Ms Linda Charlton

Thornley Leazes Care

Inspection report

Thornley Leazes Care
Allendale
Hexham
Northumberland
NE47 9NH

Tel: 01434683769

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Ratings

Overall rating for this service	Good

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

Summary of findings

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 settings, were living with dementia. In addition, some people supported with domiciliary care had physical disabilities. There were 12 people living at the care home at the time of our inspection, and a further five people in receipt of domiciliary personal care, in the local Allendale and Catton community areas.

This inspection took place on 10 and 11 November 2016 and it was unannounced. The last inspection we carried out at this service was in January 2015 when the provider was not meeting all of the regulations that we inspected which included the need for consent, safe care and treatment and good governance. The provider submitted action plans linked to each of these breached regulations, stating how and by when they would meet the requirements of these regulations. At this inspection we found 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 with the Commission, as the registered provider is an individual in day to day charge of the service and the carrying on of the regulated activity. 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.

Concerns identified at our last visit to this service in January 2015 related to the management of medicines and people's finances had been addressed and we were satisfied that measures had been put in place to support people to remain safe. Medicines were now managed safely and some small areas for further improvement were discussed with the assistant manager and registered provider.

Staff were aware of their personal responsibility to report matters of a safeguarding nature and they were knowledgeable about the different types of abuse. People told us they felt safe living at Thornley Leazes Care residential home or in receipt of care from the service on a domiciliary basis, and we found no evidence during our inspection that contradicted this.

Risks within the environment of the care home setting and in people's own homes had been assessed and measures put in place to mitigate these risks. Equipment used in care delivery had been appropriately serviced and checked to make sure that it remained safe for use. A business continuity plan had been drafted for staff to refer to in an emergency, for example if there was a loss of power to the building. Health and safety checks around the building were carried out regularly, including fire safety checks.

Staffing levels within the service were appropriate to meet people's needs and were adjusted depending on people's activities and their desire to access the community. Staff files revealed that recruitment processes were thorough and that staff were trained in areas relevant to the needs of the people they supported. They received appropriate supervision and appraisal and told us they felt supported to fulfil their roles by the registered provider, and the assistant and home care managers.

People received an effective service from staff who were knowledgeable about their needs, likes and dislikes. They enjoyed good relationships with each other. Staff provided person-centred care and understood people's behaviours and personality traits. People told us they were supported to live their lives in the way that they wanted to and that their general healthcare needs were met. Records supported this.

Staff supported people to remain as independent as possible and they maintained people's dignity when delivering care. Some conversations were not held in private when they should have been. The registered provider took our feedback about this on board and said this would be addressed. Advocacy services were available to those people who wished to assess them.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and that they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken. Records about such decision making needed to be improved.

People told us they received care that was responsive to their needs. They enjoyed a range of activities which they were supported to pursue by staff. People made day to day choices and they spent their time as they wanted to. They reported that the food was of a good standard and they could choose alternatives if they did not like the meal prepared at any one time. The care people received was appropriately monitored and feedback from people, staff and visitors about the service was gathered formally in annual surveys and throughout the year at any time in person. An appropriate complaints policy and procedure was in place and it was brought to the attention of people and visitors to the service.

Improvements to quality assurance systems and processes since our last inspection were evident and formal documented audits related to infection control, health and safety matters and medicines had been introduced. However, some of this auditing needed further development. In addition, some records and recording across the service (residential and domiciliary) needed to be improved. Some people's care records needed to be more detailed and records related to the MCA and recruitment needed to be better maintained and organised. We have made a recommendation about reviewing quality assurance processes, governance and recording within the service.

We found a small number of incidents had not been notified to the Commission in line with legal requirements. In addition, the provider had failed to display the rating they were awarded following our last comprehensive inspection of the service in January 2015. We have made a recommendation about these two matters.

We received positive feedback from people and staff about the registered manager and her approach.

The registered provider accepted all of the feedback we gave at this visit and said she was committed to making the necessary improvements to 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?

Good

The service was safe.

Medicines were managed appropriately but improvements were needed to ensure all best practice guidance about the safe handling of medicines was followed.

Safeguarding procedures were in place to protect people from harm and abuse.

Checks on the building and equipment used in care delivery were carried out regularly.

Risks that people were exposed to in their environment and their daily lives had been assessed and plans were in place to mitigate these risks.

