Ideal Care (North) Limited

St Aidan Lodge Residential Care Home

Inspection report

Front Street
Framwellgate Moor
Durham
County Durham
DH1 5BL

Tel: 01913709691
Website: www.staidanlodge.com

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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

The inspection took place on 7 and 9 March 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected St Aidan Lodge Residential Care Home on 30 April 2014, at which time the service was compliant with all regulatory standards.

St Aidan Lodge Residential Care Home is a residential home in Durham providing accommodation and personal care for up to 62 older people. There were 49 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (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 there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were well maintained. All areas of the building including people's rooms, bathrooms and communal areas were clean and odour-free. Infection control risks were well managed throughout.

The storage, administration and disposal of medicines was found to be safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). Medicines practices we observed were patient, safe and in line with the registered provider's policy.

Risks to people were managed through risk assessments and associated care plans. These risks were reviewed regularly and we saw when relevant information was provided by healthcare professionals this was incorporated into care planning and risk assessment.

Staff displayed a good knowledge of safeguarding principles and what to look out for in terms of indicators of potential abuse. People we spoke with, their relatives and healthcare professionals consistently told us the service maintained people's safety.

There were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks.

Visiting professionals were complimentary about the knowledge and skills of staff, citing a range of examples where they ensured people's healthcare needs were met. There was regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Training was relevant to people's needs, with staff completing a range of training the registered provider considered mandatory, as well as training specific to people's needs, for example Gold Standard Framework end of life training. Other training included: dementia awareness, infection control, moving and handling, first aid, person-centred care, safeguarding and medicines administration. Staff displayed a good knowledge of the subjects they had received training in.

Staff were well supported through formal supervision and appraisal processes as well as ad hoc support when required. Staff had a good knowledge of people's likes, dislikes and life histories and had built a rapport with the people they cared for.

We saw people had choices at each meal as well as being offered alternatives. People spoke positively about the food they had and confirmed they could choose whether to eat with other people or in their room. We observed calm and unhurried interactions between staff and people they supported during lunchtime.

The premises were well designed for people who used the service, with aspects of dementia-friendly design in place, spacious corridors, lifting and bathing equipment tailored to people's physical needs, and a spacious salon for hairdressing and other uses, such as visits by opticians.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming. People who used the service, relatives and external stakeholders agreed that staff were caring and compassionate.

Person-centred care plans were in place and daily notes were accurate and contemporaneous. We saw regular reviews took place, ensuring people who used the service, relatives and healthcare professionals were involved.

The service had built and maintained good community links, although there was scope to build better links with a local community centre.

Staff, people who used the service, relatives and external professionals we spoke with were positive about the registered manager in terms of their accountability and approachability.

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.

There were effective systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Administration of medicines was safe and adhered to the National Institute for Health and Clinical Excellence (NICE) guidelines.

Risks to people were individually assessed and associated care plans updated accordingly in order to reduce risks.

There were sufficient staff on duty to safely meet people's needs.

Controls were in place to manage the risk of infection control were robust and the premises were clean throughout.

Is the service effective?

Good

The service was effective.

A range of training the service considered mandatory was in place, as well as additional training tailored to the needs of people who used the service, such as dementia awareness training.

The premises were well designed for the needs of people who used the service, with further work undertaken recently, such as repainting.

People enjoyed a range of meal options and were supported to have a balanced diet.

The registered manager displayed a sound understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

Is the service caring?

Good

The service was caring.

The atmosphere at the home was welcoming. People who used the service, relatives and external stakeholders agreed that staff were compassionate and patient.

Care plans were written with the involvement of people who used the service and their relatives to ensure they were partners in their care.

People's religious beliefs and needs, as well as their preferences regarding the end of their life, were respected.

Is the service responsive?

Good

The service was responsive.

Staff liaised promptly with external healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

The service had in place a range of activities, which included regular group activities and more bespoke activities for individuals.

Regular feedback was routinely sought from people who used the service through residents' meetings. We saw new activities had been requested and subsequently delivered.

Complaints were responded to consistently in line with the complaints policy, with people who used the service and their relatives aware of who to complain to if they had concerns.

Is the service well-led?

Good

The service was well-led.

Quality assurance and auditing work was systematic and effective in addressing any inconsistencies, for example in individual care plans.

People who used the service, relatives and staff were complimentary about the positive impact of the registered manager and stated they were approachable.

The service had built and maintained strong community links with a church and was looking into ways to improve other community links.

