Care Quality Commission

Miss Lucy Craig

Cramlington House

Inspection report

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Ratings

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

Overall summary

Cramlington House provides accommodation and personal care and support for up to 63 people. Most of the people living at the home were living with some form of dementia or cognitive impairment. At the time of our inspection there were 63 people living at the service.

This inspection took place on 5 and 18 May 2015 and was unannounced. The last scheduled inspection we carried out at this service was in June 2014 when we found the provider was not meeting Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2010, Management of medicines. In January 2015 we revisited the home to check that improvements had been made and found that there was continuing non-compliance in relation to this regulation. We took enforcement action at that time and issued the provider and registered manager with a warning notice stating they must improve by February 2015.

This inspection was carried out as a comprehensive inspection to review the overall quality of the service and

Summary of findings

to rate it under the Care Act 2014. As part of this inspection we checked whether the provider had met the requirements of the warning notice related to the safe handling of medicines, that had previously been set.

At the time of our inspection there was a registered manager in post who had been formally registered with the Care Quality Commission (CQC) since August 2014. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that whilst some improvements had been made in respect of the management of medicines, a serious medication error had occurred which had not been identified by the provider. One person had received incorrect, and potentially harmful treatment, as medicines that were discontinued in hospital were accidentally restarted and taken alongside replacement, newly prescribed medicines. The error occurred because the process for booking in new medicines was not robust enough.

Safeguarding policies and procedures were in place and the registered manager followed these when matters of a safeguarding nature arose. Staff were clear on the different types of abuse and their own personal responsibility to protect people from abuse and report any incidents of abuse that they may witness or suspect. People told us they felt safe living at the home and comfortable in the presence of staff.

Risks that people were exposed to in their daily lives had been assessed, such as risks associated with mobility and skin integrity. Environmental risks within the home had been assessed and measures put in place to protect the health and wellbeing of people, staff and visitors.

Staffing levels were sufficient to meet people's needs and staff were not unduly rushed. People had their needs met in a timely manner on the days of our inspection. Staff turnover had been high recently but management had plans in place to address a small number of vacancies. Recruitment procedures were robust and ensured that the staff employed by the provider were appropriately skilled and of suitable character to work with vulnerable adults. Records showed that staff were trained in a number of key areas such as moving and handling, infection control and the Mental Capacity Act 2005 (MCA). In addition, staff had received training in areas specific to the needs of the people they supported, such as training in dementia care. Staff told us they felt supported by the registered manager and they received supervision and appraisal.

The MCA was appropriately applied and the best interest's decision making process had been followed where necessary. Some records related to decisions made in people's best interests were not appropriately maintained. The registered manager told us that this would be addressed and that in future the decision making process would be better documented.

People told us, and records confirmed that their general healthcare needs were met. General practitioners were called where there were concerns about people's health and welfare as were other healthcare professionals such challenging behaviour clinicians. People told us the food they were served was good and we saw there was a variety of wholesome food on offer. People's nutritional needs were met and specialist advice was sought when needed, for example from dieticians.

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people, and people, their relatives and healthcare professionals linked to the home all spoke highly of the staff team. Staff were aware of people's individual needs and care was person-centred. Overall people's care records were well maintained and staff told us they felt they had enough information available to them, to provide effective and safe care. People told us they were supported to engage in activities within the home if they wanted to and relatives told us they appreciated the fact that the provider arranged excursions locally for their family members.

The environment of the home aided people living with dementia care needs, by orientating them. There was signage around the home and in people's bedrooms to enable them to be as independent as possible whilst going about their daily lives. People also had unlimited access to outdoor space which benefitted their wellbeing.

The provider gathered feedback about the service from people, their relatives and staff via meetings and surveys.

Summary of findings

There was a complaints policy and procedure in place and records showed that historical formal complaints were handled appropriately and documentation retained. Low level concerns and complaints were not as well documented and we discussed this with the provider who told us that this matter would be addressed.

