HC-One Limited

Hebburn Court Nursing Home

Inspection report

The Old Vicarage
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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 6 January 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting. Hebburn Court was last inspected in June 2014. The service met all the regulations we inspected against at that time.

Hebburn Court is a care home with accommodation for up to 55 people who require nursing or personal care, some of who are living with dementia.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives were complimentary about the service and made positive comments. They were happy with the care and support they received at Hebburn Court. One relative said, "It's grand, we can come when we like, no problems at all." One person said, "Its lovely here, they look after you." Another told us, "They are so kind."

The service had a robust process in place for recruiting staff. Appropriate checks were carried out before commencing employment. We viewed current and historical rotas and found the service employed enough nurses and support staff to meet people's needs. One care worker said, "It's so nice to work somewhere orderly and to feel valued, there is a good skill mix, we are able to rely on each other."

The service uses an electronic system of online training, with face to face training for moving and assisting and first aid. Mandatory training was up to date for all staff. Staff felt supported in progressing their skills and knowledge, and received regular supervision and appraisal to aid their development.

Staff understood the Mental Capacity Act 2005 (MCA) regarding people who lacked capacity to make decisions and the Deprivation of Liberty Safeguards (DoLS) to make sure people are not restricted unnecessarily.

Staff had a good understanding of safeguarding and whistleblowing. They knew how to report concerns about people's care, health and wellbeing. Staff were confident in speaking to the registered manager and felt concerns would be acted on. The registered manager had a record of all safeguarding alerts which showed appropriate action had been taken.

Systems were in place to manage safeguarding concerns, complaints, accidents and incidents. Records were kept along with immediate actions which showed the service responded to situations with lessons learnt from such events to reduce risk. Relatives knew how to make a complaint and were confident the service would respond.

Effective systems and processes were in place for the management of medicines so people received their medicines safely.

People's healthcare needs were monitored and assessed with access to other health care professionals when necessary. Records showed community nurses, GP's and dieticians had visited the service.

Care records demonstrated person centred care with peoples' choices and preferences being acknowledged. Independence was promoted throughout the care planning process. People had access to activities in the home and in the community.

People were supported to be as involved as possible in choosing meals. People's dietary needs were assessed and monitored to ensure they had a healthy diet. One person said, "The food is lovely, lots of it and we have a choice."

Support was given in a respectful, caring and compassionate way. Staff maintained people's dignity and promoted independence in a sensitive manner. Staff knew how to communicate with people in an accessible way using gestures, pictures and body language. One person said, "It's nice here, they are so kind from the moment they come in." Relatives felt involved in their family member's care and were kept fully informed of any changes. One relative said, "My daughter goes to all the meetings." Another said, "The family are told about everything."

Staff and relatives felt the home was well managed by a supportive registered manager. One care worker said, "The manager has had a good impact." One relative said, "There are meetings every month and the manager seems to be everywhere." There were no concerns raised by the other health and social care organisations we contacted.

The service had a quality monitoring system in place. Regular audits were carried out by the registered manager and operations manager. A development plan was in place for service improvements.

Records were in place to show the service carried out appropriate health and safety checks. The service had current certificates in place for health and safety, such as gas safety and electrical installation certificates and portable appliance testing. Risk assessments were in place to cover work practices. For example, moving and assisting and infection control.

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.

Staff knew how to report concerns about the safety and welfare of people who lived at the home.

Processes were in place to ensure people's medicines were managed in a safe way, competencies of staff were checked regularly.

The service carried out appropriate health and safety checks in relation to the building, environment and work practices.

Is the service effective?

Good

The service was effective.

Staff received suitable training, support and development to meet the needs of the service.

People's healthcare needs were monitored and assessed with access to other health care professionals when necessary.

Staff understood their responsibilities under the Mental Health Act 2005 and knew how to support people.

Is the service caring?

Good

The service was caring.

Support was given in a caring, compassionate and respectful manner.

Staff knew how to communicate with people in an accessible way.

People felt the staff were kind.

Is the service responsive?

Good

The service was responsive.

People were offered a range of activities to meet their leisure and recreational preferences.

Relatives felt involved in their family members care and attended meetings to discuss support needs.

Relatives knew how to make a complaint and were confident the service would respond.

Is the service well-led?

Good

The service was well led.

The home had a registered manager. Relatives felt the home was well managed.

Staff felt supported in their role.

There was a quality assurance and information gathering system in place which was used to develop the service.

Hebburn Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6th January 2016 and was unannounced.

The inspection was conducted by one adult social care inspector, who was accompanied by an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority safeguarding team, local authority commissioners of the service, and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to decide what areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who lived at Hebburn Court. We observed staff interacting with people and how staff worked together. We looked around the premises. We also conducted a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with 12 people who lived at the service and 11 relatives. We spoke with 14 members of staff, including the registered manager, deputy manager, senior care worker, carers, ancillary

staff and the administrator. We looked at six people's care records including medicine records. We reviewed six staff files, including records of the recruitment processes. We looked at supervision and training reports as well as records relating
to the management of the service.

Good

Is the service safe?

Our findings

Family members told us their relatives were safe using the service. One relative said, "[family member] is safe here, I do not need to worry." Another relative who spent a lot of time visiting said, "I can't fault it, I can come anytime. I spend hours here and it's never any different no matter what shift, there is no difference in the care, even at night. I had a day off on Sunday, I didn't come in, that's the first time ever that shows how comfortable I am knowing he is here." A third relative commented, "It's safe and the girls are kind." One person told us, "Its lovely here, I feel safe."

The service had a range of policies and procedures in place to keep people safe. These included safeguarding and whistleblowing procedures (for staff to report poor practice). Staff were aware of the policies and when they would be used. Staff accessed policies and procedures during working hours via the computer in the service's training room. One care worker said, "I would have no problem reporting any concerns to the manager. I know they would listen." Staff had received up to date training in safeguarding and whistleblowing. Care staff gave examples of abuse and reported how people's behaviour may change if they are experiencing any type of abuse. For example, becoming withdrawn or nervous.

The registered manager kept a safeguarding file containing a log of all alerts submitted to the Care Quality Commission (CQC) and the local authority safeguarding team. These cross referenced with the notifications CQC had received from the service. Records were detailed and kept in date order. The log contained the action taken, any investigations undertaken, outcomes and lessons learnt. The process was extremely well organised, the registered manager used the log to identify any trends. For example, medication errors that had occurred, and action that had been taken to minimise risk. Details were also held on the on-line system used by the provider.

The service had an on-line system to record accident and incidents. The registered manager also kept a paper file containing accident and incident records, these contained details of investigations and outcomes. A report was generated from the electronic system to enable the registered manager to monitor accidents and incidents to identify any patterns or trends. For example, following an increase in falls being identified, a floor sensor had been put in place to minimise risk and to alert staff when the person got out of bed. The registered manager confirmed, "Staff are informed of any changes to practice or a person's support needs during hand overs, supervisions and flash meetings."

We looked at recruitment records for six staff members. These showed checks had been carried out with the disclosure and barring service (DBS), before new staff had been employed. This was to confirm whether applicants had criminal records and were barred from working with vulnerable people. Completed application forms, employment history and proof of identification were on file, along with references from previous employers The recruitment process for qualified staff included a safeguarding scenario to check their understanding and response. The service maintained a record of professional identification numbers (PIN), for qualified nurses. The PIN shows nurses have achieved and maintained a level of clinical knowledge and performance which allows them to practice as a registered nurse. The registered manager discussed how the service is keen to support nurses with their revalidation to develop their skills and performance.

The service employed enough staff to meet the needs of the service. We examined current and historical rotas. The registered manager confirmed, "Each floor has a registered nurse along with four care staff. The ratio of staff is calculated on the needs of the people who use the service." The provider had a tool in place to determine staffing levels.

The administrator explained, "The manager reviews the rota a week in advance to ensure the staffing levels show appropriate levels of cover." One care worker acknowledged "we are short at times but mainly due to sickness". The registered manager said, "To ensure safety in the home the service only use one agency staff member on any one shift, working alongside three permanent staff. Agency staff are required to read through support plans as part of their induction into the home." They also discussed how they were happy to "work the floor" if staffing requirements required them to do so.

All staff within the home were observed working as a team to meet people's needs. Ancillary staff were observed supporting people at meal times and assisting people throughout the inspection. Staff have no hesitation asking the manager, administrator or domestic staff to come and work on the floor to maintain resident safety as required.

Medicines within the service were managed safely and effectively. A policy and procedure was in place for the safe management of medications. Staff described the processes in place for ordering to disposal of medicines, including the process for the safe administration of drugs liable to misuse (also known as controlled drugs). Controlled drug checks were completed on a twice daily basis with shift handover and accountability handed over to the following shift, there was evidence of the registered manager completing weekly controlled drug checks. Competency assessment documents were in place and completed on a yearly basis for all staff with responsibility for medication administration.

Medicines were securely stored in a locked cabinet within a locked room. Medicine trolleys were lockable and stored securely in the medication room when not in use. Medicines were administered to people at the prescribed times. We looked at medication administration records, (MAR) these were mostly complete. Gaps in recording for PRN (when needed) medication were seen on one person's MAR. This had been noted on the registered manager's monthly medication audit, with an action for staff to improve. Competency assessment documents were in place and completed on a yearly basis to ensure staff were competent to administer medicines safely.

We observed the registered manager request a review of 'when required' medicines and homely remedies by the GP. The registered manager told us not all GP's had consented for homely remedies to be used for their patients. Nursing staff knew who could have them and those who could not.

Each person had a personal evacuation plan (PEEP) in place, these were detailed and specific to the individual. This meant that staff had access to up to date information to assist people in an emergency. The service had a Business Continuity Plan which was accessible to staff. The plan contained information staff would need in the case of an emergency. For example, a list of contact names and telephone numbers for utilities and senior management contact details.

Certificates in relation to health and safety for the premises were in place and up to date. For example, electrical installation, fire safety and PAT (portable appliance testing) records. The service also had a range of risk assessments for the building and the environment. These included moving and assisting equipment, water temperatures and emergency lighting testing. These were reviewed on a regular basis to ensure they were up to date. Policies and procedures were also in place to ensure safe working practices, the

organisation reviewed policies on an annual basis.

Staff used PPE, (personal protective equipment) and were seen to follow universal infection control procedures during the course of the daily work, when undertaking personal care, serving food at mealtimes or carrying out cleaning tasks. For example, washing hands between tasks, using appropriate cleaning products. Ancillary staff understood and were able to explain the cleaning processes in the home. For example, detailing the rolling programme of a room a day having a deep clean on each of the floors in the home.

The home was clean and tidy. Corridors were wide, spacious and well lit. Handrails were in place to support people with their mobility if they wished to use them to reduce the risk of falls or to assist in balance.

Good

Is the service effective?

Our findings

Relatives felt the service was effective. One relative said, "[Family member] has been six months and the improvement is terrific, [family member] was not eating, couldn't walk alone, now they have put on half a stone and can walk unaided, it's marvellous." One person said, "It's so nice here, they help me with my meals."

We observed the nurse in charge give a list of people she wanted the visiting GP to see and the reasons behind the request. They explained "You have to be on top of these little things otherwise it can get away from you so quickly, especially if someone is frail." This demonstrated that staff proactive in their approach to people's health needs. A relative said "The family are told about everything or if there is an emergency, they (staff) are good that way."

Staff we spoke with felt confident and suitably trained to support people effectively, training was refreshed on an annual basis. They discussed the computer based training management system the service had in place and the range of training they had completed. For example, dementia, moving and assisting, nutritional needs, communication and health and safety. The system allowed the service to book face to face training ahead of time to maintain staff's knowledge. One care worker said, "Training is really good here, there is the opportunity to progress to be a senior carer."

The registered manager arranged discussions with new staff as part of the probationary period. Records of discussions demonstrated how progress was recorded and next steps planned. Staff received an induction into the service and were supported by other staff members in the initial days of employment. The registered manager explained all staff completed mandatory training to enable them to work across the home. For example, all staff including domestic, administrative and catering staff were able to support people to eat and drink and to support with moving and assisting.
Staff received regular supervision and appraisal. Records were specific to job role, best practice was recognised along with development needs. Maintaining people's independence in the home was evident in supervision records. For example, encouraging staff to keep people skilled in personal care tasks. The service had a clinical supervision system in place for nursing staff. Records were available to demonstrate nurse supervisions were up to date. Records contained feedback from nurses regarding their development. Pastoral support was also noted following incidents. For example, following medicines errors to enable the staff member to talk through the incident and reflect on practice..

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who 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 procedure for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

DoLS applications had been made to respective authorities who were involved in people's placements. The registered manager tracked the DoLS applications and kept a log of each person who had a DoLS authorisation in place. People's support records contained details of the authorisation. Staff understood what MCA assessments were and when they should be completed. Staff were able to clearly describe the MCA and DoLS and how this was relevant to people. Care records contained details about DoLS and linked to care plans.

A four weekly menu was in place which had been developed with the involvement of people who used the service. The service plans to develop easy read versions. People were supported to maintain a varied and healthy diet. Nutritional assessments were completed regularly, along with care records to monitor people's food and fluid intake and weight.

We observed people finishing breakfast in the dining rooms and in bedrooms. People getting up later were offered breakfast. One ancillary staff member who met one person in the corridor said, "Just up? Have you had breakfast? We'll walk to the dining room." On meeting a member of the care team, they said, "Here's (person) he's just on his way for breakfast" and let the staff member take over. This demonstrated how the staff worked as a team to support people.

We observed the lunchtime meal. The tables were laid with tablecloths, cutlery, napkins and condiments. People chose where they sat, mostly in friendship groups. Some people preferred to either stay in the sitting area or in their rooms.

The staff wore protective clothing when serving meals and ensured people had access to napkins. Adaptive cutlery and drinking vessels were offered where needed. People were offered a choice of meal, plates were covered and brought to the table on individual trays from the hot trolley. People in the seating area had their tables wiped before use, and a tray with a paper doily used to bring their meal. Hot and cold drinks were offered. People were offered help or prompted as needed. One care worker remained in the dining room at all times. All members of staff, including cleaning staff, donned aprons and helped at mealtimes.

People were not rushed. The main course choices were well presented and looked and smelt appetising. People seemed to enjoy the meal. A choice of dessert was offered. One care worker said, "A hot rice pudding with jam, just like you used to have at home, or yogurt or fruit?" Meals were covered when taken to those in their rooms. Trays had doilies and napkins. One person had refused to eat but by the end of lunch was tucking into a meal whilst a staff member sat and joked with her, gently encouraging her to eat. One person told us, "I don't have a big appetite but I do enjoy the food. It's always tasty."

The TV had been turned off during lunchtime, though some music had been playing quietly. One relative said, "It creates a relaxed atmosphere, people enjoy listening." One person said "the food is lovely, lots of it and we have a choice." Another said "the food is lovely, they lay the tables up nice."

The service provided juice and water stations in all communal areas, along with a 'snack bar' with clear jars with sweets, raisins, biscuits and small cakes, paper holders were available for people to put the snack in. Bowls of fresh fruit was available around the home. Chairs were placed in small sitting areas in corridors as well as communal areas to enable people to rest when mobilising around the home. People who chose to remain in their rooms had glasses or beakers and jugs of water or juice within reach. We observed tea trolleys in the morning and afternoon, with hot and cold drinks, snacks of cake, biscuits and fruit. Individually named thickening powder was on the trolley. The staff member giving out the drinks and snacks

was able to tell us who needed thickened fluids and why.
Cooperation between care staff and healthcare professionals was evident in care records including social workers, dieticians, pharmacists, community psychiatric nurses, occupational therapists, physiotherapy, and GPs to ensure people received effective care. One visiting community nurse advised, "This is not my regular home but it seems good, none of my colleagues have ever commented otherwise."

No one was receiving end of life care at the time of inspection. The service employed staff who were able to deliver such care, syringe driver equipment was available and a limited number of staff had been trained to use this equipment. Valid DNACPR's (documents to give staff information about resuscitation) were in the front of people's care plans if appropriate. Advanced care plans which set out a person's health and support needs for the future were in place in line with palliative care guidelines. The registered manager felt it was important and had organised all staff to complete end of life care training.

There was good clear signage throughout the home, using text and pictures as well as colours to assist people to use bathrooms. The registered manager advised the home was undergoing some refurbishment, with plans to theme corridors and places in the home to assist in memory recall for people. Some areas had already been completed with a bus stop and post office. Several touchable textured art works decorated the walls, sets of drawers contained day to day items for people to rummage in. Outside was a patio garden and a safe enclosed "walk" that went around the building. The garden doors were accessible to everyone so people could go outside as they pleased.

Good

Is the service caring?

Our findings

Relatives felt the service was caring. One relative remarked, "It's a grand place, I come in when I like, and my sisters do too. We all sit and play cards or go out with [family member]. She gets her hair done every week, she loves that." Another said, "Oh it's good here, I am very pleased with it, I have never seen anything to bother me." One person said, "I like it here, they are nice to me the food is good and we have a laugh." Another told us, "Its lovely here, they do look after you, my friend is in a care home and wants to come here."

Throughout the inspection we observed positive interaction between staff and people. Staff were open and relaxed talking openly and listening to people in a caring manner. Buzzers were answered promptly, nurses carried individual pagers and answered these immediately. One person told us, "They are always on the go, never stop."

People were given choices appropriate to their needs, staff knocked on bedroom doors before entering. Staff used people's preferred names and actively encouraged decision making. One person said, "The food is lovely, I had porridge and toast and a cup of coffee at breakfast". The person had an apple in front of them. They said, "I am just waiting for a knife to cut it up." A staff member arrived and asked, "Do you want that cut up?" and fetched a plate and knife and cut it into small portions, which the person sat and enjoyed.

Staff clearly understood people's preferences and were knowledgeable about the care they required. Staff were quick to provide support and used distraction techniques when people's behaviour was causing the person to be distressed. For example, changing the conversation and focusing on something else. Staff explained to people what they were going to do before they acted and gained consent either verbally or by gestures. Bedrooms were personalised with photographs, pictures and ornaments brought from home. Staff were respectful of people's belongings and ensured people had their personal items with them during the day, such as handbags, hearing aids and spectacles. One person told us, "I get my hair done and my nails painted."

Staff spent time with people in the communal areas, engaging in conversations, reading with people and having a laugh and a joke. Music and the TV were used to provide conversation with people, remembering songs, actors and programmes. When people gestured towards staff, staff crouched down to eye level and held people's hands gently when speaking with them.

People's dignity was valued, staff supported people with choice of clothes, applying makeup and jewellery. The laundry assistant said, "People have some lovely clothes, and I keep them nice." We saw freshly laundered clothes, ironed and airing before being taken to peoples rooms.

Noticeboards contained information about Dementia for people, relatives and visitors. The registered manager had introduced, "dementia champions". These members of staff were responsible for promoting information about dementia to people, relatives and colleagues. Information relating to independent advocacy was accessible to people, relative and visitors. The registered manager reiterated the service's commitment to providing good quality care. They explained, "Dementia training is very important to the

service, staff complete five units on the subject so they have the knowledge and skills to support the people who live here." One relative told us, "I brought [family member] over here to this home from another, he is getting on so much better now."

The registered manager had implemented an equality and diversity champion. The staff member was responsible for keeping the information board up to date and was able to support new staff during their induction. There was evidence of clear responsibilities within these roles for staff. Staff were seen to be following the ethos of equality and diversity in their daily work. For example, all people were supported to access the singing and dancing activities despite their disability.

The communal areas were homely, with pictures and ornaments on display. Lounge areas had a range of seating, with small tables for people to have personal effects close by.

Good

Is the service responsive?

Our findings

People and relatives felt involved in planning and reviewing care and felt confident in giving their views and comments. One relative said, "We are involved in everything about their care." Another commented, "They are always asking if everything is okay." One person told us, "Some sit with you to chat and read the paper. They ask how you are getting along."

We looked at care records for six people. Care plans were detailed with changes documented clearly, monthly reviews were individualised and not repetitive. Care plans had been recently updated and demonstrated good person centred care and personal likes and dislikes were identified in the care plan. One care plan had recommendations for random daily blood sugars from a diabetic nurse specialist, this was not being followed. Blood sugars were being taken daily on a morning prior to insulin administration not at other times of the day. We discussed this with the registered manager who advised they would address this with the nursing staff. Care plans that identified risk to people had appropriate assessments and monitoring documents in place. For example, moving and assisting methods to promote independence. Care records and risk assessments were reviewed and updated in a timely manner.

The registered manager said, "Families are being asked to be involved in developing life stories." Work had begun to identify personalised boxes outside of bedrooms for each person. Staff were observed encouraging people to participate in activities, giving choices and options. One care worker commented, "Two people like to help me with my work, they enjoy it, this takes me longer but I like to let them be involved."

The registered manager had recently employed an activity coordinator who was awaiting their DBS check. Interim arrangements were in place with a member of the administrative staff coordinating activities and every member of staff was involved. We observed activities and interests promoted by all levels of staff from the registered manager to the cook. A weekly board of daily events was on display detailing a range of activities. For example, board games, quizzes and music. The registered manager said "I don't want it to be, this is Friday so it must be bingo, there has to be variety and things people enjoy".

The staff member said, "I am planning Burns Night, we'll have a do, I'll speak to the cook and get it all sorted, the staff will have to wear something tartan. We have a Buddy Holly impersonator in tomorrow, he is really good and the residents love it, they love a dance."

The registered manager explained they had hosted a talent contest for all the homes in the North, the Mayor and Mayoress had come to judge. They said, "The place was packed and everyone had a lot of fun, we got second, it was a good day. We are also getting involvement from a local Church, they are making some plans for visiting and such."

Staff described how people were empowered to join in with activities and how risk was managed to enable this. For example, risk assessments were in place so people could enjoy a holiday away from the home. The home had a caravan which people used, supported by staff. One person said "I enjoy going out in the minibus, we go to the caravan sometimes."

We observed staff dancing with people to sixties music in the sitting room, others were singing along or shouting advice. Staff were singing with residents, music was played or changed at people's request. In other areas a game of prize bingo was going on. Other people were reading a newspaper or watched TV or relaxed as they pleased.

We observed the responsiveness of staff during the inspection, answering emergency buzzers on two occasions. One person had an unwitnessed fall during the inspection, staff promptly responded to the emergency buzzer and put relevant observation documentation in place to monitor the person's condition for a 24 hour period. The attending nurse delegated staff to assist in a calm and caring manner. Staff offered support and reassurance to the person who had fallen whilst maintaining their dignity.

Relatives and staff we spoke with confirmed they knew how to make a complaint and felt confident in doing so. We looked at the information the provider had in place regarding making a complaint, this was accessible to people, relatives and visitors. The registered manager recorded all complaints using the online system and had a file with paper copies. Lessons learnt from complaints were recorded and information had been disseminated to staff through supervision and flash meetings.

Good

Is the service well-led?

Our findings

Relatives felt the home was well managed. A relative said "The manager seems good, he's always about doing something." Staff members we spoke with described the management as supportive and approachable. One care worker said, "It's a canny place to work" and "the manager is grand". Another said "you can have your say; you can say what you want."

A "Kindness in Care" award is an initiative the organisation had developed. The award is given to recognise and acknowledge staff members. Hebburn Court staff had won this award twice in the last year.

We observed the registered manager during the inspection and found them to be very visible in the home. Records showed a daily walk around was carried out and the registered manager used the opportunity to chat to people and check the delivery of care and support.

The registered manager had a clear vision for Hebburn Court, with refurbishment plans, staff training initiatives and ideas for improving the experience of people. They said, "I have no hesitation in challenging bad practice, making Hebburn Court better for people." The registered manager had a Level 5 Diploma in intervention training and support by the Alzheimer's Society and had won awards for their work in dementia care. This meant management had the knowledge to be able to support people and staff in the service.

The service had an information gathering process. A poster on display called, "You said – we did" showed that the service had acted on comments made by stakeholders. The registered manager had an open door and welcomed staff, relatives and visitors to call when they were in the building. One care worker said, "The manager has a lot of time for staff."

The quality assurance process contained records of regular audits. For example, the dining room experience and health and safety. Analysis from falls, incident and accidents reports had been completed with action plans containing set timeframes. Records showed that actions were checked and signed off. This meant the registered manager ensured that the systems in the home were checked. Monthly falls meetings were organised, with attendance from all departments within the home, minutes were printed out for both floors and the audit file to ensure staff were aware of any actions agreed at the meetings.

Weekly MAR chart audits, monthly medication audits and five drug audits a day were completed throughout the home. Action plans were completed following each audit and these were witnessed in the medication audit file alongside the medication policy.

The manager had implemented 'champions' for various care needs in the home, such as equality & diversity, and falls. There was evidence of clear responsibilities within these roles for staff. Reports from senior management visits showed falls had reduced in the home over the last month.

Various notice boards displaying useful information for staff and relatives were evident throughout the home.

The service had a registered manager in place. The CQC registration was on display. We examined policies and procedures relating to the running of the home. These were reviewed and maintained to ensure staff and people had access to up to date information and guidance. The service had a rolling development plan which was discussed on a monthly basis with senior management. The registered manager regularly reviewed and updated the plan.

Records showed the registered manager held regular meetings with staff, people and relatives. Meeting minutes were available. The service carried out surveys on an annual basis to capture views of relatives and people who used the service. The recent survey responses contained very positive comments. One read, "No complaints at all. I cannot believe how well [family member] has settled in."

The registered provider ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements. The registered manager kept a file of all notifications sent to CQC. The home kept all personal records secure and in accordance with the Data Protection Act.