Four Seasons (Bamford) Limited

Elizabeth Fleming Care Home

Inspection report

Off Market Street
Hetton-le-Hole
Houghton-le-Spring
Tyne and Wear
DH5 9DY

Tel: 01915262728

Date of inspection visit:
24 February 2016

Date of publication:
13 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Elizabeth Fleming Care Home on 24 February 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. We last inspected the service on 18 July 2013 and found the service met the standards we inspected against at the time.

Elizabeth Fleming Care Home is a residential home which provides personal care for up to 36 people (both older and younger adults),with dementia, physical or mental health needs. At the time of our inspection 33 people were living there.

The registered manager had been registered with us since 12 March 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with told us that they felt safe living at the service. They told us they felt they received good care and that staff were very kind and respectful. Staff spoke confidently about the procedures they would follow to take action to ensure the safety of people if they suspected someone to be at risk of harm or abuse.

Staff understood and acted in accordance with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, which meant they were working within the law to support people who may lack capacity to make their own decisions.

Appropriate checks of the building and maintenance systems were undertaken to ensure risks to people's health and safety were minimised. Personal Emergency Evacuation Plans (PEEPs) were not subject to regular review to ensure accurate reflection of people's dependency needs.

Medicine administration was not always carried out safely. Staff did not demonstrate the knowledge required to ensure safe administration when mixing two medicines together. They were unaware of the possible side effects and how the drugs could interact with other medicines. Care plans were not in place detailing this practice and no pharmaceutical information relating to this practice was available (i.e. consideration of the impact on efficacy or the impact of the interaction of the two medications).

Care records demonstrated the needs of people who used the service were subject to initial and on-going assessment. We saw these assessments accurately captured the needs of people and were used to plan and deliver effective and appropriate care. Where appropriate, risk assessments were completed, which identified risks and the measures in place to ensure that people were protected from the risk of harm. We saw that where appropriate, for example where people's care
needs had changed, staff made referrals to other healthcare professionals to ensure effective and safe care could be delivered.

Staff employment files demonstrated that staff were subject to rigorous pre-employment checks before they commenced work. Staff told us they always
completed training and that they felt well supported. Training records showed staff had completed mandatory and role specific training.

Staff we spoke with demonstrated knowledge about the care needs of people they helped to support and care for. We found staff knowledge of people's needs was corroborated by care records and from observations we carried out.

We found people who used the service were provided with information about how they could raise any concerns and complaints as necessary. We found there were systems in place to enable the service and the provider to learn from complaints and incidents.

The service promoted a positive culture that was person-centred, open, inclusive and empowering. They ensured that people who used the service and staff had opportunities to become involved and could suggest ways in which the service could be improved. The service also worked alongside external commissioning bodies and took part in internal and external reviews to help drive improvement within the service.

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.

Personal emergency evacuation plans were not subject to review so we could not be assured that they accurately reflected the dependency needs of people who used the service.

The administration of people's medicines was not always managed so that they received them safely. There were appropriate arrangements in place for ordering, obtaining and checking medicines upon receipt into the home.

People living at the service told us they felt safe. Staff were clear about what constituted abuse and had a clear understanding of the procedures in place to safeguard vulnerable people and how to raise a safeguarding alert.

Staffing levels were appropriate. Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Is the service effective?

Good

The service was effective.

Staff attended training relevant to the needs of the people who used the service and were supported by management through a supervision and appraisal process.
Consent to care and treatment was sought in line with legislation and guidance.

People had access to healthcare services and received on-going healthcare support. External healthcare professionals were involved in the on-going assessment of people's needs when appropriate.

The service ensured that people were supported to have sufficient to eat, drink and maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Positive and caring relationships were developed with people who used the service. The service had a stable staff team who knew the people who used the service well. Staff knew and understood how people preferred to be cared for and supported. Observations demonstrated that people were treat with kindness and compassion.

People's privacy and dignity was respected and promoted. Staff were proactive in their approach to offering care and support discreetly to people who used the service.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Planning and delivery of care and support was person centred and focused on assessed needs. People's needs were reviewed regularly to ensure care remained responsive to the needs and wishes of people who used the service.

The service listened and learnt from people's experiences, concerns and complaints. The service had a complaints procedure in place that was accessible to people who used the staff. People told us they felt confident in approaching the management team should they need to raise complaints or concerns and that management would respond appropriately.

