Cotswold Spa Retirement Hotels Limited

Willow Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Willow Court Care Home on 9 and 10 January 2018. At the last comprehensive inspection of the service on 21 and 22 November 2016 breaches of legal requirements were found in relation to the safety of medicine management and the governance of the service. Due to this a focused inspection was carried out on 13 June 2017 to check that the service was meeting legal requirements. At this inspection the service had made the required improvements. We found these improvements had continued and the service was meeting the legal requirements.

Following the last comprehensive inspection, we asked the service to complete an action plan detailing what they would do and by when to improve the key questions of safe, effective and well-led to at least good. We saw infection control measures were now in place and medicines were being managed safely. Staff training and induction processes were very robust and regular supervisions were being held with all staff. The mealtime experience had been improved but this was not consistent within each dining room. The governance of the service had improved and we saw evidence of regular audits and actions taken if any issues were highlighted.

Willow Court Care Home is a 'care home' located in North Shields. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Willow Court Care Home can accommodate 48 people in one adapted building and on the date of this inspection there were 40 people living at the home.

There was a registered manager in post who has been employed at the service since September 2014 and was registered with the Care Quality Commission (CQC) to provide regulated activities in June 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 and associated Regulations about how the service is run.

People told us that they felt safe at the home and relatives agreed with these comments. We found there were policies and procedures in place to help keep people safe. Staff had received training and attended supervision sessions around safeguarding vulnerable adults.

Staff were safely recruited and they were provided with all the necessary induction training required for their role. The registered manager continued to provide on-going training for staff and monitored when refresher training was required. Accidents and incidents were recorded correctly and if any actions were required, they were acted upon and documented.

The premises were safe. Regular checks of the premises, equipment and utilities were carried out and documented. Infection control measures were in place and the service was clean. We saw domestic staff

cleaning the home regularly during the inspection.

We saw positive and negative dining experiences. During lunchtime on the first day of inspection we observed that there was not enough staff present to support people in the ground floor dining room. People living at the service commented that they had to wait for staff to help them. We saw that there were sufficient staffing levels at Willow Court but the deployment of staff was an issue. People told us that staff were busy and did not help them when they needed it. We observed people asking for staff to support them to the toilet but having to wait to be assisted. We fed this information back to the registered manager who addressed it immediately.

The service had continued to provide safe medicine management. Procedures were in place to ensure the safe receipt, storage, administration and disposal of medicines. We saw a dentist visiting people and there were records regarding other professionals involved in people's care. People were supported to maintain a balanced diet and we saw people had access to a range of foods and fluids throughout the day.

The premises were 'dementia friendly' as the walls, floors and doors were painted in contrasting colours and there was pictorial signage to help people orientate themselves.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. Staff demonstrated their understanding of the MCA. The registered manager had made applications on behalf of most people living at the service to restrict their freedom for their own safety in line with the MCA. We saw staff asking people for consent when supporting and asking for people's choices for meals and drinks.

Staff treated people with dignity and respect. They showed kind and caring attitudes and people told us the staff spoke nicely to them. We observed people enjoyed positive relationships with staff and it was apparent they knew each other well.

People and relatives knew how to raise a complaint or concern. The complaints system was available to everyone who visited the service. The provider used a live feedback system which was easily accessible to everyone. The results were used to drive continuous improvement throughout the service.

The service was working in partnership with Newcastle University on the 'Supporting Excellence in End of Life Care in Dementia' (SEED) project. This had enabled the service to receive specialist support to deliver personalised end of life care for people and to support staff to deliver this.

People had person-centred care plans and risk assessments in place to keep them safe. People, relatives and external health professionals were all involved in best interest decisions and mental capacity assessments. People's care records were accurate and up-to-date.

The provider and registered manager had a clear vision to care for people living at the home. Staff told us that they could approach the registered manager if they needed support or guidance. Relatives said that they were always welcome at the service. The registered manager carried out regular checks and audits of the service and worked with the provider to achieve positive outcomes for people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received care from staff who were trained and aware of safeguarding procedures.

Risks which people faced were assessed and reviewed regularly.

There were suitable staffing levels, but there were some issues about the deployment of staff.

Medicines were administered safely and in line with safe medicines management procedures.

Is the service effective?

Good

The service was effective.

People received care that was delivered in line with the Mental Capacity Act (2005) MCA.

