dizziness). Each fall was investigated, the person's falls risk assessment was reviewed and, where appropriate, a referral was made to the falls team. Staff were reminded at every handover to be extra vigilant about checking the people who were at risk of falls. Sensor alarm mats and other equipment to reduce falls were provided to alert staff to people's movements. These measures had led to a significant reduction in the number of falls experienced by people at this home.

Good

Is the service effective?

Our findings

A comprehensive staff training programme was in place which consisted of classroom based and online learning. New staff completed an induction programme which included dementia awareness, infection control, first aid and safeguarding adults. Staff completed further training at regular intervals on issues such as food hygiene, health and safety and the Mental Capacity Act (MCA) 2005. The provider used a computer based training management system which identified when each staff member was due further training. Training records showed mandatory training was up to date. Recent staff training included caring for the dying, which was provided by local hospice staff, diabetes awareness and moving and positioning.

Staff told us they received appropriate training to meet the needs of the people they cared for. One staff member said, "The training here is really good." Another staff member told us, "I think it is really good here as we get a lot of feedback, support and lots of training."

The acting manager ran staff awareness programmes on issues such as safeguarding, falls prevention and the human rights act. These were informative for staff and prompted discussion, which was good practice.

Staff told us they had regular supervision sessions and an annual appraisal with their managers. The purpose of supervisions was to promote best practice, offer staff support and identify any areas for development. Records confirmed staff had individual supervision sessions six times a year. This was in line with the provider's policy and the requirements of the local authority. Supervisions were up to date and covered relevant issues such as monitoring people's fluid intake and supporting people living with dementia. Staff told us they could go to their managers at any time, and didn't wait until the next supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. 66 DoLS applications had been authorised by the relevant local authorities. DoLS applications contained details of people's individual needs and were person-centred. All staff were up to date with MCA and DoLS training.

Best interest meetings had been carried out when needed, for example when a person did not have capacity to make a decision about taking their medicines. This meant staff were working collaboratively with local authorities to ensure people's best interests were protected.

People told us they were asked for their choice of meals the day before. Printed menus were on each table in the dining rooms in the different units. This meant people who were able could make informed decisions about their future meal choices. The menus also had a list of daily 'on request' alternatives such as omelette or jacket potato if people didn't fancy either of the two main dishes. People confirmed they sometimes asked for an omelette, soup or sandwiches and these were made available. One person said, "If I didn't like something staff would find me something else."

If people were unable to make their own choices due to their cognitive decline, staff were familiar with people's usual likes and dislikes. Staff were also knowledgeable about any special dietary needs, such as diabetes or whether people required 'soft' foods.

During a lunchtime meal staff discreetly checked if people were eating or whether they needed some encouragement. If people did not seem to eat much staff offered them sandwiches or yoghurts. People were offered a range of drinks, for example one person had chosen to have milk, others had tea or coffee and there was a choice of three different juice drinks.

All the meals were prepared in a central main kitchen and transported to each of the units by a hot trolley. Each unit had its own dining room. There were also well-equipped

Good

Is the service effective?

kitchens in most of the dining rooms which had biscuits and bread. Options for snacks in between meals are listed on the daily menu. For example, fresh fruit, pureed fruit, milk shakes, crisps and cakes.

Staff told us how they always encouraged people to eat and drink, and if a decline was noticed this would be monitored for a short time before contacting the GP. Staff on each unit carried out monthly audits of people's nutritional needs and intake. Any weight loss was actioned by contacting the person's GP for nutritional supplements, informing the family and changing to weekly weights to check the person's progress. In this way people's nutritional well-being was promoted and monitored.

The service had links with health care professionals such as, the tissue viability nurse, GPs, speech and language therapist, community mental health team, dietetics service and district nurse. A representative of the dietetics service told us the service was effective because "staff engage with dieticians and carry out care plans. They follow malnutrition universal screening tool (MUST) and are efficient at doing this on a weekly basis."

A representative of the speech and language team (SALT) told us the service made appropriate and frequent referrals to their team when staff were concerned about the safety of a person's eating and drinking. They told us they had been asked by the service to run staff awareness sessions about people with swallowing difficulties (dysphagia), so staff knew how to support people to eat and drink safely. They said staff knowledge of how to manage people with swallowing difficulties (dysphagia) varied across the four units, as only some staff had completed the relevant training. Records showed 48 staff had completed this training. The 37 staff yet to complete this training were due to attend in March 2016. Kitchen staff had attended specialist dysphagia chef training.

The representative of the speech and language team also told us, "The nurses and carers are easy to find, professional and are able to give useful information about the patient. It is evident which members of staff have attended training and have awareness of the correct recommendations to support safe eating and drinking."

Each unit had an information file which contained essential information such as emergency health care plans, diabetic checks, fortified diet details and SALT assessments. This meant important information about people who used the service was easily accessible to staff, particularly in an emergency situation. Each unit also had its own diary and communication book which contained detailed entries. This meant communication between staff was effective in promoting the best outcomes for people who used the service.

Good

Is the service caring?

