The Charlotte Straker Project

Charlotte Straker House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Charlotte Straker House is a care home situated in Corbridge, Northumberland that provides care and support to up to 30 older persons. The last time we inspected this service was in September 2014 when we found the provider was meeting all of the regulations that we reviewed.

This inspection took place on 6 and 7 April 2016 and was unannounced.

There is a condition on the provider's registration of this service that a registered manager must be in place. A registered manager was in post at the time of our inspection who had been managing the service since October 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. We were assisted at our inspection by both the registered manager and the deputy manager, both of whom were present on the days that we visited the home.

People told us they were very happy living at Charlotte Straker House which they found very homely and caring. Risks that people had been exposed to in their daily lives had been assessed and records about these risks were detailed and regularly reviewed. Accident and incident monitoring took place and where necessary risk assessments were amended to prevent repeat events.

Staff were knowledgeable about what constituted a safeguarding incident and confirmed how they would handle any safeguarding matters should they arise. Staff had been trained in safeguarding and we saw that historic safeguarding incidents had been handled and reported appropriately and in line with protocols and procedures. People were supported to meet their nutritional and hydration needs and staff monitored people's weights to ensure they remained healthy, seeking input from GP's and dieticians where necessary.

People, staff and our own observations confirmed that there were enough staff on duty to meet people's needs on the days that we visited. Staff confirmed they were not rushed when delivering care. They had received training in key areas and supervision and appraisals were carried out regularly. Recruitment processes were thorough and medicines were managed well.

We observed friendly, respectful and joyful interactions between people and staff. People told us they enjoyed very good relationships with staff who were compassionate and caring and met all of their needs. People's privacy and dignity was promoted and we saw that they were encouraged to remain as independent as possible. A range of activities were available to stimulate and occupy people and community involvement and social inclusion was promoted by staff. Choice was evident throughout the service and people told us they were empowered to live their lives the way they wanted to through the choices that staff gave them.

Care records were extremely personalised with great attention to detail about how people should be

supported safely and in line with their needs, likes, dislikes and preferences. They were regularly reviewed and up to date. Care was person-centred and there was evidence that people and their relatives were involved in their care. No people had formal advocacy agreements in place, but the manager was aware of how to arrange this should it be necessary.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals. The MCA was appropriately applied and applications had been made to the local authority for those people who required assessment for a deprivation of liberty safeguard to be put in place. There was evidence within people's care records of capacity assessments, best interests decision making and consent to care and treatment.

Quality assurance systems within the home were extensive and very robust. The registered manager was accountable to a board of executives which compromised the provider organisation. Underneath this board sat a number of sub committees all of whom worked closely with the registered manager. Action plans and formalised reporting tools were used to monitor the service provided and to drive through improvements within the home. The registered manager was committed to developing the service further and was in the process of designing new tools to be used in quality assurance assessment of the service.

The culture within the service was described as open and the findings of our inspection supported this. The management team and provider organisation were described as approachable, by people, their relatives, staff and external healthcare professionals. The provider organisation had a clear set of visions and values and worked very well with external healthcare professionals who described the service as proactive. The provider organisation had very good links within the local community which benefitted people living at the home in terms of the service they received and the social interactions that they enjoyed as a result.

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.

People spoke highly of the service and said they felt safe.

Risks that people were exposed to in their daily lives had been appropriately assessed and mitigated against.

Medicines were well managed and systems related to medicines were robust.

People were appropriately safeguarded from harm or abuse. Staff recruitment procedures were thorough.

Is the service effective?

Good

The service was effective.

People gave very positive feedback about staff who we found were well supported to deliver effective care in line with best practice guidance.

The Mental Capacity Act 2005 was appropriately and lawfully applied.

People reported that the food served to them was of a very high standard.

The premises had been adapted to accommodate people's needs.

Is the service caring?

Good

The service was caring.

People and staff enjoyed very good relationships and people were fully involved in their care.

People were respected and involved in the service and care delivery. Their dignity was promoted and they were encouraged to be as independent as possible.

Advanced care planning had been considered wherever people wished to discuss such matters and it was personalised.

Is the service responsive?

