Tamaris Healthcare (England) Limited

Astell Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 31 August 2016and 1 September 2016.

Astell Care Centre consists of two locations Walker Lodge and Brampton Court that have now been combined. They were last inspected in 2014. At those inspections we found the services were meeting all of the legal requirements in force at the time.

Astell Care Centre is registered to provide nursing and personal care to a maximum of 96 people. This includes a single sex unit for men who are unable to live harmoniously in a mixed gender environment. It also includes a separate unit for females who require more supervision and support because they may display distressed behaviour. A unit also accommodates people who live with dementia. The home is equipped for people with a disability.

A registered manager was in place. 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.

Due to their health conditions and complex needs not all people were able to share their views about the service they received. Those that could speak with us told us that care was provided with kindness and we observed that people's privacy and dignity were respected. People said they were safe and staff were kind and approachable. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had received training and had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves but we have made a recommendation about the use of covert medicines and best interest decision making. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

There was a good standard of record keeping and records reflected the care provided by staff. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people. The environment was being refurbished and it was bright and promoted the orientation and independence of

people who lived with dementia.

People told us they felt confident to speak to staff about any concerns if they needed to. Staff and people who used the service said the registered manager was supportive and approachable. People had the opportunity to give their views about the service. Feedback was acted upon in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided.

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.

Checks were carried out regularly to ensure the building was safe and fit for purpose. People told us they felt safe.

Staff were appropriately recruited. Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner. We have made a recommendation about medicines management.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received the training they needed.

Most best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates were made available to represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping. This meant people received support in the way they wanted and needed because staff had detailed and accurate guidance about how to deliver their care.

People were provided with activities and entertainment. People had information to help them complain. Complaints were investigated and any action taken was recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were complimentary about the refurbishment that was taking place around the home.

Improvements had been made by the provider and were being maintained by the registered manager and management team to promote the delivery of more person centred care for people.

The home had a robust quality assurance programme to check on the quality of care provided.

Astell Care Centre

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 31 August 2016 and 1 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector and two experts-by-experience who assisted at the inspection on the first day. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 service as part of 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 CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We also undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 26 people who lived at Astell Care Centre, three relatives, the deputy manager, two registered managers from another service, an area manager, two registered nurses, ten support workers including one senior support worker, the activities organiser, two members of catering staff, one domestic staff member and two visiting health and social care professionals. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was

managed. We looked at care records for seven people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people told us they felt safe and staff were around when they needed them. People's comments included, "If I need anything I just shout and someone comes to help," "I've just had a bath. They won't let me fill it myself just in case I scald myself," "The staff help me to move my bed up and down as I can't do it, in case I fall," and, "I don't leave here unless someone is with me as I know I can't manage to look after myself the way they do."

We were told staffing levels were determined by the number of people using the service and their needs. We considered there were sufficient staff to meet people's needs at the time of inspection on most units. There were 75 people who were living at the home who were supported by one deputy manager, two nurses and 13 support workers between the hours of 8:00am and 8:00pm. These numbers did not include the registered manager. Staff told us there was one nurse, one senior support worker and seven support workers to support people overnight between 8:00pm and 8:00am. Staff comments included, "We've time to spend with people," "I think we have enough staff," and, "If we're short staffed we can pick up extra shifts."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, distressed behaviours, moving and assisting and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. 22 safeguarding alerts had been raised since 2015. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. One safeguarding alert that had been raised by CQC was under investigation at the time of inspection

Staff had an understanding of safeguarding and knew how to report any concerns. Records showed and staff confirmed they had completed safeguarding adults training. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members' comments included, "I'd report any concerns straight away," "I haven't needed to report any safeguarding concerns to the manager," and, "I'd inform the nurse in charge."

Records were in place for the management of behaviour which was described as challenging. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. This guidance helped ensure staff worked in a consistent way with the person, to help reduce the anxiety and distressed

behaviour. Two staff members commented, "I've been on training for communication and distressed reaction and I found the training very useful," and, "I find the training very helpful, even though I've done the job for 15 years you can learn something." The deputy manager told us, "Staff will receive distressed reaction training as part of their induction in future." Care plans were in place to show peoples' care and support requirements when they became distressed or agitated and they were regularly updated to ensure they provided accurate information.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known. A health care professional commented, "The nurses and support workers manage challenging behaviour very well."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

We checked the management of medicines and found medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Care plans were in place that provided guidance for staff about how to support a person take their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Systems were in place to ensure that all medicines had been ordered, stored securely, administered safely and audited. Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Information was available with regard to the use of 'when required' medicines which may be required when people were in pain or agitated or distressed. Detailed information and guidance was available for each person to help staff support them if they were agitated or distressed. We were told this guidance was followed to try to calm people before any sedative medicine was administered, which was used as a last resort. Guidance was in place to advise staff 'when required' medicines should be used for agitation and distress to ensure a consistent approach.

