Ascot Care (St Anne's) Ltd

St Annes Care Home

Inspection report

1-4 Rockcliffe
Whitley Bay
Tyne And Wear
NE26 2BG

Tel: 01912529172

Date of inspection visit:
19 July 2017

Date of publication:
04 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 19 July 2017 and was unannounced. This was the first rated inspection of the service since the provider re-registered the home with the Care Quality Commission (CQC) in July 2015 following a change to the company name. We previously inspected the service in January 2015 and rated it as 'Good'.

St. Anne's Care Home is a large three storey property overlooking the seafront at Whitley Bay and is close to the local amenities. The service is registered to provide accommodation and personal care for up to 40 older people who may also be living with a physical disability or a dementia related condition. Nursing care is not provided. At the time of our inspection there were 38 people using the service.

The established registered manager was still 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 told us that they felt safe living at St. Anne's with the support from the staff. There were safeguarding policies and procedures in place. Staff demonstrated that they were knowledgeable about what action they should take if they suspected people were at risk of harm. The local authority informed us that were no concerns regarding the service.

Records were kept up to date regarding accidents, incidents and near misses. These were recorded, investigated and reported in a timely manner to other relevant authorities such as the local authority or CQC as necessary.

The service managed risks associated with the health, safety and well-being of people, including completing regular checks of the property, equipment and utilities in line with their legal responsibilities. People's individual care needs related to aspects of daily living had been risk assessed and these were frequently reviewed.

Medicines were managed and administered safely and medicine administration records were organised, detailed and correct. Medicines were stored in a safe and secure place. Staff followed a strict policy and procedures regarding the receipt, storage, administration and disposal of medicines.

There was a sufficient level of staff deployed to safely meet people's needs. Staff records showed a robust recruitment process was in place and staff had been safely recruited. Staff training was up to date, and they were supported in their role by the management team through regular supervision and appraisal sessions.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a

law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the service was complying with legal requirements and applying the principals of the MCA.

Nutrition and hydration needs were met. We observed people received a choice of wholesome meals which were prepared by the catering team. People had choice around mealtimes but often ate one of the planned meals from the menu at a set time in the communal dining room. We saw people could chose an alternative meal, time and room if they preferred and individual dietary requirements were fulfilled. The service had involved external health professionals as necessary to meet people's changing needs and to support their general health and welfare.

People's individual health and social care needs had been assessed and a person-centred support plan was in place. We saw these were reviewed regularly to ensure staff were aware of people's current needs.

An activities coordinator was employed at the service and we saw a wide variety of activities on offer which people and their relatives enjoyed. One-to-one and group activities were promoted to reduce social isolation amongst people. Visitors were welcomed into the home at any time.

The registered manager told us how complaints were investigated and managed. Records confirmed this was done in a timely manner. The complaints procedure was on display and had been shared with people, relatives and external professionals. The service had received many compliments and 'Thank you' cards.

We heard a lot of positive comments about the staff. They were described as kind, caring and considerate of people's needs. People were treated with dignity and respect and their privacy was maintained. The registered manager and deputy manager were very visible and involved in delivering care to people.

The management team conducted regular quality assurance checks. These were overseen by a representative from the provider's organisation. These included daily, weekly and monthly checks of care monitoring tools to ensure people received high quality, appropriate care which met their needs. Regular staff meetings took place to ensure there was consistent and effective communication.

Surveys had been recently issued to gain the opinion of people, staff, relatives and professionals about how the service was managed and how it could be improved. We saw there had been an overall positive response to the survey and the results of which had been sent to the provider for evaluation and publication. Staff spoke highly of working at the home and they told us they felt valued and appreciated by the management team.

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 remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

St Annes 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 took place on 19 July 2017 and was unannounced. The inspection was conducted by one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about St. Anne's Care Home, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their 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 required to inform us of.