Good

The service was responsive.

People received person-centred care.

Management and other staff displayed an in-depth knowledge of people and their needs.

Care records were detailed and regularly reviewed to ensure they remained current.

Choice and social inclusion was promoted within the service and complaints were investigated thoroughly.

Is the service well-led?

Good

The service was well led.

The culture within the service was positive, open and honest. There were clear visions and values.

People benefited from a service which had a structured and organised leadership team.

Auditing was robust and accountability was evident. Action plans were used to drive through improvements within the service.

Strong community links were evident and the provider promoted the organisation and its fundraising locally.

Charlotte Straker House

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 6 and 7 April 2016 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor with a specialism in nursing care of older people and people with dementia, and an 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.

A Provider Information Return (PIR) was not requested 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 all of the information that we held internally about the service, including statutory notifications that the provider is legally obliged to inform us of. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We also sought feedback from Northumberland safeguarding adults team, Northumberland County Council commissioning team and Northumberland Healthwatch. We used the information that they provided us with to inform the planning of this inspection.

During our inspection spoke with the 13 people who used the service, five visitors - four of whom were people's relatives and two visiting healthcare professionals. We also spoke with the registered manager, nominated individual, deputy manager, two nurses and five care workers. The nominated individual is a person who is named as a 'responsible person' in line with Care Quality Commission requirements, and they represent the provider's organisation. We looked at seven people's care records and a range of other records related to the operation of the service, including five staff training and recruitment records, care monitoring tools and quality assurance documentation.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Charlotte Straker House and they were comfortable in the presence of the staff who supported them. One person told us, "This is a nice place, they are good to me. I have never felt unsafe here". Another person commented, "Oh I feel safe here, definitely". One person's relative commented, "We have no concerns about her when she is here". Visiting healthcare professionals told us they had confidence in the leadership of the service and they had never witnessed anything of concern during their visits to the home. One visiting healthcare professional told us, "I have no concerns whatsoever".

Risks that people were exposed to in their daily lives had been assessed, mitigated against and were regularly reviewed. There were detailed records about the measures staff should take to ensure that risks were reduced as much as possible. For example, there were risk assessments in place for people who had choking and/or breathing difficulties. People who had problems with mobility had been appropriately assessed in respect of the risk of falling and where necessary they had been provided with equipment and/or referred to specialist falls teams for input into their care. Several people had been issued with call fobs that they could wear around their necks to summon help quickly if needed. Risk assessments in relation to the use of bed rails were in place and were regularly reviewed, together with a record of the person's capacity to consent to the use of these. People had personal emergency evacuation plans (PEEPS) in place which were reviewed monthly. These provided staff and emergency workers with the necessary information they would need to evacuate people from the building in an emergency, if they were unable to leave safely themselves.

Environmental risks had also been assessed within the home, including a risk assessment of the development of Legionella bacteria in the water supplies and potential fire hazards. A range of safety checks were carried out within the home including checks on the suitability of the electrical installation within the home, gas supplies, fire equipment, water temperatures, boiler checks and servicing of the home's lift. Servicing of equipment used in care delivery was evident regularly to ensure that equipment remained safe for use.

A business continuity plan and emergency contacts were available to staff and management. This included information about where people would be evacuated to in an emergency. There was a full list of senior staff contact details and external contractors such as plumbers and electricians to be contacted in an emergency.

Individual accidents and incidents were recorded with detail about the circumstances, environment and contributing factors. Action plans were drafted where any measures needed to be put in place to prevent repeat events. There was a date for completion of actions and an allocation of the task to a specific staff member. An overall monthly analysis of falls took place monthly. The service also maintained a file about adverse events and this recorded actions taken in response to certain situations such a medication error.

People's medicines were well managed and systems and audits were in place to ensure any issues were

identified and addressed promptly. Staff competencies in medicines were carried out annually. The ordering, storage, disposal, administration and recording of administration of medicines was robust. Topical medicines application records were used for recording the application of topical medicines such as creams and ointments, and included body maps which highlighted where staff should apply these, how to apply them and how often. The home's medicines were audited by an external pharmacist regularly who told us, "We can speak to any member of staff or they'll ask if they aren't sure. I get a really good feeling in the home, I've noticed a huge difference with the management side. We do refresher training yearly with staff, staff are really, really receptive it's a good team".