Records showed three people received covert medication. Covert medicine refers to medicine which is hidden in food or drink. Signed documentation was not available to show why this was required, other than the record referred to the need and that it had been authorised by the GP. We saw the decision making did

not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. "A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

We recommend that the registered manager considers the National Institute of Care and Excellence (NICE) guidelines on managing medicines in care homes.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of other checks were available and up to date. They included the Nursing and Midwifery Council to check nurses' registration status and a form was completed by all applicants to check people's right to work in the United Kingdom. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "I've done training about dementia awareness and person centred care, it was good," "I'm up-to- date with all my mandatory training," "I've just been assessed to start my National Vocational Qualification NVQ" (now known as diploma in health and social care), "We do e-learning as well as face to face training," "We do lots of training," and, "I do e–learning training."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member commented, "I did three days induction when I started."

The staff training record showed all staff were kept up-to-date with safe working practices. The area manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. The training gave staff some knowledge and insight into people's needs and this included a range of courses such as, dementia care, person-centred care, equality and diversity, allergen awareness, mental capacity, pressure ulcer prevention, information governance and basic life support. Several staff had obtained or were studying for a diploma in health and social care. Some staff we spoke with described with enthusiasm the recent training they had received about dementia and person centred care. They told us the training had increased their understanding of how to support a person who did not express their views verbally to tell staff how they wanted their care to be delivered. One staff member commented, "Dementia awareness training made you smell things and wear glasses to show how a person with an impairment may experience their care, it was really good." The deputy manager also told us all staff were receiving training about sensory impairment and dementia.

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "I had supervision last week," "I do supervisions with some support workers," "I get supervision with one of the nurses every two months, we talk about my performance and training," and, "The senior does my supervision." Staff told us they were well supported to carry out their caring role. Staff said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

Staff told us communication was effective. Staff members' comments included, "Communication is really good," "All staff attend the handover at the start of the shift," "We have a handover in the morning and in the evening when different staff are coming on duty," "Communication keeps me up to date," and, "Communication is generally very good." We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. A formal verbal exchange of information took place about all people to ensure staff were aware of the current state of health and well-being of each person. Staff told us the diary and communication book also provided them with information.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists and the speech and language team (SALT). People had regular access to their GP or district nurse when appropriate. Records were kept of visits and any changes and advice was reflected in people's support plans. For example, advice was available in one person's care plan from the speech and language team. A health care professional told us, "The nurses can appear to have a 'laidback attitude' but when we discuss residents with them they know each person as an individual, and often have referred as appropriate to other services and are proactive with their care especially with residents who have complex needs."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The regional manager told us 47 applications had been authorised, seven people did not require one and seven applications were being processed by the local authority.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Most records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. They told us they received information from the registered nurses when people required a specialised diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available, for example, diabetic, vegetarian and soft or pureed diets. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce.

We saw food was well presented and looked appetising. People were offered a choice and a menu advertised what was available each day. People were positive about the food saying they had enough to eat and received good food. Peoples' comments included, "I'm trying to lose weight so I asked for salad when they came round this morning," "I have scrambled egg for breakfast," "You can have cooked breakfast each day," "I'm having quiche for lunch," and, "There's plenty to eat." Drinks were available during the day with biscuits provided.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool.

There was a programme of redecoration around the home. The environment was well-maintained and promoted the orientation and independence of people who lived with dementia. Lighting had been replaced so the environment was brighter, flooring had been replaced and hand rails were painted a different colour to the walls so they were more easily identifiable to guide people as they walked. People's comments included, "The home is looking much better," "It's much lighter downstairs," and, "I like the garden." A sensory room was being created to help people who lived with dementia or distressed behaviour to relax. People were able to identify different areas of the home. There was appropriate signage and doors such as lavatories, bathrooms and bedrooms had large signs for people to identify the room to help maintain their independence. Memory boxes that had been filled, contained items and information about people's previous interests and they were available outside some people's bedrooms to help them identify their room. The boxes also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