In addition, we contacted North Tyneside's local authority commissioning team and adult safeguarding team, the local Healthwatch service and the local fire service to obtain their feedback about the home. We also asked the provider to complete a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

As part of the inspection we spoke with 15 people, who lived at the service, four relatives and a visiting professional. In addition, we spoke with five members of staff, including the registered manager. We reviewed a range of care records and information kept regarding the management of the service. This included looking at four people's care records, five staff files and records relating to the quality monitoring and safety of the service.

Good

Is the service safe?

Our findings

People told us they felt the home was a safe place to live. Comments from seven people to describe the service included, "Everything in the home is fine. I can get up when I want and I can get a bath or shower, I feel very safe here", "They try their best here, and they succeed, we are very well looked after here", "It's very nice living here. I am very well looked after", "I have everything I need and feel very safe here", "I have a good room and I am well looked after," And, "I feel very safe and looked after here." Relatives echoed these comments.

Safeguarding policies and procedures remained in place to assist staff and help them to protect people from abuse or improper treatment. Staff were trained and knowledgeable about safeguarding vulnerable adults. They displayed a good understanding when we asked them about their role and responsibilities. Records of incidents of a safeguarding nature were monitored by the registered manager to help identify any patterns. They were also referred to the local authority and CQC as necessary.

Staff told us they were not afraid to speak up if they heard or witnessed misconduct. They told us, "I would report it (suspicious activity) straight away." The management team felt confident that staff would 'blow the whistle' on colleagues who mistreated people. The registered manager told us she was proud of the fact that staff questioned practice and were not afraid to speak up. This demonstrated that the service protected people well from improper treatment that may breach their human rights.

People's care needs had continued to be assessed on admission to the home and they had a corresponding risk assessment around aspects of daily living such as continence, pressure, mobility, medicines and nutrition. We saw that individual risks to people and environmental risks regarding the property were reviewed frequently. Records of accidents, incidents and near misses which occurred were kept and a separate log of any falls people had was closely monitored. The service had considered positive risk taking to promote independence. This meant people had freedom and their choices were respected, however all the risks were managed and reviewed in order to protect people from harm and reduce the likelihood of an accident or incident.

Personal Emergency Evacuation Plans (PEEPs) were available in care records. These are plans which the staff devised after assessing a person's ability to escape the building in the event of an emergency, such as a fire. Fire fighting equipment was in situ and we saw practice evacuation drills had taken place. All the staff we spoke with were confident about the emergency procedures. The provider had an up to date business continuity plan in place in the event incidents which may disrupt the service. This included local contact information and instructions for staff on how to deal with emergencies such as a loss of power or a flood. This meant the provider had considered the needs and safety of people in any event.

The property was safe and well maintained. The provider had undertaken all of the checks which are required by law, including servicing and tests of fire fighting equipment and the utilities. There were no issues with infection control. The home was clean, tidy and comfortable. A visiting professional told us, "There is never any mal-odour in this home." There were high standards of cleanliness expected and

designated domestic staff had responsibility for cleaning the bedrooms and communal areas. The catering staff ensured the kitchen area met the expectations. We saw all staff followed best practice guidelines in relation to infection control and food hygiene which reduced the likelihood of cross contamination.

We saw staff carried out their duties in a relaxed and unhurried manner. They appeared to have time to chat with people in between their tasks. We reviewed staff rotas and the service's dependency tool. A dependency tool measures the complexity of people's needs against the amount of hours each member of staff on duty works. These indicated that there were more than enough staff deployed to meet people's needs in a consistent, safe and timely manner. One relative told us, "There are always lots of carers around when I visit."

We checked the recruitment records of five members of staff. We saw there continued to be a robust recruitment procedure in place to ensure staff were suitable to work with vulnerable people. Staff were subjected to an application process which included an interview and reference check. The service also undertook a check with the Disclosure and Barring Service (DBS). These checks help employers make safer recruitment decisions as the DBS check a register to ensure candidates are not barred from working with vulnerable people.