Consent was sought before staff provided care to people.

Staff providing care to people had received appropriate training and support to carry out their roles.

People were supported to eat and drink well to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff upheld people's privacy and dignity.

People were treated with kindness and respect by staff.

People and their relatives were consulted and supported with planning their care.

Is the service responsive?

Good

The service was responsive.

People received person-centred care which met their needs and was regularly reviewed and updated.

People were supported with end of life care.

People enjoyed a wide range of social activities.

The provider had a robust complaints procedure in place. This information was used by the service to learn and continuously improve.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

The registered manager understood their role and responsibilities.

The provider and registered manager had a clear vision, strategy and plan to deliver quality care.

The provider had quality and assurance processes in place to monitor the quality of the service and rectify any issues identified.

Willow Court 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 comprehensive inspection took place over two days on 9 and 10 January 2018. The inspection was unannounced on the first day which meant the staff did not know we would be visiting the home. During the inspection we reviewed documentation, carried out observations in communal areas and had discussions with people who used the service, their relatives, staff and visiting professionals.

The inspection was carried out by two adult social care inspectors, an expert by experience and a specialist advisor. The specialist advisor was a registered nurse. 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, the registered manager completed a Provider Information Return (PIR). This is a form that the registered manager sends to CQC with key information about the service, what improvements they have planned and what the service does well.

We also reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events, which the provider is required to send to us by law.

We sought feedback from the local authority contracts monitoring and safeguarding adults teams, and reviewed the information they provided. We contacted the NHS Clinical Commission Group (CCG), who commission services from the provider. We also contacted Healthwatch, who are the independent consumer champion for people who use health and social care services.

During the inspection, we spoke with 10 people who used service, four relatives and eight members of staff including the registered manager, a representative from the provider organisation, one nurse, one cook and four care assistants. We reviewed the care records for four people and the recruitment records for four

members of staff. We looked at quality assurance audits carried out by the registered manager and the provider. We also looked at the staffing rotas, training records, meeting minutes, policies and procedures and information related to the governance of the service.

Good

Is the service safe?

Our findings

People and their relatives described the service as safe and were happy with the care provided by the service. One relative said, "I am happy that she is safe and happy with the care she receives." All staff we spoke with were aware of the safeguarding procedures, escalation routes and they understood their role in keeping people safe. One member of staff said, "I would have no hesitation going to [registered manager] with any suspected safeguarding information." All staff had received safeguarding training and had covered this topic as part of their induction.

We saw evidence of supervision meetings between the registered manager and staff discussing safeguarding cases presented in the media. This showed that the registered manager reviewed best practice guidance and shared learning with staff. We reviewed the safeguarding information at the service and these records were accurate, linked to the appropriate accident/incident, had in-depth investigation reports, follow up actions highlighted and lessons learned.

There were safeguarding policies for protecting vulnerable adults available for all staff and people at the service. The registered manager also included a "policy of the month" at each staff meeting to refresh the awareness of the policy with staff. We saw evidence of this in the staff meeting minutes from November 2017.

Risks to people were identified and managed well so people were safe. This included an assessment of the level of risk and action taken to mitigate the risks to the health, safety and welfare of people. Risk assessments were completed for the moving and handling, mobility, falls, use of bed rails, nutrition and hydration, choking, continence and skin integrity of people living at the service. Assessments were completed in partnership with people, their relatives and external health professionals. The plans encouraged independence and respected people's choices.

Staff recruitment was safe. We saw evidence that all staff had a current Disclosure and Barring Service (DBS) check in place. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. Other pre-employment checks had been carried out such as gathering references from previous employers.

There were enough staff to support people to stay safe and this was in line with the service's dependency of needs tool. The registered manager had recently reviewed the staffing levels. We looked at the staffing rotas over a four week period and noted that there were 12 agency staff used from several different agencies. This showed a high use of temporary staff however, the registered manager told us they were actively recruiting to fill the roles permanently. Dependency assessments were completed for people, which ensured there was a summary of their care requirements, to make sure staff had the capacity and skills to be able to provide appropriate care to meet people's needs.

