Indigo Care Services Limited

Ashlea Mews

Inspection report

Stanhope Parade
South Shields
Tyne And Wear
NE33 4BA

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22 March 2017
23 March 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2017. The first day of the inspection was unannounced. This meant the staff and registered manager did not know we would be visiting.

Ashlea Mews Residential Home provides personal care and accommodation for 40 older people. The service was supporting 39 people at the time of this inspection.

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.

Food and fluid charts were not fully completed, target amount of fluids were not recorded. Where people had refused meals, there were no records to suggest staff had returned at a later time to offer food again.

We have made a recommendation about maintaining records regarding people's nutritional needs.

There were robust recruitment processes in place with all necessary checks completed before staff commenced employment.

There were systems in place to keep people safe. We found staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Accidents and incidents were recorded and monitored as part of the registered manager's audit process.

The registered provider used a dependency tool to ascertain staffing levels. We found staffing levels to be appropriate to meet needs of people who used the service. These were reviewed regularly to ensure safe levels. Call buzzers were answered in a timely manner and staff were visible throughout the building.

Medicines were administered by trained staff who had their competencies to administer medicines checked regularly. Medicine administration records (MAR) were completed with no gaps, medicine audits were completed regularly. Policies and procedures were in place for safe handling of medicines for staff to refer to for information and guidance.

Staff training was up to date. Staff received regular supervision and an annual appraisal. Opportunities were available for staff to discuss their performance and development.

People were supported by kind and attentive staff, in a respectful and dignified manner. Staff discussed interventions with people before providing support. Advocacy services were advertised in the foyer of the service accessible to people and visitors. Staff knew people's abilities and preferences, and were knowledgeable about how to communicate with people.

People's nutritional needs were assessed and we observed people enjoying a varied diet, with choices offered and alternatives available. Staff supported people with eating and drinking in a safe, dignified manner.

Care plans were individualised and person centred focussing on people's assessed needs. Plans were reviewed and evaluated regularly to ensure planned care was current and up to date.

People were supported to maintain good health and had access to healthcare professionals when necessary and were supported with health and well-being appointments.

The registered provider had an activity planner with a range of different activities and leisure opportunities available for people.

The registered provider had a quality assurance process in place to ensure the quality of the care provided was monitored. People and relative's views and opinions were sought and used in the monitoring of the service. Processes and systems were in place to manage complaints.

The service adhered to the principles of the Mental Capacity Act and had made applications to the appropriate agencies to deprive people of their liberty and keep them safe.

The registered provider ensured appropriate health and safety checks were completed. We found up to date certificates to reflect fire inspections, gas safety checks, and electrical wiring test had been completed.

A business continuity plan was in place to ensure staff had information and guidance in case of an emergency. People had personal emergency evacuation plans in place that were available to staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were safe systems and processes in place to manage medicines. The registered manager had checks in place to ensure they remained competent to administrate medicines.

Recruitment processes were robust in ensuring checks were made to ensure prospective staff were suitable to work with vulnerable.

Staff levels were appropriate to the needs of the service. The registered provider used a dependency tool to monitor staffing levels.

Is the service effective?

Requires Improvement

The service was not always effective.

Food and fluid charts were not fully completed. Fluid targets were not recorded. Where meals were refused there were no records on the food and fluid charts to show staff had returned to offer food at later time.

Staff were given the training required to support people who used the service. Staff received regular supervision and an annual appraisal to provide opportunities for learning and development.

Staff had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberties Safeguards. (DoLS). People's rights were upheld and protected by the service.

Is the service caring?

Good

The service was caring.

Staff knew people well and had genuine caring relationships with them. People were treated with respect in a dignified way by staff that supported their independence.

The service had information regarding advocacy which was

available to people, relatives and visitors.

People's rooms were personalised containing items that were important to them.

Is the service responsive?

Good

The service was responsive.

People's care plans were personalised and contained information about like, dislikes and preferences. People and relatives felt involved in care planning.

People, relatives and visitors had opportunities to complain, give comments or raise issue. The service had received several positive compliments about the care they provided.

