St Cuthberts Care

St Catherine's Care Home

Inspection report

St Cuthberts House
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 4 and 6 May 2016 and was unannounced. This means the provider did not know we were coming. We last inspected St Catherine's Care Home in February 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

St Catherine's Care Home is a 45 bed care home that provides personal and nursing care to older people, including people with dementia. At the time of our inspection there were 44 people living at the home.

The service had a registered manager. 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.

We found that clear processes were followed for reporting and responding to any safeguarding issues. The provider was open about their safeguarding procedures and trained staff in how to recognise and protect people from harm and abuse.

People and their relatives told us they felt the care provided at the home was safe. Risks had been assessed and measures were in place to ensure people's personal safety. Steps were taken to provide care in a safe, comfortable and hygienic environment.

The risks associated with the safe use of medicines were not fully mitigated. Administration of medicines was not always accurately accounted for in records. Omissions in the application of topical medicines were evident and there had been an undue delay in one person receiving their medicines.

New staff were robustly recruited to check their suitability in working with vulnerable people. Enough staff of all grades were employed to ensure people received safe and consistent care. There was an appropriate skills mix and staff were given training and support which enabled them to care for people effectively.

People and their families were consulted about and asked to agree to their planned care. Where people were unable to give their consent, formal processes were followed to make decisions in their best interests.

People were given support to meet their health needs and access a range of health care services. A varied menu with choices of meals was offered and people told us they enjoyed the food. Nutritional risks were monitored and people were supported with eating and drinking where necessary.

Staff had a good understanding of people's individual needs and preferences. They were caring in their approach and promoted people's privacy and dignity. People were supported to express their views and make choices and decisions about their care and treatment.

Care needs were regularly assessed and recorded in personalised care plans. People's care was kept under review, with their involvement, and adapted when their needs changed. People were able to engage in social activities and have their spiritual needs met.

The home had a defined management structure that provided staff with leadership and support. There was a continuous system for assessing and improving the quality of the service. Feedback about the service was actively sought and any complaints were properly responded to.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the management of medicines. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The management and recording of people's medicines was not fully safe.

Appropriate measures were in place to safeguard people from harm and abuse.

Risks to personal safety were suitably assessed and managed.

Sufficient staff were employed to safely meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had received the relevant training, supervision and support to ensure they could meet people's needs effectively.

People's rights under the Mental Capacity Act 2005 were understood and upheld.

People were supported to maintain their health and well-being and had their dietary needs met.

Is the service caring?

Good

The service was caring.

People and their relatives told us the staff were caring and kind and our observations confirmed this.

People were given the information and support they needed to make choices and decisions about their care.

The staff treated people with respect and protected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans for meeting their needs and

preferences.

A varied activities programme was provided to prevent people from being social isolated. People's spiritual needs were well met.

Complaints about the service were taken seriously and responded to promptly and appropriately.

Is the service well-led?

Good

The service was well-led.

The registered manager provided leadership and support to the staff team.

There was an open culture with systems to obtain and act on feedback from people, their families, and staff.

Regular audits were carried out to check the quality of the service provided and a number of developments were planned.

St Catherine's 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 was 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.

The inspection took place on 4 and 6 May 2016 and was unannounced. The inspection team consisted of an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted local authority commissioners who told us they had carried out a monitoring visit to the service in April 2015 and there were no major issues. They said the provider had been given a short action plan and had made the necessary improvements by the time of their follow up visit in July 2015.

During the inspection we talked with 12 people living at the home and nine relatives. We spoke with senior management, the registered manager and with seven nursing, care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at five people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The service had arrangements for the ordering, supply, recording and administration of people's medicines. The registered manager reported they received a reliable and flexible service from the supplying pharmacy, who were able to provide same day delivery, where required. Medicines were administered by nurses and senior care staff, using a monitored dosage system. The staff who were responsible for administering medicines were trained, supervised for their first three medicines administration rounds, and were subject to thorough annual competency checks.

Medicines were kept securely in a locked room and were administered from lockable drugs trollies. Records of the administration of people's medicines were clear, including information such as allergies and protocols for when 'as required' medicines should be given. Staff told us they did a self-audit at the end of each medicines round to verify medicines had been given as prescribed and to record the reason(s) for any not being administered. There were also daily stock checks and weekly and monthly audits of medicines.