Is the service well-led?

Good

The service was well-led.

The service promoted a positive culture that was person-centred, open, inclusive and empowering. They ensured people who used the service and staff had opportunities to become involved and suggest ways in which the service could be improved.

The service worked alongside external commissioning bodies and took part in internal and external reviews to help drive improvement within the service.

Elizabeth Fleming Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 24 February 2016 and was unannounced.

The inspection lasted one day and the inspection team was made up of one adult social care inspector, one specialist professional advisor and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection specialised in dementia care and care of elderly persons.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information about any incidents we held about the home. We contacted the commissioners of the relevant local and health authorities before the inspection visit to gain their views of the service provided at this home. We also spoke with professionals from the local speech and language therapy team to gather intelligence and feedback on care within the home.

During the inspection we spoke with six people who lived at the home and six visiting relatives. We also spoke with one visiting health and social care professional. We spoke with the registered manager, the provider's regional manager, two registered nurses, one care home assistant practitioner (CHAP), one senior carer and six care workers. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included care records relating to ten people, recruitment records relating to three members of staff, training records relating to all care and nursing staff and quality monitoring reports.

We used 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 talk with us.

Requires Improvement

Is the service safe?

Our findings

We saw that each individual who used the service had a 'Personal Emergency Evacuation Plan' (PEEP) in place. These documents contain details pertinent to ensuring the safe evacuation of individuals from the premises in an emergency, such as to the moving and handling requirements. We looked at ten PEEPs and found that three had not been reviewed since 2010. This meant that PEEPs were not being reviewed to ensure the accurate reflection of people's dependency needs.

We found that medicines were managed within a 'clinic environment'. This meant that medicines were stored securely with the dedicated key holder being a registered nurse on each shift. We found that where medicines were required to be stored within a fridge, temperatures of the fridge and room were checked each day to ensure medicines were appropriately stored. We saw that secure medicine bins were available for the safe disposal of medicines. Drug cards (detailing medicine needs) were in place and reviews had taken place by the prescribing general practitioner (GP); requests for review as changes occurred were highlighted.

We observed two medicines rounds completed by staff. These rounds highlighted two issues in medicine management. One issue related to a non-qualified member of staff's understanding of medicine being given, its possible side effects and how it could interact with other medicines. The second issue related to a registered nurse mixing two separate medicines in the process of administration. There was no care plan detailing this practice, no pharmaceutical information relating to this was available (i.e. the impact on efficacy or the impact of the interaction of the two medicines). Additionally in discussions with the registered nurse the reasoning behind the mixing of two separate medicines related to covert administration (this is where medicine is administered in such a way that they person is not aware of what they are taking). There was no care plan or assessment relating to covert medicine available, as such we could not be satisfied that the administration of medicines was safe. As a result the staff member was asked to cease dispensing the medicine and this information was relayed to the deputy manager by our specialist professional advisor who took immediate action to ensure safe administration.

A relative we spoke with said, "We are very satisfied in the way [family member] is looked after, we have never seen anything to concern us" and "We know [family member] is safe and when a relative has to go into a care home that's the one thing you want to know." Another relative we spoke with said, "We feel [family member] is safe here and really well looked after."

Staff were visible around the service at all times. The home is made up of two mixed sex units and throughout the inspection staff were visible at all times across the whole home. For example, throughout our observations in the Eppleton unit we saw that a carer was present in the communal areas at all times.

We found some people chose to spend their time in their bedrooms and we saw they had the staff call system to hand. There were very few calls sounding throughout the day and those that were, were answered promptly and without delay.

The registered manager told us they used a dependency tool – 'Care Home Equation for Safe Staffing' (CHESS), to determine staff levels within the home. CHESS considered the dependency needs of individuals who lived at the home. People we spoke with, including staff, raised no concerns over staffing levels and told us they felt the home was adequately staffed. In discussions with the registered manager she spoke clearly about the need to ensure the home was sufficiently staffed. She said, "You can't work short." One person who used the service said, "There are always plenty of them (staff) about. You only have to pop your head out of your door and they are right there". Healthcare professionals who visited the home told us that they had no concerns about staffing levels. One professional said, "There are usually one or two carers in the main areas, and nurses are easy to find." This meant the service reviewed dependency needs to ensure that sufficient numbers of staff were available to safely meet the needs of people who used the service.