Quality assurance systems and care monitoring tools such as weight charts, were used to monitor care delivery and the overall operation of the service. For example, audits related to health and safety within the building were carried out regularly. Checks on the building and equipment used in care delivery were undertaken in line with recommended time frames.

This inspection found that the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was related to safe care and treatment of service users, in respect of the proper and safe management of medicines. Where we have identified a breach of regulation which is more serious, we will make sure action is taken and we will report on this when it is complete.

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

Inadequate

Whilst improvements had been made in the management of medicines since our last inspection, we found a serious medication error which had resulted in a person receiving potentially harmful treatment. This meant there were continuing shortfalls in the management of medicines.

Safeguarding policies and procedures were in place and we could see these had been followed where necessary. Staffing levels were sufficient to met people's needs in a timely manner and recruitment processes were robust.

Risks that people had been exposed to in their daily lives had been assessed and were reviewed regularly, as were environmental risks around the building.

Is the service effective?
The service was effective.

Good

People received care from staff that were appropriately skilled and supported to carry out their roles. Supervisions and appraisals took place and staff told us that the induction programme was thorough and effective.

People's general healthcare needs were met and where input was required from specialist healthcare professionals this was arranged. People's nutritional needs were met and their weights and food and fluid intake were monitored, if required, to ensure they remained healthy.

The MCA was applied correctly but the documentation related to decisions made under this legislation needed to be better maintained.

Is the service caring?
The service was caring.

Good

Staff displayed caring and compassionate attitudes and engaged with people in a polite and respectful manner.

We witnessed some good examples of care that promoted people's right to independence and choice. People's dignity was maintained.

Is the service responsive?
The service was responsive.

Good

People received care that was person-centred and appropriate to their needs.

Care records were individualised and regularly reviewed and amended accordingly. Care monitoring tools such as food and fluid charts were used to monitor the care that people received and to respond when people's needs changed.

Summary of findings

Complaints were handled appropriately and feedback was obtained from people, relatives and staff on a regular basis through meetings within the home and annual surveys.

Is the service well-led?
The service was well-led.

Staff told us the registered manager was approachable and they felt confident she would address any issues that were brought to her attention.

Quality assurance systems were in place and included a range of audits and checks to ensure the service operated safely and appropriately. Actions were generally taken where matters needed to be addressed as a result of audit findings.

The medication audit was not robust enough to identify the serious medication error that we found related to one person during this inspection.

Requires improvement

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Cramlington House

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 5 and 18 May 2015 and was unannounced. The inspection team consisted of three inspectors and a pharmacy inspector.

Prior to our inspection we reviewed all of the information that we held about the service. This included reviewing any statutory notifications the provider had sent us in the 12 month period prior to our inspection. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch (Northumberland). Healthwatch is an independent consumer champion organisation, who gather and represent the views of the public about health and social care services. We used the information that they provided us with to inform the planning of our inspection.

During our inspection we spoke with 17 people living at Cramlington House, five people's relatives, five healthcare professionals linked to the home, 14 members of the care staff team, the deputy manager, the registered manager, the general manager and the provider. We walked around each floor of the home, all communal areas such as lounges and dining rooms, the kitchen and we viewed people's private space in their bedrooms, with their consent. We carried out a short observational framework for inspection (SOFI) to help us understand the experience of people who were unable to communicate their views and feelings to us verbally, due to their dementia care needs. We analysed a range of records related to people's individual care and also records related to the management of the service and matters of a health and safety nature. For example, we studied nine people's care records, staff recruitment records, training and induction records, people's medicines administration records (MARs) and records related to quality assurance audits and utility supplies certifications.

Inadequate

Is the service safe?

Our findings

At our last inspection we took enforcement action against the provider in respect of medicines management and issued a warning notice saying they must comply the relevant regulation of the Health and Social Care Act 2008. We carried out this inspection to check if the provider had achieved compliance in this area. We looked at medicines administration records (MARs), medicines in use, and guidance related to the use of medicines. Whilst we found improvements had been made, we continued to find errors in the handling of medicines.