Activity coordinators planned regular activities for people to maintain their hobbies and interests and to access the community.

Is the service well-led?

Good

The service was well led.

There were systems and processes in place to monitor the quality of the service. Senior managers visited the service on a regular basis.

People and relatives felt the service was well managed with a supportive manager and team. The registered manager was described as open and approachable.

Opportunities were available for people, relatives and staff to meet. Meetings were held on a regular basis.

Ashlea Mews

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.

The inspection took place on 22 and 23 March, the first day was unannounced. This meant the registered provider did not know we were coming.

The inspection was carried out by one adult social care inspector and an expert by experience who spoke to people and relatives to gain their opinions and views of the service. An expert by experience is a person who had personal experience of using or caring for someone who used this type of service.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with 11 people who lived at Ashlea Mews. We spoke with the registered manager, the deputy manager, four care workers, the activities coordinator and catering staff who were all on duty during the inspection. We spoke with a GP, one social care worker and one health care professional who was visiting the home. We also spoke with five relatives of people who used the service.

We carried out some observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of three people, the recruitment records of three staff, training

records, and records in relation to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Ashlea Mews. One person told us, "Yes, no bother, the staff are kind." Another said, "They treat me alright." A third said, "Safe, oh yes I am pet." Relatives felt their family member was safe in the home. One relative told us, "Yes, it's a home within home." Another said, "They are all decent people, friendly and nice who can't do enough for you." One visiting health care professional told us, "People are safe here, senior staff act on anything we say which is good."

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We saw the registered provider sought two references and DBS checks. These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

Risks to people were recorded and reviewed with control measures put into place to mitigate against any assessed risks. For example, mobility assessments were carried out to include the use of equipment to mitigate risk of falling. Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls.

People and relatives told us the staff were always busy but did a good job. One person said, "You could always have more staff." One relative added, "There always seems to be enough staff available to call when I visit." We found the staffing rota showed dedicated numbers of staff on each floor. Staffing levels were monitored by using a dependency tool we found this covered areas such as people's mobility needs and personal care needs. The registered manager told us, "I take this with me when I do an assessment so I can see whether I have the correct level of staff if anyone new is coming in." The dependency tool had been reviewed on a monthly basis. The staffing rota confirmed the level of staff matched the registered manager's assessment. During the inspection staff were visible and buzzers were answered in a timely manner.

Staff we spoke to had a clear understanding of safeguarding. One care worker told us, "Someone could be agitated or panicky, not their usual self, that would make you think. I would report it straightaway." Another said, "I would report anything I thought was not right, you couldn't stand by could you?" This meant staff were aware they needed to report any concerns they may have.

The registered manager kept a safeguarding referral log containing notifications sent to the Commission along with the local authority consideration logs. Documents contained details of action taken and outcomes along with lessons learnt. Staff were made aware of lessons learnt through staff meetings or supervisions. The registered manager told us, "We can also use our daily handover meetings."

Policies and procedure were in place for safeguarding and whistleblowing which were accessible to staff for support and guidance. We found staff had received training in safeguarding during induction, and

safeguarding training was refreshed on a regular basis.

We found the provider had systems and processes in place for the management of medicines. Staff were trained and had their competency to administer medicines checked annually. Staff had three observations before they are deemed competent. We reviewed six people's medicine administration records (MAR). These were completed correctly with no gaps. We checked two peoples controlled drugs and found the stock balance to be correct. Topical MAR's were in place. (Topical MAR's are used to record the application of prescribed creams and ointments to the skin)

Guidance for staff for 'as and when' medicines was recorded in the person's medicine care plan in the care file. This meant that staff did not have easy access to guidance for people who were prescribed this type of administration when carrying out medicine rounds. We discussed this with the registered manager who addressed this immediately. Separate protocols for 'as and when' medicines were placed alongside the MARs.

The home had two medicine rooms, one on each floor. The rooms were very small, the registered manager had identified the temperature in each room had been fluctuating between safe and unsafe levels. A request had been sent to head office for air conditioning units. We saw the approved purchase order for two air coolers to be delivered to the service within the next few days. This meant the medicine rooms would be at a safe temperature for the storage of medicines.