The registered manager told us they currently had one vacancy relating to night shift nursing staff and they were recruiting to fill the post. They said existing staff had been working overtime to cover this, and agency staff could be used as a last resort, but that if necessary they ensured the same staff were used to ensure continuity of care for people who used the service.

We looked at three sets of recruitment records which demonstrated that staff were subject to rigorous pre-employment checks before they commenced employment. These checks included checks with the Disclosure and Barring Service (DBS). DBS checks help to protect people from receiving care and support from individuals who may be barred from working with vulnerable people.

Further recruitment records showed all nursing staff employed at the home held a valid registration with the nursing and midwifery council (NMC). This meant that nurses employed were not subject to any restrictions or conditions on their registered ability to deliver nursing care and treatment. There was a wide skill mix of both registered nurses and trained care staff within the home. Recruitment records looked at demonstrated that non registered staff had completed national vocational training in care.

We found that where people required specialist equipment to keep them safe, this was made available to them following appropriate assessment. For example we saw that one person, who was at risk of falls from their bed, had a crash mattress in situ. This meant that appropriate and unrestrictive measures had been put in place to prevent serious injury or harm occurring.

Staff we spoke with demonstrated a good understanding of peoples' life histories and preferences and demonstrated this in the interactions that we observed between staff and people who lived at the home. Staff we spoke with also demonstrated how they used this information to de-escalate challenging incidents that occasionally occurred.

Throughout the course of the day we observed one person laying themselves on the floor in a communal area. We saw that the changing behaviours of this person had been assessed and care plans adjusted to ensure their needs could be met safely. For example, one to one care was allocated at key times throughout the day. We spoke with the key worker who explained the behaviours of this person with understanding. They described what happened in response to these behaviours. Our observations demonstrated that staff responded in line with assessed care needs and appropriate equipment and numbers of staff were used to ensure the safety of the individual at all times.

Our observations demonstrated that there was a lot of mobility equipment in use throughout the home. This included the use of hoists and slings, wheelchairs (including specially adapted wheelchairs) and walking aids. We saw that staff had been trained in the safe moving and handling of people, and that they put this training into practice to ensure peoples' safety.

The home was clean and no one raised any concerns over cleanliness when we spoke with them. One relative we spoke with said, "It's spotlessly clean, I used to be a housekeeper so I know, they pull the wardrobes out and clean behind and everything." 100% of staff had completed their training on infection control and we saw actions from the training put into practice by staff. For example, we saw that there was personal protective equipment (PPE) available and used by staff when delivering care to people. We saw that disposable aprons and gloves were used by staff when preparing to deliver personal care, or when preparing to handle food. This meant that consideration was given to the prevention of infection occurring and people who used the service were protected against the risks associated with infection.

Records we looked at confirmed that checks of the building and equipment were carried out to ensure risks to the health and safety of people, staff and visitors were minimised. Relevant checks had been carried out on the boiler, fire extinguishers and portable appliance testing (PAT) available throughout the service.

We saw that the service had a 'Safeguarding vulnerable adults' policy which was accessible to staff. Training records demonstrated that 100% of staff had received and completed training in the safeguarding of vulnerable adults. Staff we spoke with demonstrated a good understanding of their role and responsibilities in relation to safeguarding and were able to describe to us the actions they would take should they need to raise concerns or take action to safeguard people from abuse. Where appropriate we found that the registered manager completed referrals to the local safeguarding authority for investigation and also completed and returned required statutory notifications relating to these referrals. This meant that appropriate action was taken to protect people from abuse.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that 16 people who lived at the home were subject to a DoLS at the time of this inspection. We reviewed the documentation relating to this and found they had all been authorised by the local supervising authority, and the home was acting within the legal authorisation of each of these safeguards.

We saw the registered manager had completed a number of DoLS applications relating to one person who used the service. These applications had deemed that the person concerned held capacity and as such the applications were rejected by the local supervisory authority. We spoke with the registered manager about why so many applications had been made and they told us this was a result of the persons fluctuating capacity. This discussion demonstrated that the registered manager understood that the capacity of this person required review due to their changing behaviours, effects of medicines and fluctuation of capacity. In total there were 12 applications pending authorisation and after a review of the applications, associated care plans and observations throughout the day we found that staff were acting in accordance with the legal requirements of the Act. For example acting in the best interests of the individuals and acting in the least restrictive way whilst the authorisation was pending.