Staffing levels were appropriate to meet people's needs and recruitment procedures were robust.

Is the service effective?

Good

The service was effective.

The Mental Capacity Act 2005 (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made in line with legal requirements.

Staff were knowledgeable about people's needs and people told us they were happy with the service they received.

They were supported to meet their healthcare needs and food served to people was healthy and wholesome.

Staff received regularly and appropriate training and they were supervised and appraised within their roles to ensure they remained competent and delivered effective care.

Is the service caring?

Good

The service was caring.

Staff and people enjoyed good, positive relationships that promoted people's wellbeing.

People told us they felt involved in their care and relatives said they were kept informed.

In practical terms people's dignity and independence was promoted and they were respected. Some conversations between staff needed to be held in more private areas to avoid them being overheard.

Independent advocacy services were available to people.

Is the service responsive?

Good

The service was responsive.

People and their relatives gave positive feedback about the responsiveness of the service.

People were given choices about how they lived their lives and they were supported to access activities within the local community.

Care was person-centred and overall care records were appropriately maintained.

Monitoring of care delivery took place and ensured continuity of care for people.

A suitable complaints policy and procedure was in place that was brought to the attention of people and visitors.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements in the quality assurance systems within the service had been made since our last visit. Audits had been introduced and matrices were used to monitor training, supervision and appraisal requirements.

Further improvements were needed, particularly to records and recording systems.

Overall notifications about incidents had been made but some had been overlooked, as had displaying the previous rating given to the service on the company's website.

People and staff gave positive feedback about the registered provider, who strove to fulfil the service's mission statement in the delivery of care.	

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 the 10 and 11 November 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to our inspection we reviewed all of the information that the provider had sent us since our last inspection to evidence the steps they would be taking to achieve compliance with the legal requirements of the Health and Social Care Act 2008. This included evidence submitted to the Commission in the form of an action plan report.

We did not request a Provider Information Return (PIR) in advance of this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed statutory notifications that the service had submitted since our last visit and obtained feedback about the service from Northumberland contracts and commissioning team, and Northumberland safeguarding adults team. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used the information that we had gathered to inform the planning of this inspection.

During our inspection we spoke with the registered provider, assistant manager, home care manager, four members of the care staff team, four people who used the service and one visiting healthcare professional. We carried out observations around the premises and reviewed records related to health and safety matters,

infection control, medicines management, governance and quality assurance. We also reviewed five people's care records to establish if they were appropriate and well maintained, and we looked at five staff files to review recruitment processes, training and the level of support staff received to fulfil their roles.

Good

Our findings

At our last inspection we identified concerns with the management of medicines on the domiciliary care side of the business. At this inspection we found that improvements had been made in terms of the practices that staff adopted and record keeping. More information was needed within care records on the domiciliary care side of the business about the level of medicines support people required. We fed this back to the home care manager who said that this would be addressed as soon as practicable. We reviewed Medication Administration Record sheets (MARs) for those people who received medication support within the community setting and saw there were no gaps in recording.

On the care home side of the business the management of medicines was good. The procedures that were in place for the ordering, storage and disposal of medicines, and the recording of the administration of medicines, were appropriate. A system was in place to record stocks of medicines moving in and out of the home when people spent time away from the service overnight, for example, if they resided with family or friends for a short break away. We carried out a random stock check of four people's individual medicines and found that the remaining balances tallied with MARs about the medicines that had been administered.

A small number of people had been prescribed medicines to be given 'as and when required'. For example, specific care plans about when these medicines should be offered to individuals depending on their needs and presentation, were not in place. However, staff were able to tell us about when they would appropriately offer the relevant people such medicines. The assistant manager told us that this would be addressed and individual care plans about the administration of these medicines would be drafted. Body maps were also not used to give instructions and to highlight where on a person's body topical medicines such as creams and ointments should be applied. This was not in line with best practice.

We recommend the provider reviews and corrects these medicines management shortfalls, to ensure best practice guidelines about the management of medicines in care homes and domiciliary care services are correctly followed.