When we spoke with staff they displayed knowledge of how to safeguard vulnerable adults and the procedures they should follow if they witnessed or suspected abuse. Records showed staff had been trained in safeguarding and this was regularly refreshed to keep staff knowledge up to date. Matters of a safeguarding nature which had occurred in the home had been appropriately dealt with and investigated by the provider in addition to being reported to Northumberland safeguarding adults team for investigation where necessary.

Staffing levels were appropriate to meet people's needs on the days that we visited the home. People told us they did not usually have to wait very long for staff to come to them if they used their call bells to summon assistance. We saw staff had time to sit with people and meet their social needs as well as support them with personal care and any other activities. Staff recruitment was thorough and procedures were in place which included checking staff identity, obtaining references, conducting Disclosure and Barring Service checks (DBS), checking nurses registration with the Nursing and Midwifery Council and interviewing staff. The DBS support providers to make safer recruitment decisions as they check potential employees against a list of people barred from working with vulnerable people, including children. Staff records showed that where necessary the provider had appropriately applied their disciplinary procedures and they supported staff to address any identified issues. This showed the provider had measures in place to ensure that people were supported by sufficient numbers of staff, who were vetted and deemed of suitable character to work with vulnerable adults.

Good

Is the service effective?

Our findings

Staff demonstrated a thorough knowledge of how to meet people's needs. They described the support they gave to certain individuals that we asked about and the information they provided us with tallied with people's care plans and risk assessments. People told us that staff supported them appropriately and they considered them to be well trained. One person said, "Staff help me and always come quickly when I need them". Another person told us, "The staff are very good". Other comments included, "The staff are very good here; I get very good treatment", "We get good care here" and "The staff really look after me".

Staff told us they were trained to provide effective care to people. Records showed that staff undertook an induction and training in a number of key areas such as safeguarding, medicines and infection control, and in addition, ad hoc training in areas such as delirium, enteral feeding tubes, venepuncture and syringe drivers. A syringe driver is used to administer a continuous subcutaneous infusion of drugs from a syringe. A visiting healthcare professional told us, "They ask for a lot of training here. I have sessions booked in soon about pressure area care, catheterisation and an update about Parkinsons". One member of staff told us, "I have requested training in leadership and management and they (the provider) said they would support me to do that this year". This showed that the provider supported staff to maintain and develop their skills and also keep abreast of best practice in specific topic areas within the care sector and apply them within the service.

Training was well maintained and could be viewed electronically by individual staff member, staff teams or the organisation as a whole. There were set training courses for specific roles within the home and minimum standards which included for example administrators being trained in dementia care so that they could understand and support people with such needs when interacting with them. Training was delivered either face to face or completed online via external organisations.

Staff received regular supervision and appraisal. Supervision sessions and appraisals are one to one meetings between staff and their line manager where performance, future development and any other issues or personal matters are discussed. One nurse said, "Supervisions are every two months or anytime in between if needed. We can go to the manager anytime though. X (manager) is very focussed on doing everything right. It is great here. From the first day I came in, everyone has been very supportive". A matrix was in place to monitor that staff supervision and appraisals took place within the timescales set by the service.

Staff reported that communication within the service was very good. Handover records were comprehensive and showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift. Information about people's health, moods, behaviour, appetites and the activities they had been engaged in were shared, which meant that staff were aware of people's current state of health and well-being. We observed the afternoon staff handover and witnessed robust handover arrangements in place for staff, both orally and in writing. People told us information about the service and any changes were communicated to them and they felt informed as a result. Communication boards in the foyer of the home held information and messages for people to review

at their leisure.

The involvement of external health and social care professionals was regularly evident in people's care records. Records showed details of appointments people had attended and visits made to the home for input into their care. Staff had worked well with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GPs, consultants, district nursing teams, social workers, dieticians, the speech and language team (SALT), physiotherapists, podiatrists and dentists. Care plans reflected the advice and guidance provided by external health and social care professionals and visiting healthcare professionals themselves told us that they service implemented their instructions.