However, we found a number of errors and omissions in the medicine administration records (MARs). On the first day of our inspection, the morning medicines given to three people had not been signed for, to confirm they had been administered by staff. We saw a staff member had initialled they had administered a person's medicines before actually having done so. The person in question had subsequently refused their medicines and the MAR entries had been overwritten with the code for refusal. In a person's MAR the code 'O' (for other) was entered without any additional explanation as to why the medicine had not been administered. Records of the application of topical medicines (creams and ointments) did not always clearly specify how many times a day they should be applied. There was also evidence that topical medicines directed for application more than once a day were not being applied at the stated frequency.

It was evident that staff had contacted GP's when people consistently refused their prescribed medicines. However, we determined there had been an unnecessary delay in obtaining dispersible medicines for a person to enable their medicines to be given covertly (disguised in food or drinks), following a decision made that this was in their best interests.

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

All of the people we spoke with told us they felt safe in the home. Relatives said they felt their family members were safe. One relative commented that the home had an air of calm and said that staff had built up a sense of trust with their relative. Relatives of a person who was very new to the home told us they felt there was a nice atmosphere and the staff were very friendly. Another relative felt their family member was safe and well cared for and said the home gave her "peace of mind".

The service had policies and procedures for guidance on protecting people from abuse. Copies were held in the reception area of the home so that they were accessible to people, their visitors and staff. The registered manager had also included a question about personal safety in care review meetings to get people's

opinions about how they were treated by staff.

All staff received training in safeguarding issues during their induction to the service and at least every eighteen months thereafter. Training in challenging bad practice was also provided. The provider had introduced a 'duty of candour' policy which had been disseminated to the staff team. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

Records were kept of safeguarding concerns. In the last year, four concerns had been logged, three of which did not implicate staff employed at the home. The records demonstrated each of the safeguarding concerns was reported to the relevant authorities and appropriate action had been taken in response. The staff we talked with confirmed they had been trained in safeguarding and had a good understanding of whistleblowing (exposing poor practice). They told us they would not hesitate to report any form of abuse or poor practice they observed.

Steps were taken to prevent the possibility of financial abuse. These included establishing where people had an appointeeship in place or representatives with power of attorney over their financial affairs. Each person had a finance care plan setting out the agreed arrangements. The service assisted a number of people by holding personal monies on their behalf. Systems were in place to account for and audit cash held for safekeeping, with receipts and double signatures obtained for all transactions. The registered manager acknowledged the regular cash/account reconciliations conducted between audits should be recorded as additional checks.

An appropriate recruitment process was followed to check the suitability of new staff. Pre-employment checks included proof of identification and completion of application forms with work history and details of training. At least two references, included one from the last employer, were obtained and verified. Checks were carried out with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. The Personal Identification Numbers (PINs) of nurses were checked annually, to ensure they were still professionally registered.

The registered manager told us people's dependency levels were calculated on a monthly basis and the service was staffed according to these needs. The current levels were one to two nurses and eight to nine care and senior care staff rostered on duty during the day, supported by the registered manager and deputy manager, who were both nurses. Night cover consisted of one nurse, one senior carer and three care staff. The service was fully staffed with a full complement of nurses, care and ancillary staff. The staff team normally covered any absences and the home rarely needed to use external agency staff. A tiered 'on call' system was operated outside of office hours to support staff in the event of emergencies.

The people we talked with gave variable comments about staffing. One person thought there were enough staff except at mealtimes when they said they sometimes had to wait 20 to 30 minutes for the meal to be served. Another person, who said they were happy living in the home, commented they had to be prepared to wait for some things though felt the staff responded quickly to requests for other things. Two relatives told us there appeared to be sufficient staff available to care for people whilst another relative said there were sometimes enough staff and sometimes not. One relative commented on how hard the staff worked. During the inspection our observations identified no evidence of there being insufficient staff to meet people's needs safely.

Risks associated with people's care had been assessed. Measures to reduce identified risks were in place, for

example, in relation to moving and handling, nutrition, medicines and skin integrity. Specialist advice was sought, where necessary, and health care professionals such as occupational therapists had been involved in assessments and care planning.