The staff we spoke with confirmed these pre-employment checks had been carried out. Records relating to the management of staff included monitoring of sickness absences and any disciplinary action taken. This showed that the registered manager had ensured staff continued to be suitable to work with vulnerable people and their performance was monitored.

Medicines were managed safely and hygienically. We spent time with a senior care worker who was responsible for administering medicines to people. We observed them dispense people's individual medicines into separate containers. They approached people with care and spoke with them gently. We heard them say, "Hello (person's name), I've got your tablets here". They crouched down to be at the same level as the person and quietly encouraged them to take the medicine. People were not rushed and they were encouraged to take their medicines one at a time. An additional drink was offered and left with the person after administration. Medicine administration records (MARs) were completed after each task was completed. This meant accurate records were made if people accepted or refused their medicine.

We also spent some time in the treatment room. Medicines were stored safely and securely in line with nationally recognised best practice guidance. Within the locked room, there was a locked trolley which was securely fastened to the wall. It contained each person's individually labelled medicines. There was a separate locked cabinet fixed to a wall which contained controlled drugs. Controlled drugs are those medicines which require tighter legal control measures under the Misuse of Drugs Act (1971) because they are liable to misuse. We carried out a random check on the medicines and the controlled drugs. We found them to be accurately recorded and monitored.

Medicines which are only taken when required, such as paracetamol for pain relief were appropriately managed and individually labelled. Topical medicines were managed in line with best practice and a separate MAR was in place for these. They contained instructions for the staff about where to apply the topical medicines and how much was required. Topical medicines are those which are applied to the skin such as creams and ointments.

A locked refrigerator was in place for those medicines which required refrigeration. Staff completed checks on the temperature of the refrigerator and the treatment room. Daily, weekly and monthly auditing took place to ensure that medicines were administered safely and that staff accurately maintained records with

regards to the receiving of new medicines and disposing of unused medicines.

Good

Is the service effective?

Our findings

The provider ensured staff were trained in key topics which they deemed mandatory such as safeguarding, moving and handling, medicine management, infection control, food hygiene and first aid. Staff received training from a range of sources which included in-house training, distance learning, e-learning and external training providers. The registered manager had sourced additional training to meet specific needs related to end of life care, dementia care and other health conditions. This demonstrated that staff were able to care for people with a variety of healthcare needs.

Staff told us they completed refresher courses regularly and records confirmed this. We reviewed the training matrix which was a computer database the management maintained to monitor training requirements. We saw evidence of a wide range of training and health and social care qualifications in the staff files. A member of staff told us, "There is on-going training here all the time, if we need updating on best practice we can cover it in our team meetings or training will be arranged."

Staff files contained evidence which showed they had received a robust induction suited to their role, and they had been supervised during a probationary period. More recently, new care workers (without previous experience or qualifications) had undertaken the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. Competency checks were carried out by a senior care worker who was also a qualified 'Care Certificate' assessor to ensure people where competent in their role.

Records showed that regular supervision and an annual appraisal took place and staff confirmed this. We reviewed the most recent supervision and appraisal records. We saw topics such as safeguarding people and whistle blowing were routinely discussed and staff had an opportunity to speak with a manager openly and confidentially. Actions plans were devised which included training and any performance related improvements. A member of staff told us, "Appraisals are very good, I received good feedback and this helps to improve my work."

Handover meetings took place three times per day. The senior staff held these meetings with the staff team at the start and end of each shift. They then passed any relevant information to the registered manager to deal with. The registered manager told us, "Myself and [deputy manager] attend handover every morning." Staff meetings took place regularly and we saw they these were separated into senior care, care and ancillary staff meetings. We reviewed the minutes from staff meetings and handovers which showed that staff where communicating effectively to ensure people received necessary care and support.

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).