People told us that the food they received was excellent. One person commented, "The food is excellent. We enjoy a lot of home baking". Another person told us, "The food is lovely. It could not be better". A third person said, "The soup here is special and the puddings are out of this world!" One visiting relative told us, "My mother enjoys the food here. There is a big choice and it is very good".

Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals, such as GPs, dieticians and speech and language therapists, for advice and guidance to help identify the cause. Choking risk assessments were completed to identify if people were at specific risk of eating and drinking and whether referrals should be made to external professionals. Monitoring charts were available should any concerns develop about people's food and fluid intakes in the future.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The 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). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

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. Assessments had been made to check whether people had capacity to make care based decisions. There was evidence of people's capacity being assessed and reviewed and we saw examples of decisions being made in people's best interests. These decisions were formally documented and copies of meeting minutes retained within people's care records. Some people had deprivation of liberty orders in place which had been granted by the local authority supervisory board. The service demonstrated that they understood their legal obligations under the MCA 2005 and they applied the Act lawfully.

Consent to care plans and treatment records was evident as they were signed by people where they were

able. There was evidence that people's agreement to having photographs taken had been sought.

The premises had been adapted with people's needs in mind. Handrails were available around the home to assist people to move around independently and there was a lift to assist people who were not able to ascend the stairs. Externally there was a beautifully maintained garden area with a summerhouse and decking area for people to enjoy and access at their leisure. Measures were in place to prevent slips, trips and falls such as slip resistant strips on the edge of steps.

Good

Is the service caring?

Our findings

People and staff enjoyed good positive relationships and the atmosphere within the home was pleasant and relaxed. People told us that staff interacted and supported them in a friendly, caring and respectful way. They described how they felt cared for and lucky to be living in such a high quality care facility. One person commented, "If you have to be in a care home this is a nice place. They are good to me. I know staff so well and I can tell them if anything bothers me. I get on with them very well". Another person said, "The staff look after me very well here". One visiting healthcare professional told us, "If it was me choosing a care home, I would come here myself".

The interactions we observed throughout our visit between staff and people who used the service were friendly, encouraging and supportive. People looked clean, comfortable and well cared for, with evidence that personal care had been attended to. People were asked what they wanted to do and staff listened. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. People told us that they were called by their preferred names. One person commented, "They call me X (name) and I am happy with that".

We observed some very pleasant interactions and engagements during our visit which demonstrated the relationships that people and staff enjoyed. During lunch one person drinking sherry commented, "I am breathing fire with this sherry" and the staff member sitting next to them chatting said, "That's the sign of a good sherry if you are breathing fire". Everyone in close proximity laughed and enjoyed the engagements which continued throughout the meal. People shared jokes and stories with staff and staff demonstrated that they knew people well by reflecting on their backgrounds and life histories with them. One person was waiting near the front door of the home when a staff member walked past. They asked the person, "Are you off out anywhere nice X (person)". The person informed the staff member that they were going to a local restaurant for lunch at which point the staff member replied, "Oooo, that will be lovely; have a nice time".

We heard many engagements that were positive and caring. These included comments such as; "What's the matter X? Are you alright? Don't you worry"; "I will sort that out for you"; "Be careful"; and "You are doing grand, you are doing grand". One person commented to a staff member, "What would we do without you?"

On the first day that we visited a birthday party had been arranged for one person and cakes had been made by kitchen staff and pink champagne provided. A communal invite had been sent out to all people who lived at the home and the person's relatives also joined the fun. People said they had enjoyed the event and the following day the birthday person commented to staff that they had thoroughly enjoyed themselves and loved having their relations celebrating with them in the home. This showed the provider promoted people's involvement and they made special occasions special for people, which impacted positively on their wellbeing.

People told us they felt involved in the service and were regularly asked for their agreement or opinions to new initiatives and arrangements introduced. Information about menus and activities was available to

people within their own rooms. We heard staff asking people in advance if they wanted help, more food for lunch, and if there was anything they needed support with. A number of people lived independently in bungalows within the grounds of the home which were provided and supported by the Charlotte Straker Project. These people were independent in terms of personal care, but they were able to eat within the main house (Charlotte Straker House) if they so wished and they were supported with household chores such as washing and ironing if needed. One person told us how they had wanted to be involved in picking their own duvet and cushion covers as they had different taste to the soft furnishings provided within their room. Their involvement was fully supported.