We looked at the management of changes to medicines following hospital discharge for one person. We found that changes to medicines immediately after discharge from hospital were made correctly. However, when the new cycle of medicines was received and put into use, these had not been checked against the changes made in hospital. This resulted in the person receiving incorrect, and potentially harmful, treatment as medicines that were discontinued in hospital were accidentally restarted and taken alongside replacement, newly prescribed medicines. These medicines were blood thinning medicines. We looked for guidance for managing high risk medicines such as blood thinning medicines but found that there was no specific written guidance in place to ensure that all staff managed these medicines safely, and that they monitored people for side effects that may require medical review.

This continuing failure to safely manage medicines, albeit for only one person, had placed that person at significant risk of receiving care which did not meet their needs or ensure their safety and welfare. The evidence also showed that the service did not have an appropriate system in place regarding the monitoring and review of medicine prescribing and administration. The provider and registered manager responded promptly to this matter and took immediate steps to seek medical advice, establish exactly what had occurred in this instance and to effect immediate changes to staff practice and systems.

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

We looked at information relating to the use of “when required” medicines. Protocols were in place for most medicines that explained what they were for, the maximum dose to be given in one day and ways to identify when they were needed.

Appropriate arrangements were in place in relation to the recording of medicines. We looked at records for the use and administration of medicines in detail for six people. MARs were signed correctly when medicines were given. We counted a sample of 11 medicines and checked the balance against records. These tallied suggesting that most medicines were given correctly. The provider was introducing new arrangements for recording the application of creams and the system still needed to be fully embedded. Body maps that showed where and how to use creams were mostly in place and records for administration were mostly complete.

Medicines were kept safely. Storage was clean, tidy, secure and at the correct temperature so that medicines were fit for use. We looked at the handling of medicines liable to misuse, called controlled drugs. These were stored safely to reduce the risk of mishandling. The record of stock for one controlled drug was incorrect on four consecutive occasions despite being second checked. The actual stock, however, was correct.

People told us they felt safe and comfortable living at the home. One person told us, “Oh yes, I feel safe here”. Other comments included, “The staff are lovely with us here” and “I have never felt uncomfortable in here”.

Staff were able to describe the provider’s safeguarding procedures and the appropriate action they would take if either a person raised concerns with them, or they witnessed or suspected abuse had occurred. They said they would feel comfortable if they had to raise any concerns and were satisfied these would be taken seriously by the registered manager and senior staff. They were aware of the whistleblowing policy and said they would report any poor practice. All of the staff we spoke with told us they had not had any concerns about care practices or people’s safety within the home and they had undertaken safeguarding training. CQC records we reviewed prior to this inspection, and feedback we received from Northumberland safeguarding team, confirmed that management within the service were aware of their responsibilities to report safeguarding matters and they did so.

Inadequate

Is the service safe?

Records of accidents and incidents that occurred within the home showed they were managed appropriately to ensure that people remained safe. A monthly analysis of accidents and incidents was carried out by the registered manager to identify if any trends or patterns had developed that needed to be addressed. People had been referred to external healthcare professionals for input into their care if necessary. For example, one person was referred to their general practitioner for a blood test following a short period of falls and another person was referred to an occupational therapist as their legs had weakened.

Risks which people were exposed to in their daily lives had been assessed and written instructions were in place for staff to follow in people's care records about how to manage and reduce these risks. This was so that ways to lower the risk, or stop harm from occurring, could be identified (risk assessments). For example, risk assessments were in place for people who were assisted to move using hoists or other lifting equipment. These were regularly updated and at other times when people's needs changed. For example, we saw when someone returned to the home from hospital, their risk assessment for moving and handling had been updated to reflect changes in their needs.

Environmental risks around the building had been assessed and these were reviewed on a regular basis. Regular fire and health and safety checks were carried out and documented. Equipment was serviced and maintained regularly in line with recommendations. Checks were carried out on, for example, electrical equipment, the electrical installation within the building and utility supplies, to ensure they remained safe. Legionella control measures were in place to prevent the development of legionella bacteria, such as checking water temperatures. This showed the provider sought to ensure the health and safety of people, staff and visitors.