We observed that staff were not always deployed adequately throughout the service and some people had to wait to be supported. One person said, "I have to wait too long when I need help to go to the toilet." We

asked staff if they felt there was enough staff to support people living at the service. One member of staff said, "We have the right number of staff." On the first day of inspection we observed the dining experience on both floors. The ground floor dining room did not have enough staff to support people with their meals. We observed one care assistant supporting people with the help of one kitchen assistant. The care assistant left the dining room, leaving only the kitchen assistant to support people. We raised this with the registered manager who confirmed that there should have been three members of staff present in the dining room. The registered manager addressed this immediately with all staff in a team briefing. On our second day of inspection this issue had been addressed and there were three care assistants, one nurse and the kitchen assistant present in the dining room.

We looked at the arrangements for the management of medicines. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Medicine stocks were recorded when medicines were received into the home. This is necessary so accurate records of medicines were available and nursing staff can monitor when further medication would need to be ordered.

One person received their medicines covertly. The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example, mixed with food or drink. There was documentation to support that the person's GP and the pharmacist had authorised this and staff were following the correct guidance.

The medicines administration records (MARs) contained recent photographs of people to reduce the risk of medicines being given to the wrong person, and all of the records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine that they are allergic to.

Medicines were given from the container they were supplied in and we observed staff explained to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. People's medicine support needs were accurately recorded in their care records and the MARs showed staff recorded when people received their medicines and entries had been initialled by staff to show they had been administered.

Protocols were in place to administer 'as required' medicines. The protocols assisted staff by providing clear guidance on when 'as required' medicines should be administered and provided clear evidence of how often people require additional medicines such as pain relief medicines.

We reviewed a medication audit recently undertaken by an external pharmacist. They had highlighted some areas for improvement. We spoke to the nurse who told us they were working through the actions associated with the issues identified.

We carried out a tour of the home to make sure the premises were safe for people. We found fire exits and routes were clearly marked, fire doors which stated "keep locked" were locked, the fire escape route was clear but the neighbouring care home had placed a large drum of oil on the shared escape route. This was highlighted to the handyman who arranged for this to be removed immediately. The bin storage area, which was shared between the two care homes were full and the bins were unable to be closed. The handyman also addressed this and the bins were emptied by the second day of inspection. There was a legionella risk assessment in place and monthly water checks were carried out in line with the assessment. There was a fire risk assessment for the service and this was used in partnership with people's personal emergency evacuation plans (PEEP). A PEEP is an individual escape plan for a person who may not be able to reach an area of safety unaided or in a safe amount of time in an emergency situation. PEEPs included how many

staff would be required to support people and what action should be taken. There was a clear evacuation route throughout the service and the lights, doors sensors and alarms were tested regularly.

We saw that there were regular recorded audits of the premises including bed checks, bed rails checks, portable appliance testing (PAT), firefighting equipment and electrical socket checks. The service had a valid gas safety and electrical periodical inspection certificate. We observed regular cleaning of the service throughout the inspection and regular cleaning audits. There were risk assessments in place for the control of substances hazardous to health (COSHH) and these included data information sheets and protocols for each substance.

Staff followed infection control procedures and we saw them using personal protective equipment such as disposal gloves and aprons when supporting people with personal care. Domestic staff ensured soiled laundry was transported through the home safely and in line with best practice.

Good

Is the service effective?

Our findings

People's treatment and support were delivered in line with current national best practice standards and guidance, such as National Institute for Clinical Excellence (NICE) and mental capacity assessments (MCA). The registered manager discussed learning opportunities and there was evidence of themed supervisions taking place with staff around best practice.

People received care from skilled staff who had completed training that the provider deemed as mandatory for their roles, such as safeguarding vulnerable adults, infection control, first aid, dementia awareness and moving and handling people. All new care staff who did not have previous qualifications or experience in health and social care, received a detailed induction in line with 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 staff to provide safe, effective and compassionate care. The service was also part of a pilot programme with the provider for auditing care plans. This pilot was a quality assurance tool called "TRaCA D" (Thematic Resident Care Audit – Dementia) and allowed for a robust review and audit of care plans for people who had a diagnosis of dementia.

Staff received regular supervisions and an annual appraisal from the registered manager. There was a training matrix for all staff so any knowledge gaps or refresher training requirements were easily identified. Staff had access to an e-learning portal and there was evidence of discussions in supervision around the required training modules and expected completion dates. Nursing staff had their qualifications and registrations checked by the registered manager; these were documented in their recruitment file.

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, for example because of permanent or temporary problems such as mental illness, brain impairment or a learning disability. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). For the four people whose records we reviewed applications had been submitted to the 'supervisory body' for authorisation to restrict their liberty, as it had been assessed that this was in their best interests to do so.