We checked whether the provider had continued to work within the principles of the MCA. Care records showed, and the registered manager confirmed that most people who used the service were subject to a DoLS. We reviewed the records regarding the applications to the local authority and outcomes of these decisions. The registered manager had also notified the Care Quality Commission of these applications and decisions. People who lack mental capacity may still have the ability to consent to some aspects of their care and support. Records showed that people had been included in any decision making processes along with their supporters as far as was reasonably possible. Records also showed that people (and/or people who lawfully made decisions on their behalf) had given their consent to receive the planned care and support along with other matters such as, having a photograph taken or sharing of information with external professionals.

We spoke with a member of the catering team. They told us they received good quality produce and fresh ingredients which enabled them to meet people's nutrition and hydration needs. They also told us they had plenty of staff in the kitchen which enabled them to routinely undertaken deep cleaning. We saw they followed best practice guidance in relation to the storage of food, separated areas for cooked and raw food, equipment and temperature monitoring.

There was a board in the kitchen to remind staff of people's differing dietary needs, such as diabetic, allergy and textured food requirements. They also received copies of nutritional care plans when new people moved in or when people's needs changed. Menus were produced which took into consideration people's preferences and seasonal ingredients, although anyone could choose something else if they wished such as sandwiches, soup, jacket potato or an omelette. The registered manager told us the catering staff were always happy to make people anything they could if people changed their mind from the set menu.

We observed staff supporting people over lunchtime and during their evening meal. People chose where they preferred to eat their meals. Some people used the communal dining area and we saw people were sitting together and positively interacting with the staff during their meal. We observed staff discreetly supported some people to eat their meal. Other people had equipment and adaptations such as coloured crockery, shaped cutlery or plate guards to allow them to remain as independent as possible. There were plenty of staff around during mealtimes, nobody waited long for their meals and people were not rushed.

People were complimentary about the food. Comments included, "The food is good, there is always a choice", "The food is very good", "There is plenty to eat if you want it, it's like being on holiday" and, "The food is good, I like everything they serve." The food was well presented, healthy and nutritious. Some people chose to stay in their bedroom to eat their meal. Staff served their meals on a tray and if necessary spent time assisting and encouraging them with their meal too. We heard staff offered people choices, which included choices about food, drinks, portion sizes and additional servings.

Care records showed that people's health and social care needs continued to be met with the involvement of external professionals as necessary. Routine appointments with a GP, dentist, optician and chiropodist had taken place as well as intervention in-between appointments if necessary. A visiting professional told us, "We communicate well and work together to improve my service to the residents." The staff promoted and monitored people's health and well-being to ensure referrals were made quickly when people's needs changed. We examined the food and fluid charts that were in place for some people with complex nutrition and/or hydration needs and we saw that people's food and fluid intake and their weights were closely monitored.

The décor was homely and pleasant throughout the building. The reception area was welcoming with music playing and a relaxing seating area to encourage socialisation. All of the communal areas had ornaments and memorabilia on display which were designed to stimulate interest and conversation.

The premises were continually adapted to suit the needs of the people who lived there. The service had considered best practice with regards to people living with a dementia related condition. People had personalised their bedrooms and had brought furniture, soft furnishings, ornaments and pictures from their own home. There were handrails in place, shower rooms with walk-in facilities as well as bathroom's with bath lifts and seats. The walls, doors and handrails were painted with contrasting colours to help people orientate themselves and the signage contained words and pictures to ensure people understood what was in the room.

Around the premises, the gardens remained well maintained with grassed and patio areas. There was a secure garden at the rear of the property with pots for planting and areas for people who wished to undertake gardening tasks. This meant people had access to appropriate space for privacy or they could socialise with other people and their visitors in pleasant surroundings. They could also access the outdoor space as much as they liked.

Good

Is the service caring?

Our findings

The atmosphere throughout the home was happy and friendly. People told us they were well looked after by a team of caring and motivated staff. Comments included, "The staff are very good, I have everything I need here", "The carers are always welcoming to my visitors, they are offered tea or coffee", "I certainly think 100% I have made the right choice to come here, and I have a lovely room" and, "Nothing is a bother to the staff."