Staffing levels were generally well maintained but on one of the three units of the home there was a shortage of one staff member short due to sickness. Staff were busy but they made sure people using the lounges were not left for long periods. Generally there was a staff member present in the public areas of the home. On the other units staffing levels appeared sufficient for people's needs and staff were not unduly rushed. They had some time to spend talking with people, although staff told us that an increase in staff numbers would be appreciated to allow them to spend even more time with people. The district nurse told us, "They appear to have enough staff".

The provider's recruitment and vetting procedures related to the recruitment of new staff were appropriate and protected the safety of people who lived at the home. Checks on potential staff members' identification, work history, character and health were carried out before staff began work. One staff member said, "Here the staff have two interviews. Their second interview is on the floor seeing how they interact with the residents which is so important. We check to see how they approach the residents and if they communicate well…I've never worked in a place that does that before." This showed the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit and appropriately qualified to do their job.

Good

Is the service effective?

Our findings

People told us that the service met their needs and they were happy with the care and assistance that they received. One person told us, “The care is fine and the staff are good. They know what to do when they help me to stand. I find it difficult. As far as I am concerned they help me with my situation”. Another person told us, “They look after us; they are absolutely fantastic”. We spoke with one relative who said, “My job for 23 years was managing places like this place. It’s excellent here, I would not have put my husband anywhere else. They manage incontinence very well”.

Staff met people’s needs effectively during our visit. For example, we saw people were supported with mobility where necessary and assisted with eating to meet their nutritional needs. People with cognitive impairments received assistance to find their way around the home and were supported with daily living tasks like toileting and dressing. Staff spent time talking with people and reassuring them if they became anxious. They used distraction techniques to good effect and put the training they had undertaken in dementia care into practice. For example, one person was offered a cup of tea and something to eat when their mood and behaviour became agitated.

People’s general healthcare needs were met and we found evidence that people were supported to access routine medical support to ensure their health and wellbeing was maintained. In addition, people had input into their care from healthcare professionals such as dieticians and psychiatrists whenever necessary. One healthcare professional linked to the home shared their views of the care they saw delivered at the home. They told us, “X (person’s name) gets really good care”. Another healthcare professional told us, “The care is good, they are so good with people”.

The environment had been designed with people’s dementia care needs in mind. For example, there were brightly coloured toilet seats and toilet brushes to aid people when toileting. Walls were painted in different colours where their direction changed and people had signage to refer to around the home which orientated them. The provider had invested in a coffee shop, hairdressing salon and cinema room in the design of the home and this provided stimulation for people and occupied their minds. People also had unlimited access to secure outdoor space at their leisure.

People’s nutritional needs were met. Individual records showed that nutritional assessments were undertaken. This was done using the Malnutrition Universal Screening Tool (MUST). This tool helps staff identify people who are at risk of losing or putting on too much weight. Weights were monitored monthly or more frequently when an issue was identified. Food and fluid charts were in use where necessary to monitor people’s intake where concerns had been identified. There was evidence the service sought specialist advice for individuals from dieticians, if necessary. Some person’s care plans indicated that they had been referred to the speech and language team and the advice provided had been incorporated into relevant care plans. Specific dietary needs were also recorded, for example, if people had regular dietary supplements or needed regular prompting to eat their meals. There was information about people’s culinary likes and dislikes in their individual care records.

When we observed a meal being served we saw staff were aware of people’s preferences, for example what vegetables they preferred and the portion size for each person. People were supported to have their meal. We heard one care worker ask, “Do you want your potatoes cut up?” Staff assisted people to be independent. One care worker said, “I think it would be easier to use your spoon” and “That one is your knife, the fork is beside you?” We asked one person whether he liked his meal, he replied, “It’s very nice.” One relative told us, “The food is spot on; I have Sunday lunch with X (person’s name) every week. People have a good diet”.