96% of staff employed at the home had completed certified training in the Mental Capacity Act (MCA) 2005. Staff we spoke with demonstrated a good understanding of the principles of the act, for example staff said people should be assumed to have capacity unless proven otherwise. Staff told us how it was important for people to make their own choices and decisions in relation to their care and treatment and day to day living. Care plans we looked at demonstrated use of the principles of the MCA when considering the use of safety restrictions such as bed rails and lap belts. We saw people's capacity was considered before multi-disciplinary best interest decisions were made. From our observations we saw that staff always engaged people in discussion before obtaining consent to carry out or initiate any personal care. For example, discussions often included, "Would you like to…", "How do you feel about doing…." and, "Is it okay if…" This demonstrated that staff obtained consent and the views of people who used the service before engaging in any personal care or support.

We saw that some people who used the service were free to go about their own business day to day as appropriate. For example we saw one person who frequently left the home to go to the shops and for a walk. They told us, "I go out to the shops if I want; I am going out in a minute for a bar of chocolate." We observed

this person walking down the corridor and speaking with staff about their wish to go out. "Let us out love," "Where are you off to?" "Just the shops, I want some choc", "Okay you wrap up, it's cold out". The staff member opened the front door and let colleagues know that that resident had gone out. Staff told us that it was important to this person that they maintained this independence and ability to go out for a walk on their own.

We spoke with a visiting healthcare professional who told us they felt staff at the home were very good at ensuring that people who used the service had access to and received on going healthcare support as appropriate. They told us they always felt comfortable when visiting the home, and said, "The best way to describe it is to say the home is a very nice house, it really is home from home for a lot people. Staff have a nice manner, there is good rapport and I find it very comfortable as a visiting professional." They went on to explain why they were visiting the home that day. They described the changing needs of an individual and how this was being managed. "Staff are working with us on the needs of this person, if they have any problems that will proactively query things with me or raise further referrals." They also added that another person had recently moved into the home, they said, "Professionally I think it has been a good move for them, the staff here are able to engage with them and better manage their needs."

During the inspection we saw a local GP visit the home to review someone who used the service. Staff we spoke with told us how they ensured people had access to healthcare professionals and support. They spoke confidently of the links with the local GP surgeries and how they ensured referrals were made to appropriate professionals.

One relative we spoke with told us their family member's needs had been subject to regular review and that the staff had taken action to ensure the appropriate professionals were involved in their care. They said, "My relative has had a nasty eye for a couple of weeks, the doctor has been and prescribed stuff but it's getting worse so now has been referred to the hospital".

We spoke with professionals from the local hospital's Speech and Language Therapy team (SALT) who provided us with feedback on their experiences from visiting and working alongside the home and its staff. One therapist said, "Staff appear to be friendly and kind to residents, on recent visits carers have been keen to learn more about the specific dysphagia recommendations and reasons behind these. After discussion with the manager, many of the staff have attended the 'Dysphagia Awareness' training. It is now evident that the staff generally have an increased awareness and understanding of swallowing difficulties and how to support the recommendations (e.g. providing appropriate food and drinks, improved supportive feeding) and improve the swallow safety of the home."

In addition to the comments from SALT we saw that all staff employed within the home had also completed dementia awareness training. These additional training needs had been identified and completed to ensure that people receive effective care from staff with appropriate knowledge and skills. During the inspection we found that three people were receiving one to one care from external care providers for significant periods of time each day. We spoke with the registered manager about how this ensured the safety of the individuals. We also discussed the need for these external care providers to have the level of knowledge about individuals to forge caring relationships and build rapport. This is an important factor to ensure that people receive effective care and support that is meaningful to them, during this one to one time. For example, we observed one individual join in with a group discussion about life history when their one to one support went for lunch. The member of staff who was present spoke with this person about their life history and they began reminiscing with other people in the lounge about their past histories. This time was full of chatter and laughter but when the external care provider returned the person became withdrawn from the interaction and sat quietly with very little personal interaction between the two. Guidance issued by the

National Institute of Clinical Excellence (NICE) under quality standard 30 states that, 'It is important that people with dementia can take part in leisure activities during their day that are meaningful to them. People have different interests and preferences about how they wish to spend their time. People with dementia are no exception but increasingly need the support of others to participate. Understanding this and how to enable people with dementia to take part in leisure activities can help maintain and improve quality of life' (quality statement 4).