St Aidan Lodge Residential 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.

We visited the service on 7 and 9 March 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service, in this case nursing and dementia care.

We spent time speaking to people and observing people in the communal areas of the home. We spoke with eight people who used the service and four relatives of people who used the service. We spoke with eleven members of staff: the registered manager, the deputy manager, three care staff, the activities co-ordinator, the handyman, the head housekeeper, the laundry assistant, the cook and the laundry manager. We spoke with three visiting nurses.

During the inspection visit we looked at seven people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. A concern was raised with us by safeguarding professionals regarding the registered provider's understanding of DNACPRs and we looked at this during our inspection. A DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

One person who used the service told us, "I feel safe – there are always enough staff." Another person told us, "My room is always kept clean and tidy," and, "I always get my medication at the right time." We spoke with relatives and external visitors such as nurses who told us they had no concerns about staff ensuring people were kept safe. One healthcare professional told us, "I've never had any concerns and when there's a risk of something we're always in touch."

We reviewed the administration, storage and disposal of medicines and found it to be safely managed and in line with the medication policy and guidance issued by the National Institute for Health and Clinical Excellence (NICE). One visiting healthcare professional said, "Their paperwork around covert medicines is excellent – so much so I've borrowed it." Covert medicines are medicines administered without a person's knowledge when they have been assessed in line with the Mental Capacity Act 2005 (MCA) and it has been determined the medicine would be in their best interests. We saw decisions to administer covert medicines were supported by a clear rationale in line with MCA principles.

We found medicines were stored securely in a locked room, with controlled drugs separately stored. Controlled drugs are drugs that may be at risk of misuse. We saw the use of these drugs was recorded appropriately in a separate book and that stock levels matched the records.

We looked in detail at people's Medicine Administration Records (MARs) and found these to be sound, with no errors noted. We found allergy and staff signature information was readily available in MAR documentation. A staff signature list helps identify who has signed for each medicine administered. We spoke with staff who displayed a good knowledge of medicines administration, including effects and side effects of various medicines, and we saw their competence was regularly assessed. We observed medicines being administered and noted this was done safely, with people asked for their consent and with the member of staff administering medicine recording each administration before moving on.

We found clear practices in place when people were prescribed medicines to be taken 'when required'. Each 'when required' medicine was supported by a document explaining why the medicine might be needed, what signs might indicate the need to use the medicine and what effects staff could expect. This demonstrated people were protected from the risk of unsafe administration of medicines.

We saw risks people faced were effectively managed through a process of initial assessment, ongoing review and action where concerns were identified. For example, one person had been assessed as being at a higher risk of falls due to a decrease in their mobility. We saw appropriate help had been sought from external professionals, as well as additional checks on this person's wellbeing and detailed instructions to staff regarding how to mitigate risks, for example how to help the person ensure their footwear was properly worn. Risk assessments in place included areas such as mobility, communication, sleeping, oral care and personal care.

All people we spoke with felt staffing levels were adequate and during our inspection we saw call bells were

answered promptly and people were not put at risk due to understaffing. There were sufficient staff on duty to meet the needs of people and we saw staffing levels had been calculated using a recognised dependency tool. One person we spoke with confirmed the call bell was responded to promptly, day or night. One relative told us, "They have plenty of staff – [Person] never has to wait." Another said, "Staff work extremely hard and sometimes they're stretched if everyone needs help at the same time." They confirmed they did not think their relative was ever placed at risk of harm. This meant people using the service were not put at risk due to understaffing.

Staff we spoke with had a good understanding of their safeguarding responsibilities and were able to describe potential risks and abuses faced by people, as well as their actions should they have any concerns. We saw safeguarding policies were comprehensive and safeguarding information should people who used the service, relatives or staff have concerns were clearly displayed throughout the service.

We saw incidents and accidents were documented in a manner that allowed for analysis of them to identify any trends and patterns and saw that this happened regularly.

The risk of acquired infection was taken seriously, with an infection control champion in place and a recent visit by local infection control professionals finding no areas of concern. We observed staff using personal protective equipment (PPE) such as gloves and aprons at appropriate times and saw these were readily available throughout the building. We saw infection control training had been delivered to staff and the subject was discussed at staff supervisions and team meetings to ensure staff took a consistent approach. People who used the service and their relatives commented on the cleanliness of the home. We found the communal areas, people's bedrooms including en suite facilities, kitchen, bathrooms and laundry areas to be clean. We spoke with the head housekeeper, who was one of four cleaning staff at work on the first day of our inspection. They showed us the systems in place for ensuring the service had a ready supply of cleaning products. We saw there were no gaps in a sample of cleaning rotas we looked at and found the provision of cleaning to be sufficient. This demonstrated staff had successfully protected people against the risk of acquired infection.