The garden was secure and well maintained. It was overlooked by some bedrooms. It was ornate and well planted and provided seating areas for people to sit outside. The garden was colourful and attractive and provided interest and stimulation for people who lived in the home.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were all very positive about the care provided by staff. People's comments included, "I like it here because they (staff) all know what they are doing with this feeding tube, (Percutaneous Endoscopic Gastrostomy (PEG) is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.) Staff have said if I improve a bit more I might be able to go onto regular food," and, "Staff are good, they'll do anything for you." Relatives comments included, "All the staff are very kind," "It was great [Name] coming here as we live nearby," "[Name]'s really happy here," "Care staff are lovely with residents," and, "The staff are all approachable." Two staff members commented, "I love working here," and, "The residents are great."

During the inspection there was a relaxed and welcoming atmosphere in the home. Many people had complex needs and we saw staff interacted well with people who we saw were relaxed with them. Staff engaged with people in a sensitive and quiet way. Staff were enthusiastic and knowledgeable as they described people's needs. They engaged with people and spent time with them whenever possible. People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. For example, as they offered people drinks or assisted them to move from their chairs. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. We observed one member of staff was encouraging a person to do some exercises and the relationship bond was evident. The staff member told us, "[Name] is having a good day. I try to get them to do these on a good day to keep [Name]'s legs moving. They wouldn't have done them yesterday I knew by the look they gave me when I came into the room."

Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. For example, "Is it okay if we put this on you?" We heard a staff member ask people how they wanted to receive their medicine, "Are you going to sit up and take your tablets."

Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say, for example, if they were in pain. Staff also gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Other people told us they were offered choices and involved in daily decision making about other aspects of their

care. For example, activities, bathing and rising and retiring routine. One person commented, "I get up when I want." Peoples' care plans contained detail of how staff were to support them with their choice. For example, one care plan recorded, "[Name] would like to choose their own meal from the daily menu."

People's privacy and dignity were respected. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. One person's care plan stated, "[Name] likes to eat alone as this has been their preference most of their life." People told us staff were respectful. Care plans provided information about respecting people's dignity. For example, one stated, '[Name] needs to be encouraged to wear pyjamas for bed so they are not embarrassed when staff come into their bedroom."

We observed the lunch time meal. The meal time was relaxed and unhurried. Staff interacted with people as they served them. Tables were set for three or four and staff remained in the dining area to provide encouragement and support to people. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. For example, "Are you ready for some more?" We observed people were given a choice of meal and staff verbally described and showed people what was available.

Important information about people's future care was stored prominently within their care records, for instance where people had made 'Advance Decisions' about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt cardiopulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told an advocate was to become involved with one person to provide an independent 'voice' due to the person's circumstances.

Good

Is the service responsive?

Our findings

People commented there were activities and entertainment. Their comments included, "I go out more than I'm in," "I go to the day centre one day a week," "I like to do jigsaws," "I like going into town and I go to the cinema," and, "I like to play snooker."

There was an advertised activities programme around the home that included, bingo, board games, gardening, pamper sessions, one to one, sing along, residents letters, shopping, movie night, reminiscence, doll therapy, armchair exercises, cake making, ball games, and music. We were told there were two activities people employed but one had been absent for some time. The available activities person spoke with enthusiasm about their role and their affection for the people. They told us, "I sit down with the new person and any family and get an idea of what they like to do so I can gear my activities towards that." They told us that some people didn't want to get involved in large group activities but staff had access to a games cupboard that contained dominoes, board games and jigsaws. We observed some staff playing dominoes and a 'Jenga' building block game with some people on the units. A church service was also held in the home and the hairdresser visited weekly. Outside entertainers regularly visited and included, pat a dog and singers.

The registered nurse informed us arrangements were in place to carry out pre-admission assessments of people to the service. This was to ensure the compatibility of people and to check that staff had the required skills to meet people's needs before they were admitted. There was a good standard of record keeping. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Examples included with regard to nutrition, communication, distressed behaviours, mobility and falls and personal hygiene. Evaluations were detailed and included information about peoples' progress and well-being.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the behavioural team were asked for advice with regard to people's distressed behaviour as required. Care plans provided information for staff to support the person and to help reduce the person's anxiety. For example, one care plan recorded, "[Name] likes the staff to explain any intervention to them so that [Name] can cooperate and to alleviate their anxiety."