Our findings

People were positive about the caring and compassionate nature of the staff who cared for them. One person said, “Staff are so kind and polite, and they are very friendly too so you can have a good laugh with them.” Another person told us, “The best thing about the place is the staff – they’re lovely. You can’t help but bond with them because they are so nice.”

A relative told us, “The staff couldn’t be nicer, when they ask how you are its genuine interest, they aren’t just asking for show. We couldn’t be happier with [relative’s] care.”

People felt the standard of care was good and that staff treated them with respect. One person told us, “It’s very nice here. I would recommend it to anyone. I wouldn’t live anywhere else, not even Buckingham Palace.”

People told us they felt their dignity and privacy were upheld by care staff. One person said, “It’s usually the same staff on, which makes me feel secure because they know me and I know them. It’s really important to me because I feel embarrassed when they have to help me shower or use the toilet but they do it in such a nice way.”

A staff member said, “All my colleagues are kind and get to know people really well. It’s hard when staff leave because we build such good relationships with the residents.” Another staff member told us, “The standard of care here is really good. The staff are really good at treating people with respect and dignity.”

A dietetic support worker said, “I love visiting Sycamore, it’s my favourite care home.” A representative of the speech and language team said about the staff, “I would be happy for my family members to be cared for by them. I have seen good rapport with residents and good examples of kindness, compassion, dignity and respect.”

People felt the accommodation was of a high quality and this made them feel valued. One person told us, “It’s lovely here. I’ve got great views of the garden with squirrels and birds on the birdfeeders. I have a lovely room and my own ensuite shower.”

People told us their choices were respected. One person said, “I’m having a lazy day today, I’m usually up but I have decided to stay in bed today, I can please myself.” Another person told us, “It’s very nice here, they ask me what I want, and I have a choice. My visitors can come when they want.”

During our inspection staff communicated with people in an appropriate manner according to their needs. For example, when staff supported a person to move from their wheelchair to a chair in the lounge they were competent, reassuring and supportive. Staff also dealt with a person who was distressed in a caring and kind manner. This meant staff were compassionate and knew people well.

Access to independent advice and assistance such as an advocate was well advertised throughout the service. At the time of our inspection two people used advocacy services.

The service had received numerous thank you cards from family members of people who used the service. One relative wrote, ‘We just can’t thank you enough for everything you’ve done for [relative]. We appreciate everything you have done. Thank you so much for your dedication’.

Good

Is the service responsive?

Our findings

People had been fully included in their own care planning, where capabilities allowed, and had given their consent. Some people had limited involvement in their care planning because their specific needs meant they could not always communicate. Relatives we spoke with said they felt involved in planning and reviewing their family member's care. A relative told us, "We were involved in all the care plans and we had a review recently. They ring us if anything is wrong." Another relative said, "We discussed everything before [relative] came in, all their likes and dislikes, what they like to drink, everything".

Care plans were clear, well written and specific to the individual's needs. They contained relevant risk assessments, daily notes, emergency health plans and people's likes and dislikes. Care plans were reviewed and updated regularly. This meant staff had access to up to date information about how to support people in a way appropriate to their needs. One person told us, "Staff get to know us and what we like or don't like. And for people who can't speak for themselves, staff know if they're not themselves or poorly."

There were clear examples of the service responding to and acting on people's changes in needs. For example, care staff noticed deterioration in the condition of one person's skin so they made a referral to the tissue viability nurse. The tissue viability nurse assessed the person and advised staff about pressure relieving equipment which made the person more comfortable.

A relative told us, "My [relative] had a chest infection recently and they were on it straight away, they had the doctor in and phoned me". Another relative said, "I get consulted over everything, they ring me if anything is wrong".

Staff told us how they deal with people who become anxious and agitated during twilight hours. Staff said they used different approaches depending on the person's needs, but included giving people one to one support in a quiet location or distraction techniques.

The service also responded to people's needs quickly in terms of maintenance issues. The head of estates told us, "We are as responsive as possible to service user needs and keep everything ticking over from light bulbs to heating. We respond swiftly to service users' and relatives' requests. This is a great place to work, my team has been here for years and we all love it".

The service employed two activities staff who provided a range of social events, activities, entertainment and outings. There was a large arts and crafts room in a central unit where people from all units were invited to take part in arts and crafts and other activities. One person said, "I go to the activities that I like then the staff bring me back when I'm ready. It's very, very good." A relative told us, "The activities lad is marvellous." During our inspection activities were well attended. The activities co-ordinator had a good rapport with people.

The activities staff held a family 'crafts club' each Saturday for visiting families and children to take part in alongside the people who lived there. Staff also supported people to join in events in the local community. For example, some people enjoyed going out to a cookery class at the nearby community centre where they could prepare a light meal which they ate together. Some people were supported to go to the Alzheimer's Society 'singing for the brain' class, which is a stimulating singing exercise for people living with dementia. There were also good links with local schools and people were invited to school concerts. Recently school children had supported people to record their life stories.