Relatives told us the home was kept clean and had no unpleasant odours. A person living at the home said it was kept "spotlessly clean". The registered manager conducted a daily 'walk-through' of the service to check the safety and suitability of the environment. Monthly audits of the building and grounds were carried out by the maintenance person, who checked for any potential hazards, repairs and decorative issues. A maintenance log was kept that demonstrated fire safety and other safety checks had taken place. Other regular audits included checking hand-washing, infection control, waste management and use of personal protective equipment. Contingency plans were in place in the event of emergencies such as fire, power failure, severe weather warnings and staff shortages.

Detailed records were kept of accidents and incidents, including any actions taken to prevent reoccurrence. Each accident was reviewed and signed off by the registered manager and reported to the senior managers who were responsible for reviewing risks and safety. The registered manager told us in future they would revise the analysis of falls to make it more explicit in looking for any trends or safety issues.

Good

Is the service effective?

Our findings

A relative told us they felt that staff were well trained to do their job. They commented, "They must choose their staff very well because if you have a problem you can always find a member of staff who can help you."

New care staff were required to complete the Care Certificate as part of their induction to the service. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

We saw that ongoing training for staff was designed to meet the needs of their various roles and responsibilities, including advanced training for senior staff. A rolling programme of classroom based training was in place and staff were encouraged to access distance learning and development courses. All staff were provided with mandatory training in safe working practices, such as fire safety, moving and handling, and food safety. Training specific to the needs of people living at the home had been undertaken, including dementia awareness and the management of actual or potential aggression. Nurses received training in clinical aspects of care including catheterisation, skin integrity, palliative care and the use of resuscitation equipment. The registered manager told us information was being collated during staff appraisals to devise a workforce development plan, covering important areas in addition to mandatory training.

70% of care staff had completed nationally recognised care qualifications and the remainder were either studying or being enrolled to study for these qualifications. The registered manager was studying for the NVQ Diploma level five in management and leadership and a deputy manager was planning to do this training in the near future.

There was a delegated system for providing staff with individual supervision. The registered manager supervised deputy managers and senior care staff, who in turn, supervised the nurses and care staff. A schedule was in place and each staff member was given six supervision sessions a year, including observations of their practice, plus an annual appraisal of their performance. The staff we spoke with confirmed they received regular supervision and good support from the registered manager and senior staff.

We checked whether people were asked to give their formal consent to their care. We saw that people were asked to sign their consent to have photographs taken for identification purposes. The registered manager told us she was in the process of asking people to give written consent to their care plans, where they were able, and we saw an example of this. Care plan documentation was being updated to include a section to prompt the person regarding giving consent to their planned care. Relatives were also being asked to sign to confirm their agreement with their family member's care plans.

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 found that the service worked within the principles of the MCA. Guidance on the MCA and DoLS was available for staff. Where necessary, people's mental capacity had been assessed and the service had sought authorisation for DoLS. We saw mental capacity and deprivation of liberty care plans were drawn up, where appropriate, which included details of any persons appointed to represent the person. Decisions taken in the person's best interests, for instance for the use of bedrails for safety, were also clearly documented.

People's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. Nutritional care plans had been developed in line with people's identified needs. These included instructions on diet, swallowing difficulties, risk of choking, the required texture of food and support needed with eating and drinking. Care plans were personalised and covered areas such as the number of spoons of sugar a person took in their drinks and the foods they liked and disliked. Special dietary needs were catered for including diabetic, soft, pureed and gluten-free diets. Professional advice was taken from dieticians and speech and language therapists, as necessary, and incorporated into the person's care plan.

Details of people's food preferences were provided to the catering staff. There was a four week varied menu and people were given choices of meals each day. Menus were also in pictorial form to help people choose. Drinks, including fortified milkshakes, snacks and fruit were made available to people between meals and jugs of water or squash were provided in bedrooms and communal areas. People's weights were routinely monitored and we saw staff completed food intake charts in a timely way after meals. Weights had also recently been audited, checking stability or fluctuation over a period of time, and appropriate strategies were in place to meet each person's needs.