Charts were also completed to record any staff intervention with a person. For example, it was recorded when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. When personal hygiene was attended to and other interventions to ensure peoples' daily routines were also carried out, these were also recorded. This information was then transferred to people's support plans which were up-dated monthly. These records were used to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences. Care plans alerted

support staff when a person may be at risk of developing pressure areas on their body.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. One staff member told us, "[Name] used to like to garden so we sometimes take them into the garden to water the plants." Care plans were detailed and provided information and guidance for staff about peoples' care needs and how they liked to be supported. Examples in care plans included, "[Name] doesn't like the hustle and bustle that mealtime creates," "[Name] likes to go to bed after supper between 9:30pm and 10:00pm," and, "[Name] does need help to carry out their personal hygiene but they do have the skills that can continue to be encouraged and to maintain their independence," and, a nutritional care plan stated, "Cut food into small pieces to eat," and, "[Name] likes snacks in between meals such as biscuits, cake and fruit."

Staff told us of links with the community whereby local college and school children visited. On the day of inspection we saw some people sponsored by Newcastle United had finished a scheme working in the garden and a party was provided for them to show the home's appreciation.

We were told resident and relative meetings were held regularly to discuss the running of the home and any changes. People who use the service and relatives told us the registered manager was approachable and they knew they could approach them at any time to discuss any issues. One person commented, "If I need to I'll see [Name], the manager."

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. An iPad, which was part of the organisation's quality assurance process, was also available in the front entrance for people to comment or complain about the care provided. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained. Three complaints had been received since the last inspection which had been investigated and the necessary action taken.

Good

Is the service well-led?

Our findings

A registered manager was in place who had become registered with the Care Quality Commission (CQC) in March 2016. The registered manager had previously been registered for Walker Lodge, one of the two locations that had now combined to create Astell Care Centre.

The atmosphere in the home was relaxed. People told us they were happy at the home and with the leadership there. Staff said they felt well-supported by the management team. They said they could approach them to discuss any issues. Staff comments included, "[Name], the manager, is very supportive," and, "[Name] is the best manager. Relatives comments included, "If I have any issues, they are addressed," and, "I go to the office if I want information."

The provider had strengthened the management team within the home to ensure consistent leadership when the registered manager was not on duty. A deputy manager's post had been filled so there was management cover over seven days of the week. The registered manager was not present to assist us with the inspection, however the registered manager covering the service and other management from the organisation were available to assist. Records we requested were produced for us promptly and we were able to access the care records we required. The provider's representatives were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way. They told us about the underlying values they saw as important, including ensuring people were treated with dignity and respect. Care staff were also enthusiastic and clear about expected standards of work and the registered manager's ethos.

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. They showed the action that had been taken as a result of previous audits where deficits were identified. A weekly risk monitoring report that included areas of care such as people's weight loss, pressure area care and serious changes in their health status was completed by the registered manager and submitted to head office for analysis.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The area manager told us a daily audit took place which was carried out by the registered manager and involved them doing a daily walk around. It was completed electronically with an iPad and all responses and outcomes were received directly by head office each day. The responses were escalated electronically, and depending upon the category of severity, were triggered to senior management within the organisation to make them aware of any issues identified. The iPad was also used to collect feedback from people who used the service, relatives and staff, with at least six people being encouraged to comment daily.

Monthly audits included checks on people's dining experience, staff supervision, medicines management, care documentation, training, kitchen audits, accidents and incidents, clinical governance and nutrition. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits

carried out by the registered manager to ensure they had acted upon the results of their audits. All audits were available electronically and we saw the information was filtered to ensure any identified deficits were actioned. Other audits included checking a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files. A weekly internal financial audit of the petty cash, amenities fund and monies held on behalf of people who lived in the home was carried out. A six monthly audit of finances held in the home was also carried out by a representative from head office. All audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Regular analysis of incidents and accidents took place. The registered nurse said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. Staff told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Staff meeting minutes were available to show the staff meetings that took place monthly to assist with communication and ensure the smooth running of the home. These included quality and clinical governance meetings, health and safety meetings and general staff meetings. Staff members told us staff meetings took place and minutes were made available for staff who were unable to attend. Minutes from general staff meetings showed areas discussed included training, staff performance, record keeping, audits and communication. A staff member commented, "Staff meetings happen two monthly."

The registered provider monitored the quality of service provision through information collected from comments and compliments that were collected from a sample of people daily and from visitors to the service. The results were analysed by head office and a report of the results was available within the home.