We found that people were proactively encouraged and supported to eat, drink and maintain a good diet within the home. We saw fresh fruit bowls available in the dining areas. The Lakes Unit had a small kitchen which people could use to make drinks and snacks. There was a water cooler and fridges that contained snacks and drinks that people could help themselves to. We saw that where people required additional support staff regularly asked and offered to make drinks and snacks. We observed a staff member gently persuading someone who was feeling poorly in bed to drink some water and remain hydrated by saying, "You'll feel better for a nice drink."

The Eppleton unit had drinks facilities in communal areas and those people who chose to spend time in their bedrooms had drinks to hand or were regularly offered fresh drinks. We observed the morning tea trolley with cream and jam scones offered to everyone. The afternoon tea trolley round had cream buns, fortified whip puddings, along with a variety of drinks choices. These trolley rounds were enthusiastically received by people who used the service. On the Lake unit cakes were put into the fridges for people to help themselves to at a later point.

Some people were identified as at risk of dehydration and malnutrition due to on going health issues. We found that staff recognised the importance of acting on recommendations from external healthcare professions. One member of care staff told us, "I am just taking this fortified drink down to [person who used the service], their drinking is hit and miss and we have to try at every opportunity to get them to drink, and they like this".

We carried out a number of observations over lunchtime (including our Short Observational Framework (SOFI)). This involved spending a substantial part of the visit observing groups of people to see how they occupied their time, appeared to feel, and how staff engaged with them. We found that the dining areas were nicely decorated and were clean and tidy. Tables were decorated with table cloths and napkins and condiments were set on the tables. We observed that food was served from a hot plate and that people's choice was reiterated. People were supported to eat their meals and some people were given gentle encouragement to eat or drink more. People were offered a choice of what they wanted to eat and drink and we found that adapted cutlery was available to support people to eat independently. For those people who were living with dementia we saw that coloured crockery and cutlery provided a contrast between the table decoration and the food itself and enabled people to eat independently.

Good

Is the service caring?

Our findings

People who used the service and visiting relatives told us they thought the home was very good. They told us staff were very caring and understanding and that this was one of the big positives within the service. One person we spoke with said, "You'd have to go far to find a better place than this, the carers are first class and that manager is spot on". Another person said, "I can go out if I want and they (staff) are all canny with me". A relative that we spoke with said, "(I) Couldn't ask for better for (family member), he loves to walk and he can here, I'm never away from the place, I've never seen anything wrong, I can't fault it, it's first class." Other relatives we spoke with said, "We blessed the day when we found this place for (family member)," "We are very satisfied in the way (relative) is looked after, we have never seen anything to concern us" and "We fund the care ourselves and could not put a price on the care that she receives here, it's excellent".

From our observations throughout the day we saw numerous interactions between staff and people who used the service. We saw that staff treated people with kindness and compassion. We saw one person, who displayed very specific behaviours; require a lot of support from staff throughout the day. At each interaction we saw staff speak with the person gently and offer them reassurance which in turn calmed them down and they appeared to relax. We saw this person go from appearing quite distressed and at times aggressive towards staff, to becoming affectionate and speaking with staff and thanking them for the support they offered.

We observed that staff were proactive in the care and support they offered to people. For example, we saw that staff anticipated people's needs and approached people and asked if they required any support rather than waiting and then becoming reactive. This meant that staff pre-empted the support needs of people who used the service and made themselves available to offer that support as and when it was required. The support offered varied from person to person and ranged from offering encouragement for people to complete tasks independently to assisting people to use the facilities or eat their meals. At each occasion we saw these interactions being carried out discreetly and with respect. This meant that people who used the service received the care and support they wanted and needed, in a manner that was respectful and upheld their dignity.

When approaching people to offer care and support, we saw staff engaged individuals and explained what they were proposing to do. They asked people if that was okay and obtained verbal consent and acted in accordance with people's wishes. For example, staff told us that one person, again with very specific behaviours, may be uncomfortable speaking with us as they were not comfortable around strangers. Staff then approached the person and asked how they would feel about us popping into their room for a chat with them. This demonstrated that staff supported people to express their own views and be involved in making decisions about the care and support offered to them.