At our last inspection we also identified concerns related to the management of people's finances, in the respect that appropriate safeguards were not in place to protect people from potential financial abuse. Relevant local authorities had reviewed each person's financial affairs since we last visited the service and we were happy that suitable measures were now in place to prevent vulnerable people from being financially abused. Staff had been trained in the safeguarding of vulnerable adults. They understood their own personal responsibility to safeguard people in their care and they were aware of the reporting

structures they should follow, to ensure that matters of a safeguarding nature were escalated to the local authority safeguarding adults team for investigation. This meant the risks of people suffering harm or abuse whilst in receipt of care from this service were reduced. The local authority safeguarding adults team told us that there were no safeguarding cases under investigation for this service at the time of our inspection.

People told us they felt happy and safe living at Thornley Leazes care home, or alternatively in receipt of care from the service on a domiciliary basis. One person said, "It's good here. The staff are nice. They have never been rude or nasty or anything". Another person told us they never felt uncomfortable or unsafe when staff delivered personal care and support to them in their own homes. Each of the relatives we spoke with told us they had no concerns about people's safety when they visited the home and observed staff engage with them. From our own observations we had no concerns about how staff supported people for example with moving and handling, or how they treated them.

Infection control procedures were followed which were in line with best practice guidelines and levels of cleanliness within the home were good. Some further improvements had been made to the premises since our last visit. A new kitchen had been fitted and some general redecoration and replacement of furnishings had taken place. The main doors used as entry and exit points, plus fire doors on the ground floor had all been alarmed since our last visit. Keypads had also been fitted internally to exit through the main doors but people had freedom of movement through these exits if they wished to leave the building. These measures had improved security around the home and they meant that if people did exit the building through a main door or fire exit, staff would now be alerted and could go to people to ensure they remained safe when leaving the building.

A business continuity plan and other emergency information was available to staff in a folder retained in the foyer area of the home. This meant they had access to pertinent information they needed to support and continue to care for people safely. It included contact details for the relatives of people in receipt of care, staff contact details, a list of contacts for services such as plumbing, builders, gas and electricity and procedures for staff to follow in an emergency situation such as a loss of power. Individual Personal Emergency Evacuation Plans (PEEPs) were being drafted at the time of our visit to be added to this file and people's care records.

Health and safety checks including fire safety checks were carried out regularly. A legionella risk assessment had been undertaken and measures were in place to reduce the chance of legionella developing within the water supplies of the building. Equipment was serviced regularly to ensure it remained safe for use and accidents and incidents that occurred within the service were appropriately recorded and measures were put in place to prevent repeat events. Risks assessments related to risks within the premises had been written and processes were in place for staff to follow to mitigate these risks. This showed the provider had sought to protect the safety of people, staff and visitors.

Risks that people were exposed to in their daily lives had been assessed and plans were in place for staff to follow about how to mitigate these risks. For example, risk assessments had been formulated for people in relation to their mental health, personal hygiene and communication needs. These were regularly reviewed to ensure they remained up to date. This demonstrated that the provider sought to promote people's safety.

Staff told us staffing levels were sufficient to meet people's needs and our observations confirmed this. Staffing levels were adjusted to take into account people's activities within the community in that they were either increased or decreased depending on requirements. The assistant manager and manager of the domiciliary care side of the business told us that 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.

Recruitment procedures were thorough. 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. Some records related to recruitment could be improved and we fed this back to the assistant manager and registered provider who advised that this would be addressed and improvements made to filing processes.

Good

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At our last inspection we identified concerns about the application of the Mental Capacity Act 2005 (MCA) and the provider's failure to comply with Regulation 11 of the Health and Social Care Act (Regulated Activity) Regulations 2014, entitled Need for Consent. At this inspection we found the registered provider and assistant manager had a better understanding of their legal responsibilities in respect of the MCA and some records around best interest decision making had improved. DOLs applications had been made to the local authority DOLs team and outcomes were evidenced within people's care records.

Since our last inspection the provider had addressed decision making that had not been made in line with the MCA . For example, a camera was no longer used to monitor people's movements at night, without their consent and the best interest decision making process being followed. People's capacity to consent to the management of their finances had been assessed and best interest decisions made by the local authority to ensure people they were protected from the possibility of financial abuse. This showed that the provider had addressed the inappropriate care practices that had previously been in place, to monitor people for their own safety.

We discussed record keeping around the application of the MCA. We saw the registered provider had documented some decision making around people agreeing to holiday trips away but these people had the capacity to understand this decision making and therefore no best interest decision making was necessary in these cases. The registered provider told us in most cases historically, capacity assessments had been undertaken by the local authority when best interest decisions had been necessary, but that these records had not been forwarded to the service. They advised that in the future they would make sure that full and appropriate records were maintained, whenever the local authority takes the lead on MCA capacity assessments and best interest decision making.