The registered provider ensured the maintenance of equipment used in the service and health and safety checks were in place. We found up to date certificates to reflect fire inspections, gas safety checks, electrical wiring test had been completed along with service report for hoists.

The registered manager had a grab box in place in case of emergencies. The box contained a business continuity plan, up to date personal emergency evacuation plans (PEEPs) as well as a resident list, name and contact numbers for GP's, next of kin information and the name and contact numbers for emergency transport. Staff had access to high visibility jackets and torches. This meant that staff had information and guidance in case of an emergency.

Requires Improvement

Is the service effective?

Our findings

We reviewed a selection of food and fluid charts for people who were assessed as being at risk of under nutrition. Where people required milk shakes as part of their dietary needs, the section for fluid intake did not describe milk shakes as part of the type of fluid that had been given. Where people had refused a meal we did not see any further recording where staff had returned to offer further snacks or to try again with the offer of a meal. The charts did not contain target fluid levels. This meant we could not be sure that people were receiving the correct amount of fluid or that staff acted in supporting people who refused their meal. We discussed this with the registered manager. During the inspection we saw staff were reminded to complete food and fluid charts when they had returned to offer food to someone who had not eaten at meal times.

We recommend that the service seek advice and guidance from a reputable source in order to maintain accurate records relating to people's nutritional needs.

We found people were offered a varied and nutritious diet and told us they enjoyed their meals. One person told us, "Yes, I like breakfast best, it's beautifully prepared, and there are plenty of drinks, water, tea or juice." Another said, "I have no problems with eating, but if I want anything they do it, I like mince and dumplings best. " A third told us, "I like fish and chips and there is enough choice if I don't like anything they will do me an omelette or toast." One relative told us, "He's a good eater, he likes everything." A second relative said, "[family member] is really happy with the food." Where people had nutritional needs these were assessed and plans were in place to support people with their dietary needs. For example, people had specialised diets such as pureed.

We observed people in the dining areas and saw staff supporting people in a safe manner, people were not rushed and were offered a choice of meal. It was clear from the chatter and people's responses that mealtimes were relaxed and informal. One care worker told us, "We always ask what they want, some do forget what they have chosen earlier." Fluids were readily available throughout the meal. People were supported with drinks and snacks throughout the day.

People and relatives we spoke with felt the staff were well trained. One person told us, "Yes, they do everything well." Another said, "They are well trained, if you want anything doing they do it straight away." A visiting relative said, "I have never had any reason to question staff training." Another told us, "I see him being looked after, he loves it here."

Staff were well supported in their role and felt their training was effective. The induction covered moving and positioning, safeguarding, emergency aid and fire safety. Staff completed all these subjects before being put on the rota. Staff completed shadow shifts working with an experienced staff member for up to seven days depending on their experience. The registered manager told us, "If they need a bit longer that's no problem, we need to make sure they are ready." One visiting social worker told us, "Staff are very knowledgeable here."

The registered provider used a mixture of face to face and online training. The registered manager told us, "Staff can access their training at home if they want to. We have a holistic competency assessment which is mapped to the Care Certificate." They went on to explain, "They [staff] are observed in everyday work on an annual basis to make sure standards are maintained." The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. One care worker told us, "I have infection control, moving and handling and first aid, I am all up to date. We have online training, the system tells us when things are due an update." Another said, "I have level three, the training is good here."

The service supported people who had elimination needs and we found not all staff had completed catheter care training. We discussed this with the registered manager who advised they would address this and arrange training and speak to the district nurse.

The registered manager had an annual planner in place for staff supervision and appraisal. We found records to demonstrate staff received their appraisal and had supervision on a regular basis. Records demonstrated staff discussed on-going development to support their learning. One care worker told us, "I have supervision every two months, we talk about any issues, and how we've been getting on." Another said, "I have supervision but can speak to [deputy manager] and [registered manager] anytime I have a problem."