Relatives also felt the service was caring. They said, "There is plenty of choice here, they [staff] make a real effort to please the residents", "I was worried at first but all the time I leave here I feel happy [person] is safe and cared for" and, "[Person] likes the staff here, and they are very settled. Since [person] arrived the staff have remained mostly the same and they have got to know them [staff] well." A visiting professional told us, "The staff here are very helpful I have got to know them all over the many years I have been coming here" and, "I only come back here because they are nice people [staff] to work with."

The staff carried out their roles with a caring and compassionate attitude. We spoke to staff who were able to tell us about the people they cared for and their life histories. It was apparent that staff knew people well and understood their needs. People appeared well cared for with their hair and nails properly groomed. People were suitably dressed and seemed alert and engaged. A visiting professional told us, "Residents are always clean and well-dressed when I see them."

We witnessed that a person who was distressed and did not fully understand what was happening due to their health condition posed a challenge for the staff. We saw this person was encouraged with patience and kindness to move into an ambulance chair in order to go to hospital. The care worker who accompanied the person to hospital told us, "I will stay with [person] until they are returned to the home, admitted to hospital or their family arrive." We noted that in the 30 minute period it took to assist the person into the ambulance, care staff worked together as a team and supported each other in order to provide care in an empathetic and calming manner.

We observed lots of positive interactions throughout the day between people, staff relatives and visitors. Staff interacted with people in a warm and friendly manner. People told us they felt they had established nice friendships with the staff and other people. Staff were kind and considerate and respected people's wishes. Staff promoted people's independence by assisting only when necessary and allowed people the time to complete some tasks themselves.

The registered manager told us that everyone living at the home had a similar ethnic background and religious beliefs and there was nobody with an obvious diverse need. People were supported to attend church services and local church leaders visited the home the in order to provide religious services such as Holy Communion. Records showed positive plans were made to ensure people's needs were met in a way which reflected their individuality and identity. Staff had undertaken equality and diversity training, which had provided them with the knowledge to put into practice.

We asked the registered manager whether any person currently used 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. The registered manager told us that they were aware of how to access an advocate if people needed this support. Most people had family who acted on their behalf with legal arrangements' in place such as relatives acting as a Lasting Power of Attorney for finances and health related matters. This was evidenced in their care records.

People and relatives explained to us about their involvement in devising care plans and we saw in care records that people and their relatives (where appropriate) had been involved in providing information to inform the staff of how care should be delivered.

People's privacy was protected and promoted and they were treated with dignity and respect by all staff. We saw on a noticeboard that the home promoted dignity in care and encouraged staff to become 'dignity champions'. There was a designated dignity champion within the staff team to ensure dignity remained a priority and a focus. The dignity champion had attended meetings, researched and shared best practice tips with staff and sourced events for people and staff to participate in. We saw staff knocked on people's doors before entering, spoke nicely to people and discreetly assisted people to eat in the dining area with dignity and compassion. For example, we heard staff quietly encourage people to wear an apron at mealtimes so their clothes would be protected.

At the time of our inspection there was no-one receiving end of life care or palliative care, however the registered manager told us they were particularly proud of the end of life care provided at St. Anne's. They said, "I think we exceed on end on life care, we get lots of compliments from families, GP's and nurses. We have even looked after a GP's and a Nurse's parent [at that time of their lives]. We have a good relationship with families, a good bond. They put a lot of trust in us to get it right." We saw that care plans were in place for those who had shared their wishes with regards to end of life care. Preferences were documented with regards to resuscitation and withdrawal of medical assistance. In some care plans people had chosen not to share their end of life wishes and this was recorded and reviewed on a regular basis.

Good

Is the service responsive?

Our findings

People and their relatives told us they thought the service was responsive. We saw staff were conscientious, attentive and responsive to people's needs throughout the inspection.