A large proportion of people were independently mobile and moved around the home with equipment such as walking frames and three wheel tri walkers which enabled them to do as much as possible for themselves. Some people had been provided with specialised equipment such as plate guards to enable them to eat independently and with dignity. One person had a curved table top fitted to the top of their wheelchair and this enabled them to sit communally at a table with other people and have their food and drink within reach for independent eating. This showed that independence was promoted within the service.

People told us they were treated with dignity and respect and our observations confirmed this. We saw there was a sign on all people's bedroom doors reminding staff to knock before entering people's rooms and staff followed this instruction. One person told us, "I am treated with respect. I would soon complain if I wasn't. They close doors if they are helping me get dressed, so that nobody will see". We had no concerns about confidentiality in the service and saw that where necessary staff held discreet conversations amongst themselves to ensure confidentiality and protect people's dignity. People's care records and other records related to the service were held securely and remained confidential. Access to records was limited to those staff who needed it and management.

Equality and diversity was also promoted. One person told us they had been involved in the local church for many years and they enjoyed the church service held in the home once a month. Communion was given in the home regularly by local clergymen/women. Another person told us, "I go to the local church from here quite a lot". This showed the provider supported people's spiritual and diverse needs.

End of life care was considered and planned where people had indicated that they wished to discuss such matters. Future wishes had been discussed with people, for example where they would like to receive end of life care, what is important to them, the first people to contact and any special wishes at end of life. Future wishes care plans were very personalised and listed specific funeral arrangements and who people would like to visit them in their final days. This showed care and attention had been given to supporting people with their advanced care planning to ensure it met their needs and they could experience a comfortable and dignified death.

The manager told us that no people living at the home currently accessed advocacy services but that as a service they advocated on people's behalf at all times. Advocates act in people's best interests to support them to make decisions that they do not have the capacity or understanding to make themselves.

Good

Is the service responsive?

Our findings

People enjoyed care that was person centred and met their needs. One person told us, "The staff are all nice. I am waited on hand and foot". Another person said, "The staff are kind and respond to my needs". A visiting relative told us, "As a family we are content with things here. Our mother receives very good care". Other comments included, "The staff are kind and respond to my needs" and "The staff are very good and helpful; they are there when you need them".

The manager, deputy manager, nurses and care staff displayed they had excellent knowledge about people's individual needs, their personalities and their preferences. A keyworker system was in operation where people had an allocated nurse to oversee their medical needs, care planning and liaise with family members and separately a care worker was allocated to each individual to oversee more pastoral care such as ensuring people had the right clothing and toiletries they needed. Each person had a personalised flow diagram which gave the reader information about their hobbies, likes and dislikes, important people in their lives, how best to support them and what was important to them. Staff also completed a similar profile about themselves and information that they provided was used to match keyworkers to people where they may have similar interests. The deputy manager told us that she had personally sought people's permission to complete and display their personalised information sheets in their rooms and it was a choice.

People told us they had choices across all aspects of their daily lives and these choices were respected. For example, one person said, "If I don't want to go to the dining room I just tell them and they bring my dinner here (to room). They are good like that". We observed people being asked what they wanted to eat and if they wanted to be involved in activities that were on offer that day. There was a choice of food and drinks at each mealtime.

Examination of care records showed they were person-centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. Initial assessments were carried out and care plans and risk assessments in place related to people's needs, to ensure personalised care was provided. The care plans guided the work of care staff and were used as a basis for quality, continuity of care and risk management. They gave staff specific information about how the person's care needs were to be met and instructions about the frequency of interventions and what staff needed to do to deliver care in the way the person wanted. They also detailed what the person was able to do to take part in their care and maintain their independence. Care records were regularly reviewed to ensure people's needs were met and relevant changes were incorporated into individual care plans.

