Ms Linda Charlton

Thornley Leazes Care

Inspection report

Thornley Leazes Care
Allendale
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Northumberland
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Website: N/A

Date of inspection visit: 15, 16 & 19 January 2015
Date of publication: 15/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

Thornley Leazes Care operates both a care home and domiciliary care service under their registration with the Care Quality Commission. The care home provides accommodation and personal care and support for up to 12 people, primarily with learning disabilities. Some people supported by the provider in both the care home and the domiciliary care side of the business, are living with dementia. In addition, some people supported with domiciliary care have physical disabilities. There were 12 people living at the care home at the time of our inspection, and a further 12 people in receipt of domiciliary care in the community in and around the Allendale area.

This inspection took place on 15, 16 and 19 January 2015 and it was unannounced. The last inspection we carried out at this service was in May 2014 when the provider was not meeting all of the regulations that we inspected which included cleanliness and infection control, the safety and suitability of premises and records. The

Summary of findings

provider submitted action plans linked to each of the regulations they were in breach of, stating how and by when they would meet the requirements of these regulations. At this inspection we found that improvements had been made in all three of the regulations that had been breached at our last visit.

Thornley Leazes Care does not require a registered manager to be in post under their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. In this service, the provider is a 'registered person' who is actively involved in the service who has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Therefore there is no requirement for them to register a separate registered person as a manager.

Systems were in place to protect people from abuse and to report any abuse to the local authority safeguarding team for investigation. Two safeguarding concerns had been raised against the provider in the last 12 months which had been investigated and not substantiated.

People's needs and the risks they were exposed to in their daily lives had been assessed. Care records were regularly reviewed in the home, but in respect of domiciliary care we found that although some improvements in records was evident, further work was needed as there was a lack of information and instruction for staff.

Care planning and risk assessing around the administration of medicines was not sufficient in the domiciliary care service. Records related to the administration of medicines did not accurately reflect how staff supported people to take their medicines. No agreements were in place about the level of support staff provided to assist people to take their medicines. Where there were medicines care plans or risk assessments in place, these were not detailed enough.

Regular health and safety checks were carried out on the premises and on equipment. The provider rectified an issue regarding door security during our inspection. Recruitment processes included checks to ensure that staff employed were of good character. The staff team and staffing levels were consistent and people's needs were met. Staff records showed they received training related to their role which was up to date. Staff told us they received supervisions and appraisals and they could feedback their views directly to the registered provider at any time.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards exist to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered provider was in the process of applying for DoLS to be put in place for those people who lived at the home who needed them. We found the MCA was not always applied appropriately in that the best interest decision making process had not always been followed. Records did not fully reflect people's capacity levels and we found the management of some people's finances required review.

People told us, and records confirmed that their general healthcare needs were met. People's general practitioners were called where there were concerns about their welfare as were other healthcare professionals such as dentists and chiropodists. People told us they were happy with the food they were served and they could ask for anything they liked and it was accommodated. People's nutritional needs were met and specialist advice was sought when needed.

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people, and people spoke highly of the staff team. Staff were aware of people's individual needs. People and staff told us that regular activities took place within the home and the local community.

There was a lack of suitable quality assurance systems in place to monitor the service. For example, audits were not done in areas such as infection control, medication and health and safety. This had resulted in some shortfalls which the provider and staff team were unaware of. The registered provider had recently appointed a deputy manager whose role was to develop the administrative side of the business and introduce quality assurance measures to drive improvements within the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and their corresponding regulations under the Health and Social

Summary of findings

Care Act 2008 (Regulated Activities) Regulations 2014. These were; Regulation 10, Assessing and monitoring the quality of service provision which corresponds to Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 13, Management of medicines, which corresponds to Regulation 12(f) & (g), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and Regulation 18 Consent to care and treatment which corresponds to Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

Medicines were not managed effectively and appropriately in the domiciliary care service.

Safeguarding policies and procedures were in place and staff were aware of their personal responsibility to report incidences of abuse or potential abuse.

Recruitment processes were safe and staffing levels were sufficient to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act 2005 was not always applied effectively and decisions about peoples care had not always been made in line with the best interest decision making process.