Person-centred care plans were in place and they detailed people's individual needs and preferences. Each person had a care plan for the aspects of their daily lives in which they required support with, such as personal care, medicines, mobility and nutrition. For example, the cook told us that they had a separate fryer which they used especially for one person who had a shellfish allergy. They told us, "I just cook anything they want in there just in case their meal gets into contact with anything that may have been in contact with shellfish." The service ensured there was a holistic approach to caring for people and that all needs were met such as physical, social, emotional and religious. This meant information was available to staff to ensure they provided care and support to people in the way that they preferred. The staff carried out a number of reviews to ensure the service continued to meet people's needs appropriately. However we found these were sometimes brief and repetitive. The registered manager told us they would look to streamline the reviews to ensure a more comprehensive approach.

Each person has a 'transfer document' completed. These are sometimes known as 'hospital passports.' Emergency healthcare plans were in place and records of people's wishes with regards to resuscitation. This documentation ensured people's needs, wishes and preferences in urgent situations or at times when they are unable to make their views known would be taken into account by staff and other external professionals such as paramedics and doctors who are required to provide additional care and treatment. 'Hospital passports' are used when people move between the home and a hospital to ensure effective communication.

On the day of our inspection, the activities coordinator was not available but people and relatives told us that social needs were met. They commented positively on how their days were spent and the activities and social support on offer. One person told us, "There isn't much to do at the minute, the activities lady retired and the new man is on holiday, but normally there is something happening." Others told us, "The young man (activities co-ordinator) used to take us for walks", "We went on a trip out and had a meal, we often do this in the summer", "They are very good, we have bingo and music, the staff are smashing" and, "We have clothes parties where we can buy clothes." The registered manager told us that in the absence of the activities coordinator they had a designated care worker who covered the activity arrangements to ensure there are some activities scheduled. We saw a full programme of activities were on display on the noticeboard. Records showed that people had enjoyed a recent bus trip to Amble and had ice cream from a visiting ice cream van. Other planned events included students from a volunteering project and younger school children visiting to interact and socialise with people, entertainers, theatre trips, toiletry, chocolate and clothing parties and individual birthday parties and buffets for special occasions.

We saw people were engaged with staff and each other. The home was busy all day with people and visitors coming and going. People chose which area of the home they preferred to sit in and we saw people chatting to each other in the communal lounges which overlooked the seafront, the dining room and the reception

area, which was furnished with large comfortable chairs. Only a few people remained in their bedrooms throughout the day. One person told us, "I like it here, I have made friends." Another person said, "I like it here very much, I was here for respite before, and returned because it's nice. The staff are so caring, and I can sit in the front garden and read the papers, its lovely." This demonstrated that the service actively promoted socialisation and inclusion for all of the people who lived there.

The complaints procedure remained in place. There had been two complaints recorded in the past five months. The registered managed described the action they had taken to manage the complaints effectively and how they reached a satisfactory outcome for the complainants. Comprehensive records were kept of the action taken, the outcome, conclusions, lessons learned and any preventative action that could be taken to reduce the likelihood of a repeated incident. Analysis was undertaken to identify any patterns or trends. The provider's complaints policy indicated that they took a proactive approach to resolving people's issues without the need to resort to the formal complaints process. The registered manager confirmed that their 'open door' culture within the service encouraged people, staff and relatives to speak with them immediately if they are dissatisfied with anything. They said, "Most of the time, we can quickly resolve minor issues."

Everyone we spoke with was complimentary about the service and they could not provide any examples of when they had needed to make a complaint. All of the people and relatives we spoke with told us they were confident enough to raise any issues with the staff and they felt that they would be listened to and have their issues resolved. This demonstrated that there was an established and effective complaints process in place which included thorough investigations and provided satisfactory outcomes for people who used the service.

Good

Is the service well-led?