We reviewed how the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were applied and found that due consideration had been given to people’s mental capacity levels. Applications for DoLS had been made to the local authority safeguarding team in accordance with good practice. DoLS are a legal process which is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. Decisions about these applications are made in people’s best interests by the relevant local authority supervising body. Records related to care decisions made in people’s best interests needed some improvement, to state clearly

Is the service effective?

who had been involved in the decision making process. In addition, whilst the provider had explored whether people's families had lasting power of attorney in place for health and welfare decisions, they had not obtained copies of these documents to confirm their right to make care based decisions. The registered manager told us this would be addressed.

Staff told us they had plenty of training opportunities and records confirmed this. One staff member said, "Some training is on the computer and other things face to face. It is good to get together with other people and discuss things." Another member of staff told us, "I have found the dementia training particularly helpful." Records showed that staff received training in a number of key areas such as moving and handling and infection control. In addition, staff had undertaken courses in subjects specific to the needs of the people that they supported such as dementia awareness and epilepsy awareness. Staff were enthusiastic about the training they had completed and we found them to be motivated and appreciative of the training opportunities provided.

One care worker told us she had been well supported by the management team and other staff during her "thorough" induction. They said "I worked in care, but it was a long time ago so it was good because lots of things had changed. I felt more confident when I had completed the induction training". She said she was introduced to each person in the home and had shadowed an experienced member of staff. She said she had not been asked to do anything she was not comfortable with until her competencies and confidence grew.

We spoke with a learning and development officer from the local NHS trust's learning and development team. She said that staff had been accessing their training. She also stated that the management team were "very passionate" about the service. She informed us that the registered manager had invited them into the home to map over the new Care Certificate induction standards. The Care Certificate is an identified set of standards that care workers adhere to in their daily working life. It was developed to address inconsistences in training and competencies in the workforce so that people and families experiencing care services can have confidence that all staff have the same introductory skills, knowledge and behaviours.

There was a supervision and appraisal system in place and whilst most staff said they received supervision regularly some staff told us they had not had a supervision for "a while". We discussed this with the registered manager and operations manager who told us that any oversights in this area would be addressed as soon as possible.

Good

Is the service caring?

Our findings

One person told us, “I am happy living here and my room is smashing. The staff are brilliant I have never heard a cross word from them. I don’t know how they do it.” Another person said, “The staff are busy, but they are always pleasant and helpful. I have my door open and then they speak as they go past and I can see what is going on.” One person who was cared for in bed spoke with us. She looked well-presented and comfortable. She said she was happy living at the home and the care workers were “kind.”

A relative told us they visited daily. They said they had always found the staff to be helpful and kind. Another relative commented, “The staff are caring, they have supported me as well. It’s home from home. It’s as near to perfect as you could get. I’ve never observed staff approach people with anything less than empathy and dignity”.

Healthcare professionals linked with the home gave us positive feedback about the staff team and their caring nature. A district nurse told us, “They are always attentive and friendly. I have nothing bad to say. Staff appear happy and show lots of interest. There is constant interaction between staff and people.” A social worker told us, “The care is good, they are so good with people. It passes the family and friends test.”

People appeared comfortable and relaxed with staff. We observed many pleasant, positive interactions between people and staff and there was a sense of camaraderie. We heard one staff member say to a person “Are you lost, you come here with me.” Another person was chasing a member of staff down the corridor laughing. They were both laughing as he called her “shorty pants.” She said, “We’ll have a cup of tea later on” and gave him a cuddle. One staff member was seen and heard saying, “If you need anything just press the call bell my lovely. Are you ok today? How are you feeling?” Staff approached people sensitively and assisted people in a calm manner.

Staff were knowledgeable about people’s likes and dislikes. One care worker said “X (person’s name) likes her family. She likes to sit in her room. She is comfortable with familiar faces. I like to go and sit with her with a cup of tea and have a chat”. The activities coordinator told us, “It’s all about getting to know your residents and making sure they are central to everything you do. I’ve been off recently and I couldn’t wait to get back to see all my lovely people”.