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

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available. The registered manager kept a record of all DoLS applications made along with copies of authorisations which had been submitted to the CQC. Care workers clearly understood the importance of empowering people to make as many of their own decisions and choices as possible. These included explaining options to people and anticipating needs for some people by observing facial expressions and body language. We observed staff supporting people to make decisions regarding meal choices and attending activities.

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Care records confirmed people had access to external health professionals when required. We spoke with one visiting health professional during our visit. They told us, "If there is any problems, maybe a skin tear or something they speak with us as soon as we come in, they are pretty much on the ball. There is always someone at hand to take us to the patient." They went on to confirm the staff are good with people's prescriptions and keep good records. By having such a close working relationship with community nurses people's health care needs were addressed in a timely manner. The home was linked with a local surgery with the GP visiting the home on a weekly basis. The GP carried out reviews of people's health during the visits and where necessary treatment was prescribed. The GP told us, "Admissions to hospital have reduced."

Ashlea Mews was spacious with ample space for people who used wheelchairs or mobility aids. Communal areas were set out with easy chairs, televisions and, or radios were available for people to watch/listen to.

Signage was in place for people to navigate their way around the home, such as toilet signage and exits.

The service had commenced a programme of decoration to provide stimulation areas for people living with dementia. For example, themed corridors. We saw memory boxes were in place for people, relatives were encouraged to bring in photographs and small items linked to the person to put in the boxes. The registered manager told us, "This is something that we are very keen on getting right for people."

Good

Is the service caring?

Our findings

People gave us positive views when we asked them about the care provided in the service. One person told us, "Yes, they are good and whilst taking me to the toilet they are very understanding." Another said, "The carers are lovely." A third told us, "If you're poorly, they are always there." We asked if there was anything they would change about the home. One person told us, "I don't think they could do much more really, other than take us out in the better weather." Another said, "It's great here." One relative told us, "I'd make no changes, as I can't fault them." Another said, "I would like something better for my [family member] to have a cigarette, when it's cold it's not nice to have to take them out there [outside]." We spoke with the registered manager about the arrangement for people who wished to smoke. They told us, "There is a covered shelter, I am not able to alter the arrangements for smoking, we are not able to have it fully enclosed because of company policy."
We observed care workers showed affection throughout their interactions with people showing genuine relationships. They were friendly, caring and warm in their conversations with people, crouching down to maintain eye contact, using gestures and touch to communicate. When communicating with people we saw staff waited patiently for people to respond. Staff clearly explained options which were available to the person and encouraged them to make their own decisions. For example, whether they wished to join in activities.

People were cared for by care workers who knew their needs well. People were treated with dignity and respect. Care workers told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, explaining what was happening and gaining consent before helping them.

Care workers supported people to meet their choices and preferences. People were supported to be as independent as possible. Care workers said they encouraged people to do as much for themselves as possible, or example this included eating meals or getting washed and dressed.

We joined people in the dining room at lunch. We observed staff treating people with dignity. People were asked if they wanted to have protection for their clothes during lunch and were supported with napkins or protective aprons. We observed staff demonstrating respect for people by asking what they preferred for lunch, offering choices and alternatives. Staff supported people to eat and drink at a pace appropriate to their needs which ensured people were support to be as independent as they could be. Time was taken when supporting people to eat by ensuring they had finished one mouthful before being given another. Meals were not rushed. Staff checked where people had stopped eating, approaching them with a smile and a friendly reminder to eat a bit more.

People's rooms were comfortable, some with pieces of their own furniture and items which were personal to them and each room reflected the person's interests and character.

The registered provider had information and guidance about advocacy which was accessible to people, relatives and visitors.

Good

Is the service responsive?

Our findings

Each person had care plans which were personal to them, that included information on maintaining people's health, likes, dislikes and their daily routines. The plans set out what people's needs were and how they should be met. These included identifying potential risks to the person and management plans were devised to minimise these risks such as, mobility and risk of malnutrition.