Staff we spoke with displayed understanding of the needs of people who used the service. There was a stable staff group and it was clear from the discussions we had that this contributed to the caring nature of the service. The staff we spoke with spoke confidently about the needs of people that they offered care and support to. They were able to describe people's life histories, their likes and dislikes and how this

information was used to tailor the care and support that they received. As we reviewed care records we found that the information staff had provided to us about individuals was accurate and represented the views and wishes that had been expressed by people who used the service. This demonstrated to us that staff had taken the time to get to understand the people they provided with care and support to ensure they could build caring and positive relationships. One member of staff we spoke with told us if the time came, they would like to think that their parent would be cared for in this service.

Throughout the course of the inspection we observed a relaxed, organised and quiet atmosphere between staff and people who used the service. We saw that some people chose to lock their bedroom doors for privacy, though some people preferred their doors left open and they told us that this was a matter of personal choice.

We heard many meaningful conversations between staff and people who used the service; it was evident that these were two way conversations, with people knowing about the lives of the staff as well as the staff about them.

Healthcare professionals who visited the service told us that they felt the service and staff were caring. They said, "I have seen generally good levels on compassion/caring. Most carers are responsive to the individual's needs and have friendly, good rapport with the residents. The staff have all offered helpful knowledge of the resident and I have seen good examples of kindness, compassion, dignity and respect."

Good

Is the service responsive?

Our findings

The care records we reviewed demonstrated that people's needs were assessed and care and support was planned and delivered in line with their individual care plans. Individual choices and decisions were documented within these records and we saw that they were subject to frequent review or as people's needs changed. These records demonstrated that changes in people's needs were identified and, where appropriate, referrals were made to external healthcare professionals to help ensure people's needs were met in a safe and effective way. This meant that the assessment of people's needs, including the delivery plans were accurate and responsive to the needs of the individuals.

We saw that staff had identified changes in one person's behaviours and that delivering effective care and support had become challenging as a result of these changes. We saw that following identification of these changes, referrals had been made to the mental health team and external support and assessment had been sourced with care plans amended to reflect the advice and recommendations obtained.

Care plans were person centred. Person centred planning is a way of helping someone to plan their care and support, with the focus on what is important to the person. Care records contained information relating to individual's current health needs, but also included past histories (both health and social). This meant that staff had an understanding of what had affected people's lives and could respond appropriately to any recurrence of matters.

The service had a complaints process contained within their 'management of feedback policy (complaints, concerns or compliments)' which was accessible to people who used the service, anyone who visited the service and also to staff. The process contained an assurance that any concerns or complaints raised would be investigated and responded to. We found that no complaints had been made within the last twelve months. People we spoke with, who used the service, told us that they were aware of how they could complain, but that they had not felt the need to. They told us that they felt the manager and staff were responsive to any issues they might raise.

We found that people who used the service had a variety of opportunities to get involved in activities on a daily basis. There was an activities notice board that detailed upcoming activities and trips out. This included details of ten pin bowling trips, trips to Newcastle to attend the city centre market, and shopping trips. It also provided details of Sunday mass and other church services. As well as trips outside of the home we found that internal activities were also planned. This included, planned film shows, musical afternoons, 'pub night' and photo or reminiscence afternoons. On the morning of our inspection we found that a number of people had gone out in the mini bus to go ten pin bowling.

One person we spoke with said, "We are always out and about, there is always something to do". One relative we spoke with said, "They go out on things and they have turns in, I put a little fund in so she can go out on whatever is going on, they always ask but I say to them if she's fit to go she can, it's great". Whilst some people had gone out on the bowling trip others had chosen to remain at the home. Some people chose to spend their time in their own bedrooms, some people were watching television in the communal

areas and others were engaging with staff in activities such as dominos, puzzles and reading the newspapers. We found that activities had been discussed with people who used the service and they had been given the opportunity to be involved in what activities were offered. This meant that the interests and wishes of people had been explored and they were given opportunity to engage in activities that were meaningful to them.

Good

Is the service well-led?