Our findings

At our last inspection of this service in January 2015 we found that the provider was meeting all of the regulations and rated the service as 'Good'. Following that inspection, the provider re-registered the service with CQC due to a change to their company name in July 2015.

The established registered manager was still in post. They had been in post since April 2014. The registered manager and provider were meeting the conditions of their registrations which included the submission of statutory notifications. These are records of matters or incidents that have occurred within the service that they are legally required to inform us of.

There was a consistent and stable team of staff, many of whom had worked for the provider for over 10 years. Staff told us they enjoyed working at the home and the morale was good. One member of staff said, "If it wasn't a good place to work or a good company, we wouldn't have stayed for so long." A newer member of staff said, "This is my first job in care and I am really enjoying it here."

People who lived at the home spoke positively about it. They made comments such as, "It's good living here, I can't complain, I have lived here a long time and I am getting well looked after" and, "I have lived here for nearly nine years, I am very happy here." Relatives and visitors we spoke with were also positive about the service. They told us the registered manager and the deputy manager were visible throughout the home and everyone knew them by name and sight. They told us they were made to feel very welcome at the home and they said they could visit at any time. A relative told us, "The staff always offer me a cup of tea when I visit." The registered manager told us they often invited relatives to stay and have a meal with their parent or spouse.

Communication remained effective throughout the home. Staff meetings were held quarterly and staff told us they were given an opportunity to raise any issues and felt their views would be considered. One member of staff told us, "Team meetings are compulsory to attend." Handover meetings were carried out three times per day to ensure consistent and safe care was maintained. The registered manager and deputy manager attended handover meetings every morning to ensure they had oversight of the service on a daily basis.

'Resident and Relatives' meetings were held every month and we saw records which indicated that six to eight people regularly attended them. These meetings were used to share information about the service, discuss forthcoming events and ask people for feedback and ideas for the service. We saw that the recent bus trip to Amble had been suggested at the last meeting.

Information, advice and guidance were on display around the home and were included in a 'Service user Guide' which was given to people upon admission. For example, this included local safeguarding contacts and information on dementia and advocacy services. The registered manager also produced a monthly newsletter to communicate news and events to people. It also included a welcome note to new people, birthdays and the employee of the month results. This meant that people were involved in the running of the service and it showed that the staff facilitated access to advice and guidance which would be of benefit

to people who used the service.

An annual survey had been recently carried out to obtain people's, relative's, staff's and visitor's views. The registered manager shared the responses with us which showed an overall positive result from 21 people/relative's responses, 22 staff and four visiting professionals. Comments written on the surveys included, "St. Anne's is a well-run home with good facilities and caring staff", "[Home] chosen because of its homely feel" and "[We are] very satisfied with the care and treatment."

A range of audits and checks were carried out to ensure that people received safe, high quality care, provided by competent and reliable staff. This included having oversight of the systems used to manage medicines, update care plans and ensure the premises were kept safe. Our observations and findings on the day of the inspection confirmed that there was an effective quality monitoring system in place. People, staff and relatives confirmed that checks took place. We reviewed the quality assurance records and saw these were consistently completed and up to date with comprehensive details. Action plans had been drawn up when improvements had been identified and action was taken to rectify or improve the service in a timely manner.

The provider continued to reward their staff through recognition schemes and small tokens of appreciation. One member of staff told us, "Moral here is generally good, we have an employee of the month award selected from relatives and residents nominations." The registered manager told us they felt this helped to keep the staff motivated.

The service had maintained its community links with other local providers, community services and local businesses. The registered manager told us they had a good relationship with the external professionals who visited the service and worked well in partnership with local authorities. The registered manager also told us they had a good relationship with their sister service and often arranged training for the staff to share best practice ideas with each other and activities for people to encourage them to meet other people from their community. The staff at St. Anne's had started to plan a project to introduce an 'Alzheimer's Memory Walk' in North Tyneside which currently takes place in neighbouring areas. The registered manager told us they were keen to make this an annual event and planned to involve the local community.