Staff told us they felt there was sufficient information and guidance to be able to support people safely and in the way they wished. Examples included, '[person] prefers a female carer.' Another plan advised, for night time support, '[person] likes the curtains shut, and a half hourly check', ' [person] likes to go to bed around 9pm.' This meant people were being supported and cared for in an individualised way with their preferences being acknowledged. One care worker told us, "We are kept up to date. We have good handovers so know when there is a change."

People and relatives told us they felt the service provided personalised care and that the staff were skilled. Relatives told us they were involved in their care planning and that staff were responsive to their family member's needs. One person told us, "They always talk about how they can help me." One relative told us, "They are all committed here, I always get to know what has gone on, and I am involved the care plans." Another said, "If [family member] is not well I'm always told, whether the doctor has been and what happened."

We found care plans were reviewed on a regular basis so staff had detailed up to date information to support people's specific needs and preferences. For example, if they preferred a bath or shower, or if there had been a change in medicines.

We spoke with a visiting community nurse who attended the home on a regular basis. They told us, "They get the nursing notes ready for us so that is a great help, they are very good here. We always have a member of staff to support us. The carers are very competent here and will pass messages on to the senior." We asked if they felt the service was responsive to people's needs. The nurse said. "Oh yes, if they come across a skin tear or something they speak to us." They went on to comment, "It's a nice home."

We spoke with a visiting social worker. They told us, "I have no problems here at all, the paperwork is always up to date. I had an urgent respite and they were great in less than 24 hours they had assessed them, I can't fault them."

People were visited on a weekly basis by the GP; we were able to speak with the GP during the inspection. They told us, "I have no concerns with this home. They know if someone is not well, and would get a urine sample, that type of thing." The GP told us that they felt this response had prevented hospital admissions.

People were supported to maintain hobbies and interests. One person told us, "I like memory competitions on a Monday and exercise on a Tuesday. We go out about every two weeks." Another told us they liked cooking and reading. A third said, "Oh, I forgot we went to Beamish that was great." The service had one

lounge which had been set up like a bar in a public house. Two people enjoyed sitting in the bar, we found them sitting together throughout the day. One person told us, I like the cat and like to listen to the radio, I would like to go out more in the better weather. "The registered manager told us, "We now have the mini bus so there will be lots of trips planned." The service had two activity coordinators who covered seven days a week. They told us, "We do all sorts here whatever people want to do." We found planned activities included entertainers coming in to the home, cinema afternoons, music, games and crafts. Where people enjoyed the television they were made comfortable in the communal areas. Another staff member sat with people just having a chat. People were relaxed and obviously enjoying themselves, smiling and laughing.

We found the provider had a process in place for people, relatives and visitors to complain and give comments or raise issues. Everyone we spoke with said they felt they would be able to complain to care workers or managers if necessary. All complaints were logged, investigated and where necessary discussed with staff as lessons learnt during supervision or team meeting.

Good

Is the service well-led?

Our findings

The quality assurance process included audits on areas such as medicines, care plans, and accidents and incidents. We found action plans had records to demonstrate actions had taken place with dates of completion, not all of them were reviewed and signed off by the registered manager. We discussed this with the registered manager who told us, "I do review the audits to check the actions as I discuss them with my manager. I will make sure I sign them all off from now on." For example, the installation of new door guards, dated photographs to be included in peoples files.

The registered manager sent information to head office on a weekly or monthly basis. The information related to falls, weight loss, DoLS applications and any clinical governance issues. The regional manager analysed the data then provided the registered manager with results and any actions required to improve the home. For example, new equipment purchased to support the mobility of people who used the service.

The regional manager visited the home regularly to carry out compliance reviews where information about the quality and safety of the service were analysed as part of the services comprehensive action plan. We found actions and results were signed off when completed. For example, the introduction of flash meetings with head of departments had taken place.

People and relatives we spoke to told us the service was well led and that they were involved in the service. Everyone we spoke with knew who the registered manager was and felt they could approach her with any problems they had. One person told us, "It feels like home here, it's where I want to live." Another said, "We don't want for anything, and the [registered] manager is very open and approachable. One relative told us, "It's a brilliant place, and well managed, my [family member] loves this place." Another told us, "[Registered manager] and the whole team are great, there's continuity here, with a low turnover of staff, now that tells you something."