People spoke highly of the staff team and the care they delivered. We received positive feedback from people's relatives about the service.

People were happy with the food they received and those with specific nutritional needs were supported appropriately by staff.

Is the service caring?

Good

The service was caring

Staff displayed compassionate and caring attitudes towards people and we saw pleasant interactions between people and staff during our inspection. They were treated with dignity and respect.

Where necessary advocates, mainly in the form of family members, acted on people's behalf.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs and where necessary intervention was sought by the registered provider from external healthcare professionals.

People were given choices in their day to day lives and staff provided person-centred care. Complaints were handled appropriately and people were comfortable with the concept of making a complaint to either staff, or directly to the registered provider.

Summary of findings

People's care records in the domiciliary care service lacked detail although the senior carer in charge of this area of the business gave their assurances this would be addressed.

Is the service well-led?

Not all aspects of the service were well led.

Some systems were in place to monitor care delivery but there were gaps in quality assurance systems. Limited audits were in place, although the provider told us this was under review.

People and their relatives told us the service was well led and they had faith in the provider. Staff told us the provider was very supportive and they could approach her about anything, at any time.

Requires Improvement

Thornley Leazes Care

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 15, 16 and 19 January 2015 and it was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection the provider completed a Provider Information Return (PIR). This is a form which asks the registered provider to give some key information about the service, highlighting what the service does well, and identifying where and how improvements are to be made in the future. We reviewed the information returned to us by the registered provider in the PIR, alongside information held within our own records at the Commission (CQC) about the service. This included reviewing statutory notifications the provider had sent us, and other safeguarding and whistleblowing information that had been brought to our attention over the previous 12 month period. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch (Northumberland). They did not provide us with any information of concern.

During our visit we spoke with seven people in receipt of care and support from the service, four members of staff and the registered provider. We walked around the care home and with their permission, we looked in people's bedrooms. We observed the care and support that people received and reviewed a range of records related to people's care and the management of the service. These included looking at seven people's care records (some from each side of the business), four staff files (including recruitment, induction and training records), 14 people's medication administration records, and records related to quality assurance and maintenance of the care home building and equipment used within the home.

Following the inspection we contacted two people's relatives and four healthcare professionals involved in people's care, to gather their views of the standard of service that people received.

Requires Improvement

Is the service safe?

Our findings

We identified concerns in respect of the management of medicines in the domiciliary care side of the business. We visited three people in their own homes and found in two cases people took their own medicines which had been left out for them in a pot by care workers who had visited earlier in the day. The care plans stated the service was responsible for administering all medication and recording this administration on people's MARs, but this did not reflect what happened in reality. One of these people took time-specific medication for their condition and at the time we visited them they had not taken their morning medication. Staff were administering controlled drugs to a third person without a care plan or risk assessment in place, although a MAR sheet with information about these prescribed medicines was in use for care workers to record administration. The person told us staff referred to the dosage on the bottle and handed the medication to them, for them to take independently. The risks associated with these practices had not been assessed and care planning around medication was not sufficient. As a result, people may not receive their medicines on time, safely, and as they required them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines within the care home were managed safely. We looked at each person's medication administration record (MARs) and found these were well maintained. Medicines were stored appropriately and systems were in place to reorder medicines and to account for and dispose safely of medicines that were no longer required. An appropriate system was also in place which recorded medicines (quantity and type) that were transferred out and then back into the home, and who the responsibility of giving medicines was transferred to, when people enjoyed time away.

People told us they were happy living at Thornley Leazes Care Home, or receiving a domiciliary care service from them, and they felt safe. One person said, "I have never felt unsafe, not with them". Another person told us, "I definitely feel safe and comfortable with staff". We asked people's relatives if they had any concerns about the safety of their relations. Each relative said they did not. One relative told us, "I have not seen anything unsafe when I have been there". One healthcare professional told us, "I have no concerns with this home or service".

Staff adopted moving and handling procedures that were both appropriate and safe and we had no concerns about people's safety or how they were treated by staff.