People told us they were well looked after, they enjoyed living at the home and their needs were met. One person commented, "It is fine here. it is nice. I don't need much help with things but they help me if I need them to". Another person agreed they were happy with the care and support they received and it was nice living at the home". Relatives gave positive feedback about the service and one relative said, "It is very good. Nothing worries me about the care here. They always seem to be looking after her". One visiting healthcare professional told us, "I have no concerns about the care here and they alert us if there is anything at all that we should know about".

Staff were knowledgeable about people's needs, their likes dislikes and personalities. For individuals who were unable to communicate verbally, staff told us they had learned to read their facial expressions, behaviours or the noises they made to establish their mood and whether or not they were happy with a particular action or personal care task. As a result people received effective, personalised care.

Records evidenced 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 registered provider supported people to maintain their health and wellbeing.

The residential home 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 did not like the meals planned for that day. One person told us, "The food is alright, but we don't always get told what we are having. We can ask for something else if we don't like it though". Staff told us that there were two choices at mealtimes and a menu board in the kitchen area reflected this. No one living at the home at the time of our inspection required any monitoring of their food and fluid intake to make sure that this remained above agreed minimum levels. Procedures and tools were available for this to be put in place should it be necessary. On the home care side of the business, people were supported to meet their nutritional needs as necessary and this ranged from making sandwiches for people's lunches, to providing thickened fluids in line with instructions set by speech and language therapist teams.

Staff records showed that staff had received training in a variety of different areas that were relevant to the needs of people using the service. A programme of refresher training was on-going and training took place on the second day that we visited. Staff told us their training was up to date and they felt they had been equipped with the skills that they needed to fulfil their roles. Records reflected this. For example, we saw staff had been trained recently in dementia awareness, MCA and DOLs, the safe handling of medicines and food hygiene. One member of staff said, "We are all redoing a lot of training it is all booked in. I have done stoma care and dementia care".

An induction was in place that highlighted key information about the service and policy and procedures. The Care Certificate was not yet embedded into the induction programme, although the home care manager told us they would look to do this as soon as possible. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health, and brought into force in April 2015. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers.

Staff told us they received supervisions and an annual appraisal of their performance. Supervisions and appraisals are important as they are a two-way feedback process through which the registered provider and individual staff can discuss work related issues, training needs and personal matters if necessary. Staff told

us they felt fully supported by the registered provider who they could approach at any time with any problems, suggestions or concerns.

Good

Our findings

Our observations confirmed that people and staff enjoyed good relationships that promoted people's general wellbeing. People told us that staff were, "nice", "good" and "look after me". One person said "the carers are very pleasant". Relatives' feedback echoed what people had told us and what we had gathered from our own observations. One relative told us, "They (staff) are always very attentive and they have always been very good". Another relative commented, "(Person's name) is comfortable here. They (staff) are all friendly here".

Staff interacted with people in a pleasant, polite, caring and respectful manner. There was a calm, happy atmosphere within the residential home, and in the domiciliary care side of the business, people and their relatives reflected that they were very comfortable in the presence of staff. We saw staff supported people appropriately with activities of daily living, such as personal care and moving around the home. They engaged with people when delivering care and support and they were not rushed in their duties when assisting people. Staff explained what they were going to do before assisting people. This led to a positive experience for people in receipt of care.

Relatives told us they felt informed about their relations' care. People said staff included them in making decisions about their care. Staff were knowledgeable about people's needs, their likes, dislikes and the activities they liked to pursue. People told us they were supported by staff on a regular basis to keep their personal living space clean and tidy. This showed that staff empowered people to contribute to their care.

People displayed varying levels of independence. The registered provider supported people in any way necessary to maintain, and develop, their independent living skills. One person regularly walked into the local community independently and they told us they enjoyed being supported to do this. Another person travelled by train to meet their relatives regularly.

People were treated with dignity and respect and their dignity was promoted. People appeared well looked after; they were clean and well presented. Staff reflected pride in their work and told us they enjoyed caring for people, some of whom they had supported for a long time. People were asked about how they wanted to spend their time and they were supported to do this in the way they wanted.