Staff told us they felt the service was well managed and the registered manager was very approachable. One staff member told us, "[Registered manager] rolls her sleeves up and mucks in, I can go to her with anything and she will help." Another said, "She is very hands on and works the floor." Other comments were, "They are lovely to work with" and "She has supported me".

The registered manager had several years' experience of working in a residential setting. They had completed the Health and Social Care Levels four and five, along with a leadership course. As part of the development of the service they had completed a four day end of life course with the NHS and Tyne and Wear Alliance. They told us, "I can support the staff with this type of care. It's very important we get this right. "

During the inspection we reviewed some quality questionnaires completed by relatives. Comments included, "This home has given him his life back", "Our family are very happy with the care and support our [family member] gets from staff, management, carers and cleaners."

Staff felt that there had been an increase in the amount of paperwork they had to complete since the change of registered provider. One senior care worker told us, "I sometimes feel that I don't have as much contact with the residents as I used to have, I do enjoy my work though. I do some care hours which helps." We discussed this with the registered manager who told us, "There are more records to keep than we previously had, but senior carers have more responsibilities now, we have had many changes, records are more detailed now." They told us they would discuss this with the senior care staff during supervision.

Staff meetings were held monthly and minutes were made available for anyone who could not attend. The registered manager told us, "I have regular meetings with relatives and residents but anyone can pop in at any time." We found records to show meeting were held on a regular basis. Relatives are invited by letter, if they are unable to attend the letter contained a slip to tear of and return with any comments they wish to be discussed or any comments they may have. We found several of these and evidenced that registered manager had acted on some comments by increasing the amount of activity staff. We observed the manager was accessible speaking with people and relatives during the inspection.

The registered provider held monthly meetings for all the registered managers. The registered manager told us, "The area manager chairs these, they are really helpful to all of us; we have time to discuss any concerns or issues. I usually find if I have a problem someone has already had it and found a solution. So that's always good."

We found the registered manager held flash meetings on a daily basis to disseminate information and to discuss concerns or issues. These were held with heads of all departments. Specific issues were discussed such as, senior carers, maintenance, housekeeping, staff news and updates. This demonstrated the registered manager ensured all departments were kept up to date and given the opportunity to voice concerns or issues allowing problems to be addressed in a timely manner.

The registered provider had allocated staff members to become champions who had a specific interest in disseminating information relating to supporting people using the service. For example, the registered manager was the dementia champion. They told us, "I have had three months of training in the approach to dementia. I have been able to pass on information to staff during supervisions but we also cover it in team meetings. We have changed activities looking more at memorabilia and more focus on life history work." The service had a hearing champion who had been trained to carry out hearing tests. The registered manger told us, "The company organised this training for staff, if we are concerned about anyone's hearing then we can do the test and refer on to the GP."

The registered provider had links and worked in partnership with other organisations to make sure they were aware of best practice and changes in care and support. We found links with the Clinical Commissioning Group (CCG) relating to medicines. The CCG visited the service weekly looking at how to reduce medicine stocks, documentation and covert medicines management. Other links included a partnership with a pharmaceutical organisation, where a member of staff had become the diabetes champion. The staff member was trained in carrying out blood glucose monitoring. The registered manager told us, "This is really helpful for the district nurses."

The service had been awarded a 'Gold Award for Food First'. The home was assessed by South Tyneside Foundation Trust Nutritional and Dietetics in May 2016. Homes made their own milk shakes rather than using prescribed supplements. The registered manager told us, "Six residents took part in the process, they were weight weekly, food and fluid charts were completed and these were then assessed by the dietician. We use our own milk shakes all the time now when residents are at risk."

The registered manager told us about the book club the service had and how they hoped to extend this out to the community. One relative we spoke to worked at the local blind service and was aware of the book club. They told us, "Meetings have been organised with the home to see how we can work together to form links. [Registered manager] is really keen for this to happen."

Statutory notifications were submitted to CQC in a timely manner.