People’s life history’s had been written in their care records and we saw staff sat with people and talked about information in their past during our visit. It was evident that staff thought highly of the people they cared for and they got to know them and what was important to them. People received a positive and caring experience as a result.

We spoke with six members of staff who worked night shift. One care worker said, “If residents get up through the night, we sit with them and talk to them, that’s my job, it’s important. We talk to them about their past. We don’t discourage them from talking about things. If they mention their mum and dad, we don’t say to them they are dead, we sit and listen”. Another care worker told us, “We enjoy banter and it’s nice to see them smiling, I think it helps them sleep when they go to sleep happy. Sometimes I do stupid things like do a silly dance. One person likes to have a dance, so we dance.”

Staff encouraged people to be as independent as possible. For instance, people were supported with mobility if they needed it or with orientation if they appeared confused. At lunch we saw people had the adaptations they needed to remain as independent as possible, for example, some people had adapted drinking cups to aid them to consume fluids independently.

Staff told us they always asked people before providing any care or support to make sure they were involved, agreed with and understood what they were going to do. We saw this happened in practice. They understood the need to maintain confidentiality and respect people’s privacy and dignity. Staff gave examples of how they maintained people’s privacy and dignity such as, knocking on people’s doors and waiting for permission to enter. We saw that staff promoted people’s privacy and dignity in practice. For example, we passed one lady’s bedroom and noticed her skirt had risen up her thighs whilst she was sleeping. Staff noticed this and rearranged her clothing so she was no longer exposed, to maintain her dignity. One relative told us, “They (staff) always knock on the door.”

The service supported people’s diverse needs. A chaplain visited the home on the day of our inspection, in order to meet people’s spiritual needs. He told us, “This is one of the loveliest homes I have come in. The carers are very lovely, caring and dedicated and always do their very best for the residents. If I had to come to a home, it would be this one. They really look at the whole holistic approach to care – the spiritual side is so important”.

Good

Is the service caring?

Information was recorded in people's care records about their preferences for end of life care. One person who was receiving end of life care had been visited by an independent advocate, McMillan nurse, district nurses and their GP, who were all involved in assisting the person to make choices about their care. Interventions by these professionals were clearly recorded and any changes in medication were updated in their care records.

The registered manager told us that people either had relatives who advocated on their behalf or some had formal advocates in place that had been arranged through an external advocacy organisation. This was evident in people's care records. Advocates represent the views of people who are unable to express their own wishes, should this be required.

Good

Is the service responsive?

Our findings

People said the care they received was good and changed when their needs changed. For instance, one person commented, “If I wasn’t well they would get me a doctor. They look after us”. One relative told us, “They are genuinely aware and understanding of people’s needs”.

Healthcare professionals linked with the home told us they found the service responsive to their requests for information and the care plans that they put in place. They also told us they found the service to be responsive to changes in people’s needs. A challenging behaviour clinician told us, “They (the service) are proactive and provide proactive care”. The district nurse told us, “There’s a really good culture of reporting things early and catching things before they develop”. A social worker said, “I’ve never had any concerns; I’ve got very high standards. They’re very good at handling things, they don’t panic and they do inform me”.

One relative showed us how staff had rearranged her husband’s furniture in his room to reduce the risk of falls. The relative told us, “You couldn’t get more proactive than that.” She also said, “They are absolutely responsive and they do it with dignity and sensitivity. Everything he needs is provided. He has been seen by the OT (Occupational Therapist) and he now has a larger wheelchair”.

People’s care records were individualised and contained information about how to meet their needs. The quality of recording was consistent and up to date information was provided about each individual. A comprehensive assessment of needs was carried out prior to admission to the service and a range of different care plans linked to people’s dependencies had been drafted. Individual risk assessments were in place for issues such as falling, moving and handling, nutrition, and weight loss. These were reviewed monthly and when changes were identified in risk assessments, care plans were updated to reflect this. For example, changes were made to one person’s care plan following their return to the home from hospital where they had been treated following a fall. Advice from GPs or other health care professionals was recorded within their care records and care plans were amended where necessary. This meant staff were kept informed about people’s changing needs in order to provide up to date and appropriate care and support.