People's privacy was promoted in practical terms, for example, if people were getting changed staff told us how they would ensure people were not inadvertently exposed to be seen by others. However, we observed during our visit that in the residential care home setting discussions about people's care and their current

care needs were not always held confidentially. There were times when personal information which compromised people's dignity, was overheard by other people living at the service and visitors to the home. We discussed this with the assistant manager and the registered provider who both took part in these discussions. They told us that this had been an oversight and that on reflection, steps should have been taken to ensure that discussions were not overheard by any other parties than those involved. They told us that this would be addressed promptly and that alternative arrangements would be made for all future meetings and discussions to take place in private where they could not be overheard.

Independent advocacy services could be arranged for people if they wished to be supported in this manner. The registered provider told us that most people's relatives acted as their advocates and that one person living at the home had an independent advocate in place to support them with their decision making. This showed the provider understood people's right to make their own choices and for their voice to be heard when they were not always independently able to do this for themselves.

Good

Our findings

People described how staff helped them in a responsive way, for example, if they needed support with a particular problem or medical attention. One person said, "They help me when I need them to and if I needed a doctor they would get me one". One person's relative told us, "They ring me up if there are any concerns". Another relative told us, "Thornley Leazes are spot on with things. We have had amazing continuity of care. We couldn't be happier with the service and how they respond to (person's name)'s needs". Records showed that where people had been ill, or where there had been changes in their conditions, behaviours or presentations, medical assistance or specialist input into their care had been sought on a responsive basis.

People were regularly supported by the registered provider and staff to enjoy activities in the local community such as attending day centres and visit local shops and fayres. The registered provider operated a shop in the local village which people from the care home attended regularly to undertake craft based activities and sell second hand goods. During our visit to the care home we observed people relaxing in the lounge, watching television and sewing. One person was on holiday at a regional activity centre and other people told us about a concert that they were attending in Carlisle that evening, which they were very excited about. The service promoted people's wellbeing, social needs and community involvement.

Our observations showed that people were given choices in their day to day lives. For example, staff asked one person what they would like to eat and another what activity they wanted to do that afternoon. We saw people moved around the home of their own free will and spent their time as they wished in either communal areas or in their own private space in their bedrooms. This meant people were respected and staff recognised people's individual right to make their own decisions.

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. Staff told us about the individual expressions and behaviours that people displayed when they could not communicate verbally and how they had learned to interpret these to support people appropriately. A keyworker system was in operation within the service where individual staff members were allocated to individual people living at the home. Keyworkers held responsibility for ensuring people's needs were met and that mechanisms were in place to enable them to achieve their goals and aspirations as much as possible. Care records were regularly reviewed and updated by people's keyworkers.

Care records on the residential care side of the business were individualised and were designed to contain a

summary of people's life histories, their background, skills, interests, likes and dislikes. Some care files did not have this information fully completed and it was clear that this was work in progress in some cases. A set of care and support plans and accompanying risk assessments had been developed following initial assessments of people's needs. For example, people had care plans in place related to supporting them with their medication needs, personal hygiene, communication skills and continence care. Each person had a separate finance file which contained relevant information and demonstrated the extent of the registered provider's role in supporting people with their finances. In addition, a separate file was also in place for each individual which contained any correspondence from third parties including any medical information, correspondence, appointments and reviews carried out by specialist healthcare professionals. There was evidence of regular reviews and evaluation to ensure that people's care remained appropriate, safe and up to date.

On the domiciliary care side of the business records in place since our last inspection had improved. However, more detail around people's individual care needs and more specific risk assessments was still needed. We discussed this with the home care manager who said that the care records on this side of the business would be reviewed, developed and improved as soon as possible.

Care monitoring tools such as personal hygiene charts, food and fluid intake charts and charts for monitoring people's behaviours were in place, where necessary. In addition, the service used daily evaluation records and had a diary system to pass information between the staff team and to respond to any issues that may have been identified. Each person had a personal diary which recorded their mood, any behavioural issues and any activities they had undertaken daily. Staff told us that verbal handover meetings took place when each shift changed and key information was passed to the incoming shift at this time. This showed the provider had measures in place to ensure that care delivery was monitored and that people received continuity of care.

Complaints records showed that there had been no formal complaints received by the service since November 2014. A form was available in the entrance area of the residential home for people or visitors to make a complaint should they wish to do so. The registered provider's complaints policy was posted on the wall in the entrance area of the residential home and it was available in pictorial form so that it met the needs of the people using the service.