With regard to potential emergencies, we saw each floor had an evacuation document easily accessible, with further copies accessible near the entrance to the building. These documents specified people's mobility and communication needs in the event of emergency, meaning members of the emergency services would be better able to support people in the event of an emergency. We saw these plans were reviewed weekly to ensure the information was correct.

With regard to the maintenance of premises, we spoke to the handyman, who was undertaking a rolling programme of refurbishment, incorporating redecorating people's rooms and ad hoc repairs. Additionally, we saw Portable Appliance Testing (PAT) had recently been undertaken, whilst all hoisting equipment and lifts had been serviced recently. Likewise the boiler had recently been checked and emergency systems such as the call bell system, emergency lighting and fire extinguishers/equipment had all been serviced. We saw water temperature checks had been undertaken regularly to protect against the risk of burns, whilst shower heads were regularly disinfected to protect against the risk of water-borne infections. We saw a monthly report was sent to the registered provider highlighting any outstanding actions required to maintain the premises. This meant the registered manager was accountable to them and had ensured repairs and maintenance were carried out in a prompt manner. This had prevented people from being placed at risk through poor maintenance and upkeep of systems within the service.

Good

Is the service effective?

Our findings

Visiting professionals were complimentary about the skills, knowledge and attitude of care staff. One said, "Staff knowledge is particularly good. They are confident in what they do and the paperwork is always accurate." Another said, "They ring whenever it's necessary but I wouldn't say they were too dependent." They told us staff sought and took on board advice from external professionals and incorporated this into care planning to ensure people who used the service received appropriate care. We reviewed people's care files and found this to be the case. For example, we saw one person had been referred to the community mental health team due to changes in their behaviour. We saw the recommendations made by the mental health team had been clearly recorded and incorporated into care planning.

On reviewing care files we saw other health and social care professionals had regularly been involved in people's care to ensure their needs were met, for example, dentists, dietitians, speech and language therapy team, social workers, chiropody and opticians. One relative told us, "They always have doctors and nurses in to make sure people are properly looked after."

All staff we spoke with told us they were well supported to deliver care through the training, guidance and supervision they received. We saw the registered provider had put in place a range of training they considered mandatory, such as first aid, food/nutrition, food hygiene, health and safety, manual handling, fire training, infection control, person-centred care, risk assessment and end of life care. We saw staff had also been trained in particular courses in order to meet the specific needs of people who used the service, for example, challenging behaviour training and dementia awareness training.

Staff were positive about the delivery of the training, the majority of which had been face-to-face rather than e-learning. One member of staff said, "It sinks in better than just clicking through options on a screen."

Training was planned on a training matrix which contained details for every member of staff. The registered manager explained how they updated this on a monthly basis following liaison with the training provider and their schedule of training events. We saw, where staff members were required to have refresher training in line with company policy, this had been planned and delivered. This demonstrated the registered manager had ensured staff members were supported to carry out their roles.

We saw staff were supported to achieve qualifications, with one member of staff currently completing a NVQ Level 5 in Health and Social Care. This means a member of staff other than the management were supported to increase their leadership and management skills.

In addition to training, we saw staff were supported through regular supervisions and annual appraisals. A supervision is a meeting between a member of staff and their manager to discuss performance and to identify areas of concern or best practice.

People who used the service told us they enjoyed the food, confirmed they had a range of options at each meal and were provided alternatives if they did not like the menu options. One person said, "The food is

very good here." Another said, "I am going to enjoy lunch today – I always do," whilst another, "Food is always reasonable or good." One relative told us, "[Person] likes to eat their meals in their room and they respect that." We saw evidence of this during the inspection and, when we asked people who chose to eat in their rooms, they confirmed food was served hot and that they always had a choice.

We saw there was a rotating four-week menu in place and the cook was able to show us recent new dishes they had tried, such as hunter's chicken. The menu was clearly visible in communal areas and supported by photographs of respective options. We saw people who required specialised diets or suffered allergies had their needs met through alternative options. The cook and other kitchen staff were aware of people's needs with a list of people's dietary requirements on hand, as well as a list of people's allergies on the wall.