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. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for bed rails and life changing choices about serious medical treatment or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. We found some decisions were not specific, for example they related to "complex decisions and non-complex

decisions". The MCA and Code of Practice states that a person's capacity must be assessed specifically in terms of their capacity to make a particular decision. This meant people's rights to make particular decisions may not have been always upheld and their freedom to make decisions may not have been maximised. The registered manager told us they would review these and ensure the records detailed the specific decisions.

Care records included people's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status. This meant that if a person's heart or breathing stops unexpectedly due to their medical condition, staff were aware that no attempt should be made to perform cardiopulmonary resuscitation (CPR). The DNACPR records were up to date, included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals who were involved in the decision.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GPs, psychiatrists, specialist nurses, best interest assessors, dieticians and opticians. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various external agencies and services to seek professional advice and ensure the individual needs of the people were being met.

Daily communication notes were kept for each person. These contained a summary of the care and support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift.

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped staff identify the level of risk to people. The Waterlow scale was used to assess people's risk of developing pressure sores. Assessments were regularly reviewed and updated to ensure they reflected people's current level of risk. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin. We saw a system was in place for people being cared for in bed to ensure they were re-positioned at regular intervals to maintain their skin integrity.

Some people received support with nutrition and hydration. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. The MUST was used to help staff complete individual risk assessments in relation to the risk of malnutrition and dehydration. This helped staff identify the level of risk and apply appropriate preventative measures. Staff monitored some people's food and fluid intake to minimise their risk of malnutrition or dehydration and recorded this on a chart which the nursing staff checked and evaluated in order to decide if further action should be taken. For example, referral to a GP, dietician or speech and language therapist.

Care records showed that notification of dietary requirements had been given to the kitchen staff regarding food likes, dislikes and preferences. This meant there was good communication between care staff and kitchen staff to support people's nutritional well-being.

We observed the dining experience over the two days. The food was well presented and hot and cold drinks were available. We saw that some people required pureed meals. We noted that each part of the meal was pureed separately and placed on the plate in distinct portions to make the meal look more appetising and help people to distinguish what they were eating. The care staff discreetly supported people who required

assistance to eat their meals.

The home was appropriately adapted, nicely decorated and had elements of a 'dementia friendly' environment. There were contrasting walls, handrails and doors. There was pictorial signage on bathrooms and toilets. Pictorial signage and menus help people visualise the planned meals, if they are no longer able to understand the written word. The corridors and doorways were wide enough to allow for wheel chair access.

Good

Is the service caring?

Our findings

People and relatives told us the staff at Willow Court were caring and nice. We saw many positive interactions between people and staff. Staff were aware of people's likes and dislikes, and these were reflected in their care plans. We saw staff asked people if they would like support at meal times and offered them fluids during the day. Staff demonstrated a caring attitude by comforting people when they were distressed. One person said, "The staff pop in now and then, they talk to me while they do their work." A relative said, "The staff have been fairly consistent during the past year, they seem to be very nice to [person]." We observed people and relatives being acknowledged by staff as they passed them in the corridors or in communal areas. One member of staff said, "It's a nice team of carers, morale is good amongst all the staff."

The provider and registered manager had a clear vision regarding their care of people. They wanted to make care special and to do this they recognised that they must know what every person needs and know each person as an individual. We saw initial assessments for people when they first moved to the home, detailing what care they needed and how that care was to be provided.

Each person had a "My Choices" section within their care records which detailed their own personal preferences including how they would like to be supported, their life history, relationships and what a good/bad day looks like. Staff were aware of people's personal history and we saw staff asking about their families. People had memorabilia in their bedrooms to help stimulate memories and conversations. One person had an album of photographs of their friends which was used by staff to start conversations to help comfort the person. One person had a 'comfort flower' displayed on their door which showed different things that they liked. This included hand holding and looking at pictures. Staff used this to provide emotional care and create a positive relationship.

Equality and diversity policies were in place to ensure that people were treated with dignity and respect regardless of the sex, race, age, disability or religious belief. The service promoted the 'Dignity Challenge' and made sure that people's dignity was integral to everything they carried out. The Dignity Challenge is a national project aimed at raising awareness of dignity in care settings by encouraging personalised, respectful, meaningful care to people. It encourages people's confidence, engages partnerships between families and the care provider, and maximises independence, choice and control where possible.