People spoke highly of the food provided. One person said the food was of good quality, with great variety, including lots of meat and fish. This person said that staff were always suggesting new ideas for food. Another person said the food was "As good as going into a restaurant" and that there was plenty to eat and drink. This person confirmed staff checked in the morning what they wanted for lunch. They said at times they were given something they hadn't requested but that staff were always happy to change things. A relative explained their family member liked to eat in their bedroom and said this was accommodated. This person enjoyed the food and was heard to say of an omelette meal, "This is the best meal I've ever had". As a result staff said they would provide more omelettes for the person in future.

Health needs were assessed as part of the overall assessment process. People had care plans for meeting their health needs including pressure area care, dressings and continence management. Emergency health care plans and future decisions of instructions not to be resuscitated were also documented, identifying the actions staff needed to take in emergency situations.

There was evidence in care records that people were supported to access a range of external health care professionals. Examples seen included referrals to physiotherapists, phlebotomists, district nurses, occupational therapists and podiatrists. Records were kept of all contact with visiting health professionals. A local GP practice conducted a weekly surgery in the home and there was regular input from community mental health services. The registered manager told us each person also had a full, annual review by their doctor to check their health and medicines.

Good

Is the service caring?

Our findings

People living at the home described the staff as having a caring nature. One person said, "The attitude of staff here is so nice." Relatives told us their family members were well cared for. One relative explained how staff had shown particular care and patience in the early stages when their family member moved in, as they had found the transition difficult and were often unpleasant or abusive towards staff. This relative said they had been impressed by the staff's patience and persistence when supporting the person through this process.

A relative told us that the staff were all 'lovely' and said they all took time to speak to visitors. This relative also thought the practice of having afternoon tea once a week with staff and management in the offices upstairs was a lovely touch (people took turns in going up to have a special afternoon tea). Another relative told us, "The staff are wonderful, very caring, respectful and thoughtful."

People living at the home were given a guide that informed them about what they could expect from using the service. This included the provider's stated purpose and core values. Relatives told us they were given sufficient information about the home and the services offered before their family member was admitted. A good range of information for people and their visitors was also displayed in the reception area of the home. Examples included posters and pamphlets on services offered by the NHS and local charities; making a complaint; in-house activities and events; safeguarding procedures; and the latest Care Quality Commission inspection report to refer to.

People and their relatives were supported to express their views about the care provided and the service in general. They could be involved in reviews of their care and gave feedback through meetings and surveys. The registered manager told us advocacy services were able to be accessed if anyone needed a representative to act on their behalf.

Staff were given training in equality and diversity and person-centred care to help them recognise and treat people as individuals with diverse needs. The staff we spoke with demonstrated a genuine interest in and commitment to the care of older people. A typical comment was, "We all care deeply for our residents. I know we shouldn't get too attached, but we do."

We observed staff talked to people in a respectful and caring way. We saw they engaged with people, shared jokes and we noted that people appeared relaxed in their company. We spoke with a staff member whose role was to prepare the dining room for mealtimes and support people to eat at breakfast time. They spoke very fondly of the people living in the home and told us how much they enjoyed helping them. This staff member was able to describe people's preferences, appeared to have a good, long-standing knowledge of people as individuals, and told us, "It's just so rewarding to know that you are making someone's day. This is their first meal of the day and it's important to give them a good start."

Staff were patient with people and gave them reassurance when necessary. For instance we heard a staff member reassuring a person about their pain relief medicines and a follow up visit from their GP. With the

person's permission, they supported them to go to their bedroom to have a lie down with a view to feeling more comfortable. On another occasion we heard relatives in conversation with the registered manager and one of the nurses. They discussed the new specialist chair that had been acquired, commenting on how comfortable and supportive this appeared to be for their family member. The nurse also gave the relatives an update about the person's well-being and their current good appetite.

At mealtimes we saw that people were sensitively supported and offered aprons and napkins to protect their dignity. During lunch we observed that staff sat alongside each person who needed support with eating and drinking, though we noted some people had to wait to be assisted. The registered manager told us they were looking at kitchen assistants helping in the dining rooms to make the mealtime experience less drawn out. They were also considering formalising their own observations, and those of senior managers who often dined with people, as part of the quality assurance system.