The registered provider sought feedback from people, staff and visitors in order to measure their levels of satisfaction with the service delivered. Results from the latest surveys showed that people were happy with the service they received with some comments being, "Staff listen to me" and "I look forward to the holidays, they are great". Visitors' responses were positive and comments included, "Residents appear happy" and "There is a real feeling of homeliness". Staff told us that both they and people using the service could feedback their views at any time directly to the registered provider. Staff also told us they had the opportunity to express their views either at staff meetings or via supervision sessions or annual appraisals.

Requires Improvement

Our findings

Thornley Leazes Care does not require a registered manager to be in post under its registration with the Commission, as the registered provider is an individual in day to day charge of the service. This means they directly manage the service and the carrying on of the regulated activity. At the time of this visit, an 'Assistant manager' was in post who had been working at the service in a largely administrative and governance capacity for almost two years. There was a separate 'Home care manager' who concentrated on the operation of the domiciliary care side of the business.

We were satisfied that overall, notifications about deaths and other incidents were submitted to the Commission in line with requirements. However, we found a small number of notifications had not been notified to us in line with legal requirements. In addition, the rating awarded at our last inspection had not been displayed on the registered provider's website. We discussed these shortfalls with the registered provider, who assured us that these oversights would be addressed and would not happen again. We are using our regulatory powers to deal with this matter separately.

We recommend the provider reviews and re-familiarises themselves with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, entitled Notification of other incidents and Regulation 20A of the Health and Social Care Act (Regulated Activities) Regulations 2014, entitled Requirement as to display of performance assessments.

At our last inspection we found there was a lack of formalised auditing systems in place to measure and monitor the quality of the service people received. At this visit we found improvements had been made and there was evidence that the registered provider had taken on board our previous feedback. They had introduced documented audits which reviewed infection control matters and cleanliness levels within the residential home, medication audits and health and safety audits and checks. We discussed with the assistant manager how the medication audit records did not fully reflect the extent of auditing that was carried out during weekly and monthly checks undertaken on medicines stocks and general medicines management within the service. The assistant manager told us that there was no overall analysis of accidents and incidents carried out, but that individual incidents were assessed when they occurred and they were responded to appropriately. The assistant manager told us they would consider developing an overall audit of accidents and incidents to be completed at regular intervals throughout the year, as an additional monitoring tool.

On the domiciliary care side of the business a weekly audit check was carried by either the home care

manager or the assistant manager where they visited each person in receipt of care within their own home and looked at documentation, any medication errors, daily records about care delivery and medication practices and records. They told us that there were few actions needed as a result of these audits being carried out so regularly. Action plans were not used consistently used when audits were carried out to drive improvements through the service and to provide accountability for staff to complete set tasks. The registered provider and assistant manager told us that going forward, the use of action plans would be applied across all different types of auditing within the service.

Matrices had been introduced to monitor individual staff members training requirements and the completion of staff supervisions and appraisals. The registered provider had also introduced a formal 'Management meeting' held on the first Thursday of every month, where more senior discussions about the service took place. Minutes about discussions held at these meetings were not always taken and this was a recording shortfall. Staff meetings within the service were held quarterly and 'Residents meetings' monthly. This meant the registered provider could share key messages and gain feedback from people and staff about the service they delivered with a view to identifying any shortfalls and addressing them promptly.

Some records and recording across the service needed to be improved. For example, we were satisfied that safe recruitment procedures were followed in practice but records were not always complete and they were sometimes filed away in areas other than staff files. Not all documentation in people's care records had been completed in full and the care plans and risk assessments on the domiciliary care side of the business needed to be developed further. Notes of discussions held in meetings within the service were not always taken and the application of the MCA was not always effectively demonstrated through roust record-keeping.

We recommend the provider reviews their quality assurance and governance systems, including their records and recording processes throughout the business, to drive improvements and provide accountability for staff.

We received positive feedback about the registered provider from people their relatives and staff. One person told us, "(Name of registered provider) is nice. I get on alright with her. I think she is quite understanding". One member of staff said, "(Name of registered provider) is really good, very approachable. She makes time for me".

The mission statement for the service read, "We aim for on-going change and improvement in our residential care to help and support clients with learning disabilities take their rightful place as equal members of society". At this inspection we found that the registered provider led the service in a way that endeavoured to meet this mission statement and people lived active, happy and healthy lives.