All staff were working together to create a respectful, trusting and caring environment which made a difference to people's lives. The registered manager championed the "Dignity Challenge" making sure that dignity was considered in every action carried out at the service.

Staff treated people with respect and upheld their privacy. We observed staff asking people if they could enter their bedrooms and asking people if they would like support with their meals. Staff always addressed people by their preferred name. Before carrying out personal care tasks staff asked permission from people if they could assist.

We saw one member of staff asking a resident, "Would you like salt and vinegar on your fish and chips?" This started a conversation around similar likes and dislikes of the resident and the staff member.

We saw involvement from people and their relatives on the creation of people's care plans. These included best interest decisions and mental capacity assessments. These were clearly documented and had signatures from all involved. One new resident's family were waiting to complete care plans with the registered manager when we inspected.

There was information, advice and guidance displayed around the home which was of benefit to people and their families such as local safeguarding contact information and leaflets on dementia care, advocacy services and advice on relevant topics of interest. People had been given a 'service user guide' upon admission which contained information about the service; what to expect, what services are offered and external local amenities and services which may be of interest to them.

Good

Is the service responsive?

Our findings

Following an initial assessment, care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Care plans were reviewed and updated at least once a month to ensure they contained relevant information. Each care plan we viewed was person centred and they contained detailed instructions for carrying out people's care. The service ensured there was a holistic approach to meeting people's needs. Care plans included sections on social, emotional, cultural and religious needs as well as their physical needs.

We reviewed four people's care plans which had been written in a person-centred way. Person-centred care planning is a way of helping someone to plan their care and support, focusing on what is important to the person. For example, one person's 'psychological/emotional' care plan detailed that at times they liked to have 1:1 interaction with staff in their room, they enjoyed a chat especially when taking their medicines, they liked to listen to radio 4 and enjoyed visits from their friend. Another person's 'psychological/emotional' care plan detailed that they enjoyed watching television, in particular sport programmes, and they preferred their bedroom door open so they could see people as they walked into their room.

People and relatives had been involved in initial care planning, however they had not routinely been involved with the six and twelve month reviews.

People's care plans in relation to their behaviour management were personalised and specific. They detailed the support staff were to provide and how they should monitor people after an incident. Triggers for the behaviour were documented so staff could recognise them and offer intervention before the person became increasingly anxious and distressed. Staff were directed to offer support to resolve the problem by offering the person time. This provided guidance to staff so they managed situations in a consistent and positive way, which protected people's dignity and rights.

Communication care plans were in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people. One person had poor eyesight and staff were directed to place items in their line of vision to enable them to correctly identify items. For another person, who was unable to verbally communicate, staff were instructed that the person would say 'yeah' to indicate agreement and staff were to interpret their anger by the tone of their voice. In addition, staff were directed to ask the person simple closed questions and they would reply 'yeah' or 'no' appropriately. This approach meant staff provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

There was an activities lifestyle care plan and a journal to document daily and weekly activities. On the days of inspection the activities co-ordinator was absent but there was evidence of prior activities which included dog petting, a quiz and a reverend attending to tell the nativity story. The registered manager also showed us photographs of other activities including Bollywood dancing. We saw detailed descriptions of each activity, what people have been offered and reasons why people declined to participate. This demonstrated

that people were engaged in meaningful activities which provided an opportunity for social inclusion and engagement.

There was a comprehensive complaints procedure in place at the service. This was available to people and their relatives. We reviewed the complaints log for the service and the actions taken. The registered manager addressed all complaints within the designated timescales and took action where required. Lessons learned were acted upon and shared with staff during meetings and supervisions. Compliments received about the service were also shared with staff and used as examples of good quality care. The Quality of Life Programme also allowed for instant live feedback for the service through an iPad system. The feedback was recorded and regularly reviewed by the registered manager and the provider.

At the time of our inspection the staff were delivering end of life care. We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

The service was working in partnership with Newcastle University, and was part of the 'Supporting Excellence in End of Life Care in Dementia' (SEED) programme. We saw evidence of this being implemented in the care of one person. This programme actively seeks to support people with their choices for their own end of life care. This included pain relief, comforting activities, showing photographs, food and drinks. Staff positively engaged with the end of life care being provided and suggested that they made memorial books for people's relatives when a person passed away. The service had introduced a "comfort flower" for people receiving end of life care. The staff attended a session with the person and their relatives to identify what makes them feel comforted i.e. familiar staff, calming voices, space, photos, bed rest, cuddles, tea, sweets, compliments, dog petting, dancing, holding hands, hair done and traditional music. This was then displayed in the person's room in the form of petals around a flower so staff can easily see what they could do to provide the best possible care to that person. The specialist nurse working with the university staff had arranged events with staff in order for them to be involved and understand what was required of them during the delivery of end of life care.

Good

Is the service well-led?

Our findings

There was a long term registered manager in post who had been registered with the Care Quality Commission (CQC) since June 2015. This was in line with the requirements of the provider's registration of this service with the CQC. The registered manager was also a registered nurse and they were aware of their responsibilities and had submitted notifications as and when required. The registered manager was present during the inspection and assisted us by liaising with people who used the service on our behalf. They were extremely knowledgeable about the people who used the service and able to tell us about individual people's needs. People and relatives we spoke with knew who the registered manager was and told us they were a visible presence at the service.

The registered manager had a clear vision for the service which incorporated the values described in the provider's statement of purpose. The registered manager had worked hard to improve the culture at the service and one member of staff told us, "It's [the service] picked up quite a lot… It was stressful coming to work, but it's much better now." During the inspection we saw the registered manager providing guidance to the staff team and briefing staff on best practice for meal times. One person's relative, who had only arrived at the service on our first day of inspection, told us they were happy with the communication provided by the registered manager. They were waiting to complete care plans together with the registered manager and staff. Another relative told us, "They keep me informed of any issues."

Regular staff meetings took place and we reviewed minutes from these meetings. The registered manager had created a new initiative to review one policy each month in staff meetings. This would allow them to check staff understanding and receive signatures from staff confirming they had read and understood the policy. Staff also received themed supervisions which included infection control and incidents at other care homes which had been reported in the media. The registered manager also discussed learning within supervisions and took appropriate action if staff were not completing their e-learning modules. The registered manager told us that they had supported two new nurses and were helping them with their continued professional development. The registered manager was also part of the provider's Care Home Assistant Practitioner (CHAP) initiative and had one member of staff undergoing training for this at a sister service. This initiative involved upskilling care staff to carry out basic nursing tasks under the supervision of a qualified nurse.

People living at the service and their relatives were able to feedback through the provider's 'Quality of Life Programme'. This enabled everyone to instantly feedback their own views of the service and the care provided. The feedback received from these surveys was electronically recorded and was available to the registered manager and to the provider. This allowed for a transparent feedback loop between people, the registered manager and the provider.

Resident and relatives meetings took place regularly. There were actions recorded in the minutes of these meetings where the registered manager had listened to suggestions, discussed these and implemented changes. People, relatives and staff told us they were comfortable to approach the registered manager and we saw many relatives and people living at the service positively engaging with them during our visit.

Quality audits were carried out by the registered manager and by the provider's wider management team. These were all recorded electronically and provided real-time action plans which could be analysed to see where the service was performing well and it highlighted areas for development. The registered manager carried out daily, weekly and monthly audits of the service and we saw evidence of these. The provider also carried out a quality assurance audit of the service on a monthly basis. These all allowed for the key areas of the service to be monitored and if any faults or errors were identified they could be acted upon. We saw evidence in staff meetings that learning outcomes were shared with the staff.

From the last inspection the registered manager had improved the record keeping at the home. Records were up-to-date and completed in a timely manner. We did find that there were some sections of some records with information missing. We discussed this with the registered manager who acknowledged that there was still room for improvement to ensure that contemporaneous records were kept in respect of all people with regards to all aspects of their care.

The service had an open, transparent and honest relationship with partnership agencies such as the local authority and the Clinical Commissioning Group (CCG) and we saw evidence in people's care files of joint working with external professionals to support people.

The home had their latest CQC inspection rating on display so that people living at the service, relatives, visitors, professionals and people seeking information about the service can see our judgements. The provider had displayed their ratings on their website as well. They also displayed their food hygiene rating of 5, certificates of registration and insurance details at the main entrance.

Since our last inspection the registered manager and provider have demonstrated that they have sustained the improvements which were highlighted in the last report and have continued to improve the service whilst ensuring compliance with all of the regulations.