Our findings

The home had a registered manager in place. People we spoke with told us that they knew who the registered manager was and what her role was within the service. They told us that the registered manager was visible throughout the home and as one person said, "Not locked in her office".

Staff we spoke with told us that the registered manager was very approachable. They told us that they had frequent dialogue with her and her deputy and that this was supplemented with frequent and formal staff meetings. We looked at agendas and minutes of the staff meetings and found that they included representation from all staff groups. This included senior and clinical care staff, care staff and ancillary staff. We saw that these meetings were used as a platform to ensure effective communication across the home. There were standing agenda items as well as specific incidents / issues that needed to be raised by management for discussion with staff. For example, some of the issues that were discussed included the effectiveness of staff handovers between night and day staff and issues relating to concerns raised by some staff about staffing levels at specific times of the day. The meeting minutes highlighted that staff were actively involved in discussions about how to remedy these issues and that their considerations were used to produce a remedial action to the issues discussed. This meant that staff were given the opportunity to promote improvement within the service and their suggestions were implemented by management.

We saw that the manager had inherited a 'Quality and Clinical Governance' meeting from the previous management team. We looked at the meeting minutes from these meetings and noted that they were held bi-monthly but that the agendas were very wide ranging. For example the agendas we looked at covered areas such as, information governance, safeguarding, quality audit completion, policies and procedures, surveys and feedback, as well as departmental business such as domestic and kitchen issues. From the meeting minutes we noted that no clinical staff were present at these meetings other than the deputy manager. Clinical governance is normally described as a systematic approach to maintaining and improving care provided to people within a health setting. We did not feel that the meeting minutes we reviewed covered clinical governance in this sense. We spoke with the registered manager about 'Clinical Governance' within the home. They told us that they had identified that the meetings that had taken place did not address clinical improvement and that as a result she had recently set up a new meeting which would include attendance of clinical staff to begin driving clinical improvement within the home. We saw that the first meeting of this nature was scheduled to take place following our inspection.

The service also had a local health and safety committee which met bi-monthly. The purpose of this meeting was to discuss and analyse health and safety issues that may have arisen within the home and address remedial actions that were necessary to minimise risk of recurrence. This meant that there was an open and inclusive approach to reporting and responding to issues that could potentially impact on people who used the service.

People we spoke with told us that there were regular meetings held where they could get involved and provide feedback on the service they received. Some people told us that they preferred not to attend the meetings and instead raised issues individually as and when they felt it necessary. Other people told us they

attended each meeting and offered feedback. We looked at the meeting minutes and found that people had provided feedback about the 'lack of activities outside of the home'. We saw that as a result of these concerns action had been taken to discover what types of trips people wanted to go on, including special places of interest and types of trips, i.e. shopping trips, leisure trips. This information was then used to implement plans for regular outings encompassing what was important to people.

People provided feedback on the food and menus within the home. We saw that people had requested cakes, biscuits and fruit to be offered on the tea trolleys throughout the day. We saw that action had been taken and that these snacks were now available to people. Another person had asked for kippers to be included on the menu, this again was actioned. For those people who did not wish to attend the meetings, the home had a notice board 'You said .... We did.' This notice board detailed areas for improvement that were raised and what actions the management team had taken. This means that changes were communicated across the service.

We spoke with some relatives of those people who lived with a dementia. They told us that they were often approached to give feedback on behalf of their relative when it was appropriate to do so. One relative said, "We have had surveys and questionnaires and we are involved in everything, they ring us straight away if anything is wrong". Another relative said, "We get surveys and questionnaires, which reminds me I have one sitting at home to do, but what can you say, we have no concerns, none at all".

The service had recently achieved accreditation in the provider wide 'PEARL' (Positively Enriching And empowering Residents' Lives) programme. This means that the service had achieved defined standards of dementia care set by their own dementia care team. We saw that the registered manager was the assigned 'Dignity Champion of Care' within the service and a number of staff had completed the 'Dignity Champion Certificate in Commitment'. This means that the service is continually seeking to improve, implement change and deliver a high quality of care.

The service was subject to regular quality audits both internally and by regional management. We saw that these audits were completed and resulting actions were placed into action plans which the registered manager was responsible for implementing and overseeing. The service also worked alongside the local clinical commissioning group and took part in external audits which again resulted in action plans which they worked to achieve and implement change aimed at driving improvement within the clinical care setting.