Staff were able to tell us about what constituted abuse and the procedures they would follow if they witnessed abuse. Each member of staff we spoke with was aware of their own personal responsibility to report any concerns. Our records showed that two potential safeguarding incidents had been raised by third parties about the service within the last 12 months. In both cases the claims brought against the provider, were not substantiated.

Infection control measures that were not in place when we last inspected had been introduced. For example, red laundry bags were used for the safe transportation of soiled laundry around the home and used incontinence aids were now disposed of in allocated bins in communal bathrooms and toilets. A clinical waste contract had been arranged with an external waste disposal firm. Staff told us they had plentiful supplies of personal protective equipment and we saw they used this equipment during our visit. A new cleaning regime was in place for staff to follow on a rotational basis and staff told us this allocated tasks to individuals which ensured they were done. The home was clean light and airy and shortfalls that we had previously identified relating to cleanliness, had been addressed.

The safety and suitability of the premises had improved and the home had been redecorated in most areas and a new kitchen had been fitted. The damp that had been present in the building had been treated in all but one bedroom, where it had been treated but remerged, and then recently retreated. Invoices that we viewed showed that work to eradicate damp from the building had taken place.

In relation to the security of the building we found some continuing concerns about the lack of entry and exit controls on the side door (used as the main point of entry to the care home), the front door, and two fire doors which people could exit from undetected as they were not alarmed. The provider acted on our concerns about the

Requires Improvement

Is the service safe?

side door and front door during our visit by locking these doors. They also gave us assurances that working alarms would be installed on the fire exit doors as soon as practicable.

Recruitment procedures were thorough and protected the safety of the people who lived at the home. Application forms had been completed by staff before they were employed, in which they provided their employment history. Staff had been interviewed, their identification checked, and references had been obtained from their previous employers. The provider had made appropriate checks with the Disclosure and Barring Service (DBS) to ensure that staff were not barred from working with vulnerable adults. These checks had been carried out before staff started work. This meant the registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

Staff told us staffing levels were sufficient to meet people's needs and our observations confirmed this. One person told us, "There are plenty of staff". The registered provider told us any shortfalls in staffing, for example due to sickness or annual leave, were covered internally by other members of the staff team. On-call arrangements were in place where staff could telephone either senior members of the staff team, or the registered provider directly if they needed assistance outside of normal working hours.

Staff told us there was no emergency or business continuity plan in place but that if anything went wrong with the building they would call the maintenance man who lived locally to attend to the home. They said if further assistance was required, they would arrange for a specialist in the relevant field to come out. There was no guidance available to staff on what actions they should take in the event of, for example, the loss of water, electricity, a fire or a flood, and there were no individual personal emergency evacuation plans for those people who would need assistance to leave the building in an emergency.

The environment was much improved since our last visit and people and staff welcomed the improvements that had been made to the home. Equipment was serviced and maintained regularly and safety checks were carried out on for example, electrical equipment, the electrical installation within the building and fire safety. Overall risks within the building that people, staff or visitors may have been exposed to had been assessed. However, we identified two areas that needed to be addressed. A fire risk assessment for the building was in place, but we found this was in need of review. Legionella control measures including water sample testing were carried out within the home to reduce the risks of this bacteria developing in the water supplies. However, a legionella risk assessment specific to the building had not been undertaken in line with the requirements of the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and the Health and Safety at Work Act 1974.

We discussed these matters with the provider who gave their assurances that they would be addressed as soon as possible.

Requires Improvement

Is the service effective?

Our findings

The registered provider told us she was in the process of applying for Deprivation of Liberty Safeguards (DoLS) to be put in place for those people living at the home who needed them. DoLS are part of the Mental Capacity Act 2005 (MCA). They are a legal process that is followed to ensure that people are looked after in a way that protects their safety and wellbeing but does not inappropriately restrict their freedom. These applications and decisions are made in people's best interests by the relevant local authority supervising body.