Care monitoring tools such as food and fluid monitoring charts and charts for monitoring people’s weight, continence and night time patterns were in place. In addition, handover sheets and a communication book were used to pass information between the different staff teams. Entries showed that there was good communication between staff and they were all kept fully informed. Where necessary, these tools allowed staff to identify when people may need specialist input into their care, for example, from a dietician or specialist continence nurse.

Staff were well informed about people’s preferences about their daily lives including their likes and dislikes. There was some information in people’s care files which helped to identify people’s preferences in their daily lives, their hobbies, important facts about their previous lives, however the amount of information varied between files. Profiles are particularly useful for people living with dementia and who are unable to recall past events or their particular preferences in leisure and activities. In discussion the manager agreed that it was important staff have clear information about people so that their lifestyle choices can be met effectively.

Our observations confirmed that care was person-centred and staff provided choices to people about their routines and lifestyle. For example, we saw and heard staff asking people where they wanted to sit, if they wanted lunch, how they would like their tea and if they wanted to lie down. In another instance a person became agitated just before lunch. We asked the senior care worker about this person’s care needs and they told us this was a pattern of behaviour, at a particular time, when the person was tired. They continued to say that the lady usually rested for a while and this replenished her energy levels. We observed the senior care worker ask the lady if she wanted to lie down on her bed and when she welcomed this, the senior care worker walked with the lady, arm in arm, to her bedroom.

One relative told us, “They (people) are always given choices – would you like this and would you like that? X(person’s name) has his lunch in his room every day because he likes to watch Bargain Hunt. On the day when I’m not in, staff respect his choices and ensure that he watches Bargain Hunt. They manage better than I could manage”.

Activities were available for people to partake in if they wished to and an activities co-ordinator was employed. We

Good

Is the service responsive?

spent time in the lounge where the activities coordinator had organised a singing session. There was much laughter and clapping of hands. Following the singing session a game of "Play your cards right" was organised. The activities coordinator said, "Now who can remember Bruce Forsyth?" The activities coordinator asked various questions and gave clues where appropriate. A social worker linked to the home told us, "The crafts lady is really good. X (person's name) has been painting and knitting and I know her family really appreciate this." One relative was positive about the activities provided by the service. She told us, "There's absolutely enough going on. They took my husband to Newcastle United Football Club and they book a beach hut in the summer in Blyth and they have fish and chips".

People were supplied with information about how to make a complaint when they came to live at the home and we saw copies of the complaints procedure was displayed around the home. We spoke with one relative who had made a complaint. They told us they felt satisfied their concerns were taken seriously and they were satisfied with the action taken by management to address the matter. Records were kept of each complaint. Two complaints had been made in the past year and the records showed a full investigation was carried out and a written report was prepared to show the outcome. Two people living at the home told us they would feel able to make a complaint to staff or members of the management team if necessary, but they had never felt the need to make a complaint.

It was not always clear what action had been taken with regards to low level concerns that had been raised, as opposed to formal complaints. We read the minutes of a senior staff meeting which was held 18 March 2015. We noted that complaints had been discussed. The minutes stated, "One of the residents had made a justified complaint." However, it was not clear what the complaint was and it was not recorded in the complaints log. We read that other minor complaints had been raised. For example, we read that one relative stated that he had requested a call back and this message had not been passed on. There was no clear overview of the number of complaints and concerns which had been received and the actions taken to resolve these. We discussed our findings with the registered manager who told us that records would be improved to more clearly reflect the content and handling of these low level, non-formal concerns and complaints.