Relatives told us they felt that staff respected people's privacy and dignity. They gave us examples such as family members being asked to step outside a person's bedroom when personal care needs were being addressed, and people being able to choose whether to have their bedroom door open or closed. One person said that when staff were helping them with personal care tasks they chatted to them and they had established a nice relationship. This person said they felt their dignity was preserved during these times and commented, "They never make you feel awkward." Another person told us that staff respected their privacy and were diligent in ensuring curtains and doors were closed, when supporting them with personal care. Privacy and dignity was also reflected in the way that people's care was planned. For instance, one person's care plans described their wishes to retain their independence and how to preserve their dignity in relation to toileting and stoma care.

We saw that people with dementia-related conditions were treated with compassion and dignity. Staff communicated clearly, ensuring people were not rushed and given time in which to make everyday choices. The staff were trained in working with people with dementia and two staff acted as 'dementia champions,' with roles of advocating best practice and acting as a source of information and support for other staff. The registered manager told us that as part of the management qualification they were undertaking, they intended to do a project on improving the environment to make it more dementia-friendly.

Good

Is the service responsive?

Our findings

People told us the staff team were responsive to any requests they made. One person said they felt the home would try to accommodate whatever they needed and said, "If they can supply it, they will. I'm as happy here as I would be anywhere else." Another person said that the response time to the call bell was good and said they never had to wait more than five minutes for staff to come. A relative also felt that calls and requests were responded to quickly.

A small number of people we spoke with had less positive comments about the responsiveness of the service. We discussed their comments with the management team and established that some of the issues raised were historical and had already been addressed, and other issues had not previously been brought to their attention. We noted, on the second day of this inspection, that these issues had either been acted on or were in the process of being resolved.

We talked with people about their experience of moving into the home. Relatives of a person who had recently moved in said their first impressions had been good when looking for a home and this had continued since admission. They were impressed that their relative's bedroom had been redecorated especially for them prior to arrival. The relatives commented on the smooth transition and said they had been asked lots of questions about their relative's medical history, needs and social preferences.

Relatives told us the care given in the home was very person-centred. They told us staff asked them for details of their family member's personal history, lifestyle, habits and preferences, where the person was unable to give the information themselves. This information helped the staff to become familiar with the each person's background and the ways they preferred to be supported. A relative told us that staff used the information in practice, supporting their family member to choose which clothes they wanted to wear each day and talking to them about the job they used to have.

Relatives gave us other examples of person-centred care they had observed. One relative explained their family member was sometimes unsettled in the home, due to wanting to be in their own home. The relatives were requested to remove their coats before going in to see the person, in case it unsettled the person more. A second relative told us how staff were trying different ways to get another person to accept having their hair washed and set, without becoming distressed.

Assessments were carried out before people moved into the home to ensure their needs could be met. Each person's needs were then reassessed every month to check for any changes. Care plans were drawn up for each identified need which were regularly evaluated and updated as necessary. The care plans we examined were personalised and reflected the individual preferences of the person regarding their care. The staff used an electronic recording system to log daily and nightly updates on the care they provided and report on people's well-being. This system enabled the registered manager to monitor people's care and receive daily reports of any significant events affecting their welfare.

A review of each person's care was carried out every six months. Relatives told us they were involved in this

process. One relative told us they were asked about how things were going and if there was anything that could be improved. They said they were happy to make suggestions about their family member's care and felt confident that, "If something can be done, it will be done or explained why not."

A weekly activities programme was displayed in the home, showing different activities each morning and afternoon. Activities included reminiscence, exercise, tai chi, carpet bowls, music, card and board games, quizzes, crosswords, and bingo. Staff were alert to the impact of social isolation and recorded and reviewed each person's involvement in the activities programme and other pastimes. Regular one-to-one sessions with people in their own bedrooms were also arranged. People were able to go on outings during the summer months and occasional visiting entertainers were booked.

The activities co-ordinator told us there were some volunteers from a secondary school who came into the home to support activity with people. One person told us they had taken part in activities involving the local school children. They said they enjoyed music and outings and had arranged to bake scones at the next baking session. This person had also recently been out to the local shops and on a shopping trip with a care worker to buy a special bed which had been paid for by the provider.