We reviewed how the MCA had been applied in respect of care delivery and whether due consideration had been given to people's levels of capacity in a variety of areas. We found that some decisions had been made in people's 'best interests' in line with the MCA. For example, in relation to plans made about end of life care and specialised equipment to be used in care delivery. However, not all decisions made on people's behalf had gone through the best interest decision making process, where they lacked the capacity to express their own choices and preferences. For instance, a camera was in place in one area so staff could monitor a person's movements and activity through the night, in case they needed assistance. In discussion with the provider we discovered this had not been fully explored or agreed with the wider multidisciplinary team. In another example, some people who lacked capacity to consent to care or treatment had been given an treatment to prevent them developing a particular illness. Written evidence detailing how the decision to give treatment had been made, or by whom, was not available.

Most people lacking capacity had not been appropriately assessed in terms of their ability to manage their own finances. Whilst we found no evidence of improper management of people's finances, we referred the relevant individuals to the commissioning local authorities for them to investigate further.

We concluded that the provider did not always act in line with legislation and guidance where people lacked the capacity to make their own decisions. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the care they received. One person said, "The girls are fantastic. They come morning, dinner time, tea and in the evening. They have never missed a call. I can't fault them at least not yet". A second person who lived in the home told us, "I have friends here. The food is nice. I like it here". Following our visit to the home and as part of the inspection we spoke with two people's relatives. Their comments were all positive. One person's relative told us, "I have always found the service very, very good". Another relative commented, "What I love about it is it is small intimate and friendly. X (person's name) is warm, comfortable and well looked after. Personal care such as nails, eyes, teeth etc, is all done – which is very important".

Staff explained in detail people's likes, dislikes, abilities and needs. For individuals who were unable to communicate verbally, staff told us they had learned to read their facial expressions, behaviours or noises to establish their mood and whether or not they were happy with a particular action or personal care task. Staff displayed an in-depth knowledge of people and their needs, which we saw they used to provide effective, personalised care. For example, one person needed one to one care with feeding and personal care and staff described the steps they followed when caring for this person.

There was evidence that people were supported to receive on-going healthcare support and attend routine healthcare appointments, such as those with a dentist or in a specialist hospital setting. In addition, we saw that people had input into their care from healthcare professionals such as speech and language therapists and psychiatrists whenever necessary. Records showed that referrals had been made to external healthcare professionals promptly where people's needs had changed. This showed the provider supported people to maintain their health and wellbeing.

The service provided a variety of healthy foods and home-cooked meals for people to choose from. Staff told us they offered a varied menu which was flexible and people could choose any alternative food if they didn't like the meals planned for that day. One person told us, "The food is ok. I can have what I want. I get something else if I want something different". Where people had specialist dietary requirements or nutritional needs, we saw staff supported them appropriately and ensured they got the food and fluids they needed, in a safe way, in order to

Requires Improvement

Is the service effective?

remain healthy. For example, care records showed that one person required their drinks thickened and a pureed diet and we observed staff provided food and drink of this consistency at lunch.

Staff told us they were satisfied their training requirements were met and they felt equipped with the necessary skills to fulfil their roles. One member of staff told us, "I have had plenty of training since I started at Thornley Leazes". Staff told us they had received training in a number of key areas such as safeguarding people from abuse and infection control, and they had completed an induction to ensure they were competent to carry out their role before working unsupervised.

Staff told us they received supervisions and an appraisal annually. Supervisions were used as a two-way feedback tool through which the registered manager and individual staff could discuss work related issues, training needs and personal matters if necessary. Staff told us they felt fully supported by the provider who they could approach at any time with any problems, suggestions or concerns.

Good

Is the service caring?

Our findings

People and their relatives told us they found the staff and service caring. One person said, “The staff are fantastic you can’t fault them. If you want anything doing they do it and they are always asking if there is anything I need”. Another person told us, “The staff are friendly and I think they look after me”. A third person commented, “I have never been cared for so well. They are first class. They are very gentle with me; nice and steady and not rough or anything like that. They are perfect!” One person’s relative said, “X is well looked after and well cared for”. A second person’s relative told us, “I just think it’s lovely at Thornley Leazes. It comes down to the people who look after them – the staff. All I can see when I go there is good care. They care so much. Staff spend time with people”. One visiting healthcare professional told us “If I had to describe the care I would say it is very good”.