The provider had carried out surveys to gather the views of people (where possible), their relatives, staff and health professionals linked to the home. One relative told us, "I've filled in questionnaires. Whenever I've done an evaluation of the home it's been excellent". Meetings for people and their relatives were also held and separate meetings for staff, usually on a quarterly basis. These meetings provided a channel through which these parties could feedback their views and the provider and manager could gather people's opinions about the service.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post who had been formally registered with the CQC since August 2014. She was present on both days of our visit, as was the provider. We found no concerns about the registration requirements of the service and we were satisfied that the registered manager reported incidents to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

People and their relatives told us the service was well-led. One person told us, “I know X (registered manager). She is very approachable if you call her”. A relative said, “It’s well led. Their procedures are followed 99.8% of the time. It’s exceptional. They are very open, if something is not right, they are open about it”.

We asked healthcare professionals who worked closely with the service and the registered manager for their views about the leadership of the home. They told us the management team were “passionate about the service” and they all gave us positive feedback. One healthcare professional commented, “X (registered manager) is a good manager; as far as I can tell she manages the home well. Things are dealt with and she is accessible”.

Staff told us they enjoyed working at the home. Some staff told us that morale amongst the staff team was generally good, although there were some issues with the staff rotas at present. We discussed this with the registered manager, who told us rotas were currently being reviewed. One staff member said, “It’s still a fairly new home and we’re still trying to improve things”. We looked at the minutes of a staff meeting which was held in February 2015 where staff morale and staffing levels were discussed. The meeting finished with the comments, “If we remain positive and give off positive vibes to others, making it a happier place to work, it should improve.”

We spent time with the registered manager and discussed her role. She told us she felt fully supported by the general manager who she reported to and also the provider. She told us the provider was incredibly focussed on addressing the shortfalls identified within the service related to the management of medicines and was planning to recruit a member of staff with clinical expertise to oversee and implement improvements in this area.

We spoke with the provider about her values and vision for the service. She told us that she established the business so that people living with dementia were treated as well as those people who did not have dementia. She told us she wanted to provide a calm, settled environment for people living with dementia to reside in, and one which she hoped staff would want to work in. The provider reiterated what the registered manager told us; that she regretted the breaches that had been identified in the management of medicines and had implemented improvements immediately following our inspection.

The registered manager had tools in place to monitor that staff delivered care appropriately. Handover meetings took place between staff shift changes to ensure that incoming staff were kept up to date about the running of the service and people’s care. Staff also received supervision and appraisal to support them in their role and identify any issues with their care practices. These tools enabled the registered manager to assess the care that was delivered and then identify any concerns should they arise.

A range of different audits and checks were carried out to monitor care delivery and other elements of the service. Audits including health and safety audits, infection control audits and analysis of accidents and incidents that had occurred, were completed regularly. Health and safety audits and checks around the building were also carried out, for example on fire-fighting equipment and water temperature checks. Whilst some action plans were drafted following audits being carried out this was not always the case and it was not always clear what action had been taken to rectify any issues identified. The registered manager told us that the paperwork related to the outcome of these audits would be improved to ensure that it was clear what action had been taken.

There was a medication audit in place. However, this had not been robust enough to identify the serious medicines error that we found at this inspection and to rectify the continuing breach of regulation in respect of the proper and safe management of medicines. The provider and registered manager reported on the second day of our inspection that they had immediately implemented changes to the management of medicines to ensure people were safe, following our first visit to the home on 5 May 2015. They also shared their future plans for the management of medicines with us. They told us they had decided to purchase individual medicines cabinets to be

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secured to the wall in each person's bedroom, in which only that person's medicines would be stored, together with their MARs. The provider, general manager and registered manager told us they hoped this would eliminate the risk of further errors and it would ensure people received their medication, as 'person-centred' as possible. Whilst the provider responded positively to the shortfalls in the management of medicines, a more thorough oversight of medicines within the service was essential to ensure people received their medicines safely.

The provider employed a general manager who worked above the registered manager and reported to the provider directly. The general manager's role was to support the registered manager and oversee quality assurance processes within the service. The registered manager, general manager and provider were passionate about the service and care they delivered and they all reported that they were dedicated to driving through improvements within the service.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from risks associated with medicines because robust systems were not in place to appropriately manage changes in people's medicines. Regulation 12(2)(g).