Each person's care plan contained an 'All About Me' profile, where information had been collected from the person, and where relevant their family had also given details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. It is important information and necessary for when a person can no longer tell staff themselves about their preferences and enables staff to better respond to the person's needs and enhance their enjoyment of life. Examples for people included, "Likes to offer staff chocolates, have a chat with staff while they are getting them dressed and undressed,

likes visitors and company, likes to be clean and tidy which they thank the staff for" and "X likes reading and watching TV, they have an interest in ornithology and love programmes about birds and enjoys nature". Profiles were also written in the first person and included statements such as "My radio and cd is important as I get pleasure in listening to classic FM".

Daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility, nutrition and activities and interests. This was necessary to ensure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences. In addition, care monitoring tools such as overall care charts measuring fluid intake and output and food consumption were used where there were differing concerns about people's health. Handover sheets were in place which were maintained by nursing staff. These included information about people's medical situation, their current mobility, any infection control issues, if emergency healthcare plans were in place, the number of staff needed to support and assist the person and any current antibiotics and allergies. A 24 hour report was also completed by nursing/care staff and submitted to the manager for review daily. A diary system was used for future appointments and handing over lower level actions that needed to be followed up such as contacting GP's for routine information.

People had emergency healthcare plans (EHCPs) in place. EHCPs are agreed care plans between the person and clinicians involved in their care and any relatives or care workers where appropriate. An EHCP is designed to inform healthcare professionals of the person's wishes and any treatment they should receive, and they should be quickly accessed by whoever is treating or caring for them, including acute hospitals, out of hours GP services and ambulance staff.

Activities were promoted throughout the home daily and people were encouraged to partake in these if they so wished. One person told us, "They bring people in to do talks on certain topics; things like local history. We have children in at Christmas singing and armchair aerobics happens once a week". There was an activities programme for the day in people's rooms for them to peruse. People accessed the community during our inspection and relatives and friends visited the home throughout the day. This showed the provider promoted community involvement and social inclusion.

People were confident that if they needed to make a complaint this would be handled appropriately by management. They were clear about how to complain and said they would not hesitate to bring any complaints to the attention of either staff or management. One person told us, "I know how to complain" and another person commented, "I could easily complain if I needed to". Complaints records showed that they were thoroughly investigated and referrals made to other organisations where necessary. Comprehensive records were kept which detailed each stage of any investigations, any statements that were taken, calls made and contact with family. There was a combination of six safeguarding issues and complaints received in the 12 months prior to our inspection of the service. Each complaint was resolved in line with the provider's policy and there was evidence that people's families were happy with the outcomes.

Feedback about the quality of the service was gathered annually via satisfaction surveys from people who used the service, staff, visiting healthcare professionals and people's family members. The latest survey had been issued in January 2016 and the results were being analysed and an action plan formulated at the time of our visit.

Good

Is the service well-led?

Our findings

The Charlotte Straker Project is a company limited by guarantee and a registered charity whose strategic vision is described as aiming to, "Achieve the standard of care expected of us by Health, Adult Social Care and the Care Quality Commission". Their strategic objectives were listed as, "Continuous improvement of the quality and effectiveness of services by ensuring all knowledge and system processes comply with regulatory standards" and "Developing the business by exploring and providing new services that include supporting a range of care conditions". The Charlotte Straker Project quotes its ambition as, "To deliver high quality, continuously improving, evidence based, efficient and effective services which provide value for money by enabling recovery and social inclusion. We believe high quality services produce better results for residents and statutory bodies".

We reviewed the structure of the organisation and found that there was an executive board of trustees made up of ex GP's, district nurses, solicitors, local businessmen, architects and administrators. Underneath the executive board there were three committees one focussed on strategic development, one on quality and one on finance and governance. Underneath the strategic development committee there sat a fundraising subcommittee and under the quality committee, a clinical steering group. Weekly meetings took place between the chair of the executive board and the manager and deputy manager of the home. These discussed an overview of the service and any issues that had arisen that week. At the following weekly meeting, actions from the previous meeting were reviewed to make sure they had been completed. For example, speaking to family members about elements of people's care and their health conditions.