People looked well-cared for; they were clean and well presented. Staff interacted with people in a pleasant, polite, caring and respectful manner. There was a calm, happy atmosphere within the home, and in both this setting and the community domiciliary care setting, people appeared very comfortable in the presence of staff. We saw staff supported people appropriately with activities of daily living, such as eating and mobility. Staff engaged with people when delivering care and support, and they were not rushed when assisting them. Staff explained what they were going to do before assisting people.

Relatives told us that they felt informed about their relations’ care. People said staff included them in making decisions about their care and those who were able to, told us they were aware of the care records that existed about them. Staff were knowledgeable about people’s needs, likes, dislikes and the activities they liked to pursue.

Some of the people who lived at Thornley Leazes were not able to converse with staff or us verbally. Staff demonstrated understanding of person’s diverse needs and were able to tell us about non-verbal actions and signs that people used to communicate their needs.

Staff delivered care which promoted people’s independence, privacy and dignity. For example they ensured people’s personal care needs were met. People were encouraged to be as independent as possible and staff promoted, for example, people feeding themselves and maintaining levels of cleanliness within their own rooms wherever possible.

The registered provider told us that no people using the service currently had an advocate acting on their behalf; other than those family members who were actively involved in their care. Advocates represent the views of people who are unable to express their own wishes, should this be required. The registered provider explained that she would contact people’s care managers to arrange an advocate should they require one in the future, if they had no family members who were both willing and able to support them.

Good

Is the service responsive?

Our findings

People told us they enjoyed receiving care and support from the service and their needs were met. One person said, "I like it here (at the home) and I get on very well with the staff". Another person told us, "I love it!" A third person commented, "It's fantastic". One person's relative told us, "We are absolutely delighted I couldn't speak more highly of them". Another person's relative said, "As far as I am aware X (person's name) is very well looked after. I have no problem at all and if there ever is a problem they always call me".

Two people told us they were supported by the service to enjoy activities in the local community such as attending day centres. The provider told us the service operated a shop in the local village which people from the care home attended regularly to undertake craft based activities. During our visit to the care home we observed people relaxing in the lounge, watching television and doing jigsaws. The service promoted people's wellbeing, social needs and community involvement.

Care was person centred and staff had in-depth knowledge of people's likes, dislikes and any behaviours that indicated how they were feeling. Many of the people living at the home had lived there for a number of years, some as many as 20 years, and the staff team was stable. Staff were aware of how two people, who could not communicate verbally, expressed their feelings via expressions and behaviours. They told us they used such knowledge to ensure that the care they delivered was appropriate and resulted in a positive outcome for the people involved.

Our observations showed that people were given choices in their day to day lives. For example, a member of staff asked one person, "What would you like to eat for lunch?" One person told us, "I used to go to the day centre but I don't go now – it was my choice to stop though". This meant people were respected and staff recognised people's individual right to make their own decisions.

We found some improvements had been made in record keeping. Care plans were now in place in the domiciliary care service that had not been evident during our last inspection. However, we found some examples where these care plans lacked detail in that risks that people were exposed to in their daily lives had not always been appropriately documented. Written instructions were not always in place for staff to follow about how to manage and reduce these risks. We discussed our observations related to records with the senior care worker in charge of the domiciliary care side of the business, who told us people's care records would be assessed and redrafted in order to drive forward improvements in this area.

Within the care home setting people's care records were personalised and the majority contained care plans and risk assessments that reflected their needs. There was evidence of regular reviews and evaluation, to ensure that people's care remained appropriate, safe and up to date. We saw that some documentation was out of date and this could lead to confusion when reviewing records. Diaries that were in place to monitor people's daily activities, progress and changing care needs showed that people had some needs which were not accurately reflected in their care plans where risk assessments were not always in place.

People's care records showed the provider had sought appropriate intervention and healthcare treatment for people when necessary. One person told us, "They would definitely get the doctor if I needed them". We spoke with two external healthcare professionals who both confirmed the provider was responsive to people's needs and she contacted them for help, advice and input into people's care, as and when required. One healthcare professional told us, "I would say the manager (provider in this case) is very responsive, I have never had any problems at all with getting anything done".