The provider had a clear complaints procedure which was up to date. The complaints policy referred to new legislation which meant the provider had a responsibility to act with a 'duty of candour' if something went wrong with the service. This meant the provider was fully aware of the requirements of how it should respond if people made a complaint. The policy directed staff to act on all comments and complaints "no matter how seemingly unimportant", and these should be taken seriously. In this way the provider aimed to listen to complaints and act upon them in the right way.

There was information for people about how to make a complaint in the service user guide (an information booklet that people received on admission). The manager kept detailed records of any complaints including the nature of the complaint, the actions taken and the outcome. Letters were sent to the complainant within two days to acknowledge their concerns and to let them know the likely timescales of the investigation. At the end of the

Good

Is the service responsive?

complaints process the complaint records were signed by the person to show whether they were satisfied with the outcome. The manager analysed the complaints to check if there were any emerging trends that could be addressed to improve the service overall.

All the complaints records we viewed showed the provider had resolved complaints quickly and to the satisfaction of the complainant. For example one recent complaint related to a television not working, so a new television was bought the next day. Another complaint about someone having to wait to be assisted into bed resulted in the staff member receiving supervision and extra training to help them understand how to support the person in the right way.

People who used the service and relatives we spoke with said they would speak to care staff or the manager if they had a concern or a complaint. One relative told us if they asked for anything for their family member staff sorted it immediately. Two relatives said they were concerned with clothes going missing when they went to the laundry, although they understood with such a large number of people living there “things can go missing”. They told us they had approached staff who were trying to resolve the problem.

Good

Is the service well-led?

Our findings

At the time of our inspection the registered manager had been absent since the end of July 2015. An acting manager was appointed at the beginning of August 2015. The provider notified us about this.

The people, relatives and staff members we spoke with felt the service was well-run. The provider had an effective quality assurance system and people's views about the service were frequently sought to check where any improvements could be made. People and their relatives had several opportunities to raise suggestions and comments about the service. These included resident/relative meetings which were held every two months. Also the manager had one-to-one satisfaction discussions every month with a random selection of around five staff members from the different units.

The provider also carried out annual satisfaction surveys for people, relatives, professionals and staff members. The results of the last survey in August 2015 were positive. All the people who had taken part said they were either 'very satisfied' or 'satisfied' with the care, the staff, the décor and the atmosphere. All of the people who took part said they would recommend it to others and their comments included "I am well looked after" and "it's like a 5 star hotel".

Relatives had also scored the service highly and 100% of those who replied would recommend the service to others. Professionals also responded positively on the appearance and cleanliness of the home, the assistance and attitude of staff and the general well-being of people who used the service. The provider had included any areas for improvement in an action plan to make sure that progress was monitored. For example, one area for improvement from the survey included more car parking spaces, which had been resolved.

People felt the atmosphere in the home was very good and said the care staff always seemed happy when they were attending to them. The staff members we spoke with said staff morale was good and they felt valued. People living on one unit told us they were "proud" and "delighted" that one of their care workers was voted by residents and relatives as 'Carer of the Year', an award which was organised by the provider. The staff member told us she was touched by the recognition and said, "All the staff work so hard, so it's really lovely to be appreciated by the people we care for."

Staff meetings were held every two months and the minutes showed these were inclusive and informative. Minutes of the last meeting in October 2015 reported staff felt morale was good and there was a "brilliant atmosphere" in the home for the people who lived there. Any actions were noted in the minutes for review of progress at the next meeting. There were weekly heads of department meetings to discuss any specific issues about people's health, changes in care needs (for example pressure wounds), housekeeping issues, complaints, staff training, comments or suggestions.

There was a clear organisational structure for managing this large care service. The manager was supported by a clinical lead, who supervised the nursing provision, and by three unit managers who each took responsibility for the daily oversight of three or four units. The staff members we spoke with felt supported by their line managers and by the provider. One staff member said, "I feel I can always go to [the unit manager] for advice, she's really nice. But I could also go to [the manager] or [provider] too - they are all approachable." Another staff member told us, "The new manager includes you in things and appreciates the staff. All the staff think highly of them."

The acting manager and staff carried out a number of audits to monitor the quality and safety of the service. These included weekly checks of accidents, falls, pressure care and complaints. These also included monthly audits of infection control, mattress safety, nutrition, and health and safety in all areas of the building. Areas of improvement were identified and acted upon. For example, analysis and action taken in relation to falls saw a reduction of falls.

Several staff took on additional responsibilities as 'champions' in various areas of safety or care, for example infection control champion, continence champion, dignity champion and dementia care champion. These lead roles helped to develop staff's knowledge of current best practices and they then monitored their colleagues to make sure all staff was meeting the latest guidelines. For example, the hand hygiene champion carried out observations of staff when using hygiene techniques and checked their practice. She had also held an information

Good

Is the service well-led?

session about this for people and their relatives at a recent meeting which they had enjoyed. As a result some people had also asked to be involved in fire evacuation training and this was being arranged.

The provider was also associated with, or a member of, a number of care organisations including the Care Homes Association, the National Activity Providers Association and the local Tyne and Wear Care Alliance.

In this way the provider aimed to continuously improve for the benefit of people who used its services and the staff who worked there.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).

This section is primarily information for the provider

Enforcement actions

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