We observed a mealtime in the dining room and found staff interacted in an unhurried fashion with people as they ate, supporting people where necessary in a dignified manner. We saw snacks and drinks were made available for people who used the service throughout our inspection. One person told us, "I always have plenty to drink."

Where one person was considered at risk of malnutrition we saw they had a specific care plan in place to ensure staff prompted and supported them consistently at mealtimes and that food and fluid intakes were recorded. We saw this person had regained weight since the plan had been put in place. We saw other people were regularly weighed to protect against the risk of malnutrition and we saw the registered provider planned to train staff to use the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition.

We saw the premises were well designed to meet the needs of people who used the service. For example, during our inspection we saw people using both lounges on the ground floor, and we saw relatives using the ''quiet lounge', an additional space for people and relatives to have more private time. A spacious salon area was used for hairdressing but was also a functional space for visiting specialists such as opticians. We saw the first floor had been designed with people living with dementia in mind. For example, walls and doors had been painted recently to ensure they provided clear contrasts for people with limited visibility or prone to confusion. There were also a range of tactile activities in place, such as a range of doorbells, rummage drawers and two lifelike 'pets', a cat and a dog. These were battery operated and mimicked 'breathing' by way of their chests moving up and down. We saw one person using them and they appeared to find the experience soothing.

Prior to our inspection safeguarding professionals had alerted us to a previous issue regarding the registered manager's understanding of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions in place. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. Safeguarding professionals confirmed some DNACPR forms, whilst indicating that a person lacked capacity, did not evidence that a best interests decision had taken place, for example with relatives, to ensure the DNACPR was in the person's best interests. This is the responsibility of the healthcare professional completing the DNACPR but the registered provider had initially failed to identify the poor practice. We reviewed DNACPR plans in care files and found the majority had been reviewed. We also found that safeguarding professionals confirmed the registered manager had engaged with them and the relevant healthcare professional to ensure best interests decisions were documented. Safeguarding professionals confirmed the DNACPRs they had seen had been supported by appropriate best interests decisions but that these decisions had not been documented alongside the DNACPR. Of the five DNACPRs we reviewed however, one still presented the same problem, with the person noted as lacking capacity but no evidence of a best interests decision being made. The registered manager took immediate action to address this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of Mental Capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

Good

Is the service caring?

Our findings

One person who used the service told us, "I am treated with respect and given space and time within my own room." Another said, "The staff are always nice to me," whilst one relative told us, "[Relative] loves it here and there is always a warm welcome." They stated they were welcome to visit the home at any time and that this helped them feel welcome and the person who used the service to feel more at home. Visiting professional we spoke with all spoke positively about the, "Welcoming atmosphere," and the positive interactions they had observed between staff members and people who used the service.

A range of thank-you cards provided evidence that relatives of people who had used the service found it to have been caring, for example, "Thank you for your unfailing kindness and understanding," and , "We were overwhelmed at the lengths you went to during this traumatic time. The staff have been great." This demonstrated staff treated people who used the service in a respectful, caring and compassionate manner. People had built trusting relationships with staff who cared for them.

Preserving and maintaining dignity were outlined in the service's Code of Conduct as part of each staff member's role and we found evidence of this in practice. For example, we observed staff knocking on people's doors and waiting for a response before entering. We observed people crouching next to people who were sat in armchairs, making eye contact at their level and speaking in a calm tone. We head one person stating they were cold and observed a member of staff retrieving their cardigan from another room.

We reviewed care plans and found them to have been written with the involvement, where possible, of people who used the service. We saw people had been asked, sometimes with the help of their relatives, about their likes, dislikes, personal histories and relationships and that these had been incorporated into care plans. When we spoke with a range of staff they demonstrated a good knowledge of people's individual needs, likes and dislikes, in line with people's care plans. We saw people had consented to the care plans in place by signing relevant documents or, where people did not have capacity to do so, through involvement of their relatives. The detailed nature of care plans meant staff had the relevant background and current information regarding a person's care needs before supporting them.

Turnover of staff was low and we saw this had had a positive impact on the continuity of care people felt they received. One person told us, "I know the staff by their faces; it's always the same faces and they're always smiling."

People's religious beliefs were acknowledged and respected. We saw the registered manager ensured regular Catholic and Church of England masses were held in the service, and that people could also attend services at a nearby church if that was their preference.