We talked with staff about the processes they would follow to appropriately support people to make a complaint. All of the staff we spoke with confirmed they had not been required to assist anyone to make a complaint. One member of staff said, "Nobody has formally wanted to raise a complaint with me". Staff told us there was a structured complaints policy in place for them to refer to. People's relatives told us they had not had any reason to complain about the service. Records maintained within the home confirmed that there had not been any complaints raised in the 12 months prior to our inspection. Information for people on how to make a complaint was available to them in the foyer of the home and there was a complaints and suggestions box that people could use to submit complaints. One person told us, "If I wasn't happy they

Good

Is the service responsive?

have a suggestions box or I would tell X (the registered provider) if I wasn't happy". This showed that people were aware they could complain and were comfortable enough to approach the registered provider directly.

Staff told us that people had the opportunity to feedback their views at any time directly to the provider or via residents meetings. Staff told us they had the opportunity to express their views either at staff meetings or via supervision sessions, appraisals, or through raising any issues with the provider directly.

Questionnaires had been completed by people and their families and all of the responses we viewed gave positive comments about the staff and the service delivered. One comment read, 'You all do over and above the call of duty, with an excellent attitude'.

Requires Improvement

Is the service well-led?

Our findings

The provider told us that accident and incidents which occurred within the service were monitored and most health and safety checks in the home were carried out. She told us that audits related to care plans, infection control, medication and health and safety were not undertaken, but advised that she regularly checked infection control and health and safety matters when walking around the home.

From a safety perspective, we found no evidence that there had been an impact to either the care delivered or people's safety as a result of this absence of these audits, or the lack of assessment of environmental risks such as legionella and evacuating people from the home in an emergency. However, appropriate systems were not in place to identify the shortfalls we found in the management of medicines and the records related to care planning and risk assessment in the domiciliary care service. In addition, the shortfalls in respect of the security of the premises and how the MCA was being applied, had not been identified, prior to us highlighting these matters.

Some further improvements were needed to ensure that systems to monitor all elements of the service and care delivered, were in place and were effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

We shared our findings with the provider who told us the newly appointed deputy manager was working towards developing and implementing more robust quality assurance systems across the business, and managing the administrative elements of the service.

Thornley Leazes Care does not require a registered manager to be in post under their registration as the registered provider is in day to day charge of the service and therefore manages the service directly. A senior care worker is responsible for the operation of the domiciliary care service. Since our last visit a deputy manager had been appointed to deal primarily with the administrative side of the business. It was clear through our discussions with the provider that she knew people well.

We received positive feedback from people, their relatives and staff about the provider and how the service was managed. One person told us, "I can tell X (provider) things; she is a very good boss. She talks to my sister about me too". One person's relative said, "The way it is run is just so lovely". Staff told us they enjoyed a good relationship with the provider. One member of staff told us "X (provider) is really approachable. Anything you need or have an issue with, if you tell her, she generally deals with it straight away".

External healthcare professionals told us that they enjoyed a good relationship with the provider who responded to their requests for information and any instructions they gave about the delivery of people's care. One visiting healthcare professional told us, "I think the home is well led". The atmosphere within the service was positive and members of the staff team told us that morale was good. One staff member said, "The staff team get on really well".

The provider had systems in place to measure the quality of care delivered and changes in people's needs, to ensure that where changes were necessary these were identified and actioned. Daily notes about each individual were maintained, a diary was used to record important future appointments or tasks to be undertaken, and staff handover took place to pass important information between staff shifts. These tools enabled the provider to monitor care delivery and identify any concerns should they arise.

Staff told us that the provider ensured important messages or changes were passed verbally between the staff team to those staff members who were not present at meetings, or alternatively posted on the notice board within the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate care and treatment as effective systems to monitor the service were not in place. Regulation 17(1)(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks associated with medicines because adequate care planning and risk assessment had not taken place in respect of medicines in the domiciliary care service. Regulation 12 (f) & (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 11(3).