There were many tools in place to monitor quality within the service. Meetings were held from board level to auxiliary staff level and included meetings with people who used the service. The results and findings of these meetings were drafted into detailed action plans which listed progress and were then marked as closed once completed. The manager told us that in advance of executive board meetings, quality committee meetings and clinical steering group meetings she had to prepare a report for discussion which covered audit findings, action plans, current situations, staffing and HR matters, property, health and safety, safeguarding issues, policy reviews and finance issues. The manager told us that she held responsibility for overseeing that action plans created on the back of audits and meetings were completed, other than the executive board meeting action plans which were overseen by the chair of the executive board. This showed that robust and accountable systems were in place where action plans were tracked and monitored to ensure they were completed.

The manager showed us a quality dashboard that they had to complete and submit for analysis, monthly to the clinical steering group, bi-monthly to the executive board and quarterly to the quality committee. This quality dashboard contained information, if applicable, including; falls, tissue viability, medicines errors or incidents, catheter care, deprivation of liberty orders, dependency ratings, safeguarding notifications and general illness. The manager told us that any issues or trends that were identified were discussed at these respective meetings and discussions held about changing/improving practice such as seeking falls awareness training for all staff in response to specific falls within the home. In addition to the quality dashboard the clinical steering group looked at care plans, fractures, significant events, job vacancies and

advances or changes in clinical practice to share with the staff team. The nominated individual told us that any emerging clinical issues identified through the quality dashboard tool were researched in line with best practice guidance and discussed at meetings before being incorporated into an improvement plan.

An overall risk register had been introduced by the quality committee which was used by each separate committee to record and rate by risk, any matters brought to their attention. These included matters which would have a risk to the business such as loss of staff and bad publicity. Each committee also had its own individual risk register. The risk registers showed the risk, impact, risk rating and mitigation and were reviewed at each individual committee meetings and overall for all risk registers at the executive committee meeting.

There was extensive auditing of the service including audits relating to health and safety, medicines management, infection control, call bell response times, weight management and care records. An auditing schedule was in place. External auditing of the service also took place by external companies and members of the executive board of trustees who visited on a rotating basis and carried out a "Trustee Inspection" to assess the quality of the service. These 'Trustee Inspections' were aligned to the Commission's model of inspection in respect of the five key domain areas of safe, effective, caring, responsive and well led, and they were designed to assess the service's performance in each of these areas. Reports were produced from these visits which captured feedback from people, family members, staff and management and looked at record keeping, the building, decoration, furniture and equipment. Action plans were drafted from these visits and monitored to completion. A policy review schedule was also in place whereby the registered manager reviewed and updated policies on a rolling basis, making proposals for change in line with up to date best practice guidance. These changes were then submitted to the quality committee for agreement. This demonstrated a group approach to reviewing and updating policies to ensure that they were realistic, effective and provided staff with appropriate guidance.

At the time of our inspection there was a registered manager in post who had been registered with the Commission to manage the service since October 2015. The provider was meeting the requirements of their registration. We received very positive feedback from people, their relatives and healthcare professionals about the leadership of the service. They spoke highly of both the registered manager and deputy manager whom they said were always visible and interactive around the home. One person said of the registered manager, "X (name) is the manager. You can always ask for her if you need her. She comes to see you if need be". Another person said, "I have met the manager and I think the home is very well run. I have been elsewhere but I wouldn't want to be anywhere else". Visiting healthcare professionals told us, "X (manager) and Y (deputy manager) make an excellent team; they are really proactive; they are the most proactive service I know" and "The leadership is great". They told us the service worked in partnership with them and sought clarity and feedback with the aim of providing the best possible care. They told us that whenever their input was requested by the service, it was always appropriate.

The manager told us, "There is an open door policy here. I want people to come and talk to me about anything at all". Feedback from people, their relatives and visiting professionals was gathered via surveys and reviewed on an annual basis, in addition to general everyday feedback gathered within the home. This showed that systems were in place to measure the quality of the service provided from a variety of different perspectives.

The manager told us she attended provider forums and seminars about regulation. She said, "It's all about self-regulation. There should be no surprises with inspection. You should know where you are". She showed us a self-regulation tool that she was currently developing to present