We saw people's beliefs and wishes regarding the end of their lives had been taken into account and incorporated into care planning via a 'Beliefs and End of Life' care plan. In the care files we reviewed we saw these plans were in place where people and their relatives had decided this was appropriate and had been appropriately signed. We saw staff had been trained in end of life care and one member of staff was

enrolled on the Gold Standards Framework (GSF) end of life care training. The GSF is a nationally recognised training and resource provider in palliative and end of life care.

We saw information regarding advocacy services was readily available in communal areas, whilst the registered manager displayed a good understanding of formal and informal advocacy. They told us about one person who used the service who was in the process of having an Independent Mental Capacity Advocate (IMCA) appointed. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about medical treatment.

We saw that there was a confidentiality policy in place and people's personal sensitive information was securely stored in files that kept in locked cabinets.

Good

Is the service responsive?

Our findings

When we spoke with people who used the service they repeatedly told us they were asked by staff about their care needs and were kept informed, in advance, of any future healthcare appointments.

Professionals we spoke with gave examples of people's needs changing and members of staff seeking their support to manage those changing needs, for example with regard to pressure sore care and diabetes care. One professional told us, "We are in touch every day." Another said, "They sort any niggles and incorporate advice into care plans." We found evidence in the care files we reviewed that people's changing needs were identified promptly and support was put in place accordingly.

We saw there was a full time activities co-ordinator in place who held monthly meetings with people who used the service in order to gather ideas about what activities people would prefer, as well as feedback on previous activities. For example, we saw at one meeting a number of people who used the service had asked for more physical activities. As a result, we saw giant carpet games such as carpet dominoes and giant snakes and ladders had been incorporated into the activities calendar. One person we spoke with told us the latter was, "A lot of fun."

We saw there had been a planned transition from the previous activities co-ordinator to the current member of staff, with a period of shadowing involved. This meant that people who used the service were able to continue being supported to engage in the activities they chose without interruption when a new activities co-ordinator took over the role. One person we spoke with said, "There's plenty to do. I like listening to music and singing."

We saw people had taken part in crafts such as painting a stained glass window, cushion-decorating and glass/tableware painting. We saw these were displayed in communal areas. We saw people had also made paper flowers recently. We spoke with one person who confirmed they had taken part in this activity, with support, in their own room rather than as part of a larger group, as was their choice. Another person told us they enjoyed the 'book bus' that visited regularly, meaning they could read books of their preference. We saw the service had their own minibus, which had been used to take people on various trips, for example to garden centres and on shopping trips. Staff helped to protect against the risk of social isolation through this over-arching activities programme as well as one-to-one time spent with people where practicable.

We noted the minutes of the residents meetings were brief and there was no set agenda. The registered manager agreed there was an opportunity to improve the format of the meetings to incorporate asking people about issues other than activities, such as whether they had any complaints, or whether they had any feedback regarding the menu.

We saw care plans included information about each person's individual likes, dislikes, personal histories and relationships and, when we spoke with a range of staff, they displayed a good knowledge of the people they cared for. As well as being person-centred care files were generally well-ordered with an index and staff signature list at the front. This made reviewing care files, for example by an external healthcare professional,

easier. We saw care plans were reviewed regularly and people confirmed to us they were involved in the review process. People's individual preferences were incorporated into care planning where practicable. For example, the review of one person's mobility needs had been changed to account for the fact that the person preferred to sit in a high-backed chair rather than an armchair whilst in their room. We saw instructions to staff regarding supporting the person in and out of the chair had been adapted with this preference in mind.

We saw there was a large mural on the wall on each floor, which people who used the service had contributed to the painting of. The murals depicted local scenes, including Durham Cathedral and the Durham Miner's Gala. Two people we spoke with confirmed they liked the murals.

We saw the administrator ensured new copies of 'The Daily Sparkle' were distributed in communal areas each day. 'The Daily Sparkle' is a resource which care homes can subscribe to which gives readers a combination of quizzes and 'on this day' news. People we spoke with confirmed they enjoyed quizzes and we saw one person reading a copy of this document during the inspection.

The registered manager was in the process of setting up a 'pen pal' scheme, whereby people who used the service, if they were interested, could write letters and send to people at the registered provider's other location. The registered manager stated there had been some interest in this scheme, although they had yet to think through data protection implications.

With regard to complaints, we saw they were responded to in writing, in line with the complaints policy, and that all complaints were reviewed on a quarterly basis to identify any consistent themes or trends. We saw one complaint had been made recently and that this had been resolved to the satisfaction of the complainant. We saw information regarding how to make a complaint was clearly displayed in communal areas.

Good

Is the service well-led?

Our findings

The registered manager had relevant experience in health and social care, having started as a carer in 2001 and then progressing to deputy manager prior to 2008, then registered manager from summer 2015. They had a sound knowledge of the day-to-day workings of the service. Members of staff we spoke with were consistently positive about the registered manager's impact and management style, stating, "There is an open door and it's the best thing to have," and, "[Registered manager] supports staff and listens to staff because that's their background." Another told us they felt able to discuss any concerns or queries with the registered manager.

When we spoke with external healthcare professionals they were similarly positive about the registered manager's competence, stating, "The change of manager didn't have a negative impact; [Registered manager] is really on the ball," and, "They make sure there is a high degree of personal accountability from staff."

People who used the service and their relatives were also complimentary about the accessibility and accountability of the registered manager. One person stated, "The manager is nice," whilst one relative told us, "I have noticed a changed since the new manager – care staff really care whereas before they might have been a bit more focussed on tasks. There is always a warm welcome here."

The registered manager is responsible for ensuring the culture of the service is focussed on the needs of people who used the service and we found this to be the case.

We saw staff meetings were held regularly and we saw clear guidance was issued at these meetings regarding, for example, infection control and training responsibilities of staff. Senior staff meetings were also held, as well as specific nightshift meetings, where these staff would raise any issues pertinent to them. The registered manager had oversight of all these meetings and incorporated relevant issues raised into general staff meetings and all-staff communications. In addition to these meetings we saw an additional daily '11 at 11' meeting was held. These meetings lasted no longer than 11 minutes and were an opportunity for representatives from all functions of the home (care staff, handyman, kitchen staff, managerial staff, housekeeping staff) to identify and resolve any new or anticipated problems. We observe one of these meetings and found it to be an effective means of ensuring staff and the registered manager had a regular opportunity to ensure people's care needs were being met and that already identified issues were not neglected. Staff told us they welcomed these meetings. This demonstrated the registered manager ensured staff had a range of forums wherein they could raise issues openly and had the confidence they would be supported by management and peers to resolve these issues.

We saw in pre-inspection data that staff turnover was low and staff told us they were content in their roles and wanted to build a career at the service. People who used the service consistently told us they knew their carers well and valued the fact they had got to know them over a period of time. This demonstrated the registered provider and registered manager's support of staff had a positive impact on the wellbeing of

people who used the service.

The registered manager was responsible for a range of auditing and quality assurance work. They were assisted by the deputy manager. We saw the deputy manager regularly had a day when they were a supernumerary member of staff. They used this time to support the registered manager with auditing responsibilities and other tasks as required. Audits undertaken included care plans, medicines, incidents and accidents and infection control. We saw a monthly report was sent to the registered provider confirming when these audits had been completed and detailing what corrective action had been taken. On reviewing audits we found them to be effective in identifying and rectifying errors. For example, one care plan was lacking a staff signature list and one risk assessment had not been signed by family members. We saw an action plan was put in place with actions to be undertaken and dates by which they needed to be completed. We saw this was checked by the registered manager to ensure corrective actions were taken in a timely fashion.

We saw the registered provider visited the service on a weekly basis to ensure auditing and quality assurance measures were working as well as to undertake 'walk arounds' of the service. The registered provider had also enlisted the services of an external auditor, who undertook audits of the service's paperwork twice yearly. This demonstrated the auditing regime in place was a means of making practical changes to people's care to ensure they were kept safe and received a consistent standard of care.

We saw the service was located in close proximity to a church and community centre. We saw the service had in place strong links with the church but, as yet, not with the community centre. The registered manager agreed this was a missed opportunity and committed to developing better links with the community centre.

We saw the registered manager routinely sought feedback from people who used the service through regular meetings and the use of questionnaires. We saw the results of the latest questionnaire, to which 20 people who used the service had responded. This questionnaire did not contain a specific question about the effectiveness, visibility or approachability of the registered manager but did show 97% of all responses either 'agreed' or 'strongly agreed' with a range of statements regarding the quality of: care; residents' rights; facilities; staff availability and services. This demonstrated the registered manager had ensured people were able to provide feedback about the standard of care delivered through a variety of means. It also demonstrated that people were pleased with the care they received.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. The majority of these were promptly provided, well maintained and contemporaneous.