People's spiritual needs were well catered for. The provider is a Roman Catholic charity and the home has its' own chapel. Services were held three times a week, which people were supported to attend if they so wished. Details of services, and of the home's prayer group meetings led by a volunteer, were displayed. Staff told us that people of other faiths were welcome in the home, and explained that the service would accommodate the spiritual needs of other non-Christian faiths.

A log was kept of any complaints received about the service. Records showed that all complaints, however minor, were logged and had been appropriately responded to. A relative we talked with told us they had complained in the past about a laundry problem that had been suitably resolved. Some issues were raised by people and their relatives during the course of the inspection which were acted on promptly. For example, repositioning a person's bed and providing a second armchair in another person's bedroom. One person's relatives queried some arrangements that were in place that had been explained to them as being a result of 'health and safety'. The examples they gave were that their family member's bedroom had laminate flooring rather than carpet and drinks were served in plastic rather than china cups. The registered manager assured us these matters would be readily rectified.

Good

Is the service well-led?

Our findings

The home had a manager who had been registered with the Care Quality Commission (CQC) in April 2016. The registered manager was fully aware of their registration responsibilities including notifying CQC of changes, events and incidents that occurred in the service. They told us they received good support from the provider and senior management, who were based on the upper floor in the same building and readily accessible.

Staff reported similar satisfaction with the support they received, both from the management team and from one another. Staff members we spoke with told us they enjoyed working in the home and felt proud of their work. One staff member said, "I would recommend the home and would have my own relative here."

We saw regular meetings were held to give information and feedback to staff and give them opportunities to comment on the running of the service and make suggestions. Staff meeting agenda topics included health and safety; safeguarding; care values and good practice issues; care planning; issues involving people living in the home; and training and development. The registered manager told us how important they felt the welfare of staff was, giving an example of having recently changed shift patterns to move away from staff working consecutive long days. They were also keen to develop the skills of the staff team and continue to build on delegating lead and champion roles to enhance accountability and promote best practice.

People and their relatives told us they felt the service was well-managed. One relative told us, "I have no complaints. The home is well managed and the accommodation is good. They keep me well-informed during visits and telephone me if necessary." The relatives we spoke with were confident they could raise any issues either about their family member's care or the service in general with the management and felt that they would be listened to. One relative said there had been a resident and relative meeting where they felt they could contribute with suggestions about the service. Another relative told us, "I love the culture here already."

Records showed there had been only two resident and relative meetings in the past twelve months. The registered manager told us they were not always well-attended. At the latest meeting in January 2016 topics discussed had included safeguarding, activities, meals and current building work. Minutes showed a listening culture with staff responding to people's suggestions.

The views of people and their relatives were also sought in satisfaction surveys. Questions were asked about the staff's approach including whether they were caring, compassionate, patient, responsive, showed respect and other qualities. The survey also checked whether people felt safe, had their needs met, were included in decision-making and knew how to make a complaint. The registered manager had read and considered the findings of the surveys and added comments about how any negative responses had been addressed. This had included discussing the issue with the person and their relatives, making changes to the person's care plan and amending staff practices.

A schedule of regular audits was carried out to check the quality of the service. These included monthly 'key

controls of risk' audits covering communication, people's care, welfare and safety, maintenance and hygiene, and performance management. Separate audits were conducted into different aspects of the service such as care documentation, medicines management and infection control. Bi-monthly inspection visits were undertaken by the provider's risk manager, which were based on the CQC standards of quality and safety. The findings from all audits, including any by external regulators or contractors, were fed into a live action plan. This specified any identified improvements required and were signed off by the registered manager upon completion as well as being monitored by senior management.

The registered manager told us they kept themselves up to date with best practice by attending meetings with other care home managers, the provider's management team and the Tyne and Wear Care Alliance (a local network offering workforce development support in the care sector). They also liaised with health care professionals who were part of a project supporting care homes in the Newcastle area.

The management team were committed to improving the standards at the home and a number of developments were planned over the coming year. The registered manager told us these included continuing the provider's five year plan to improve the environment; securing additional training in topics relevant to people's needs; and further developing social activities. They intended to review the end of life care provided at the home, working closely with an NHS palliative care nurse specialist for care homes, and attending training linked to the 'One chance to getting it right' report. The registered manager was also aiming to set up an aftercare group for families and hold an annual mass for those people who had died at the home in the previous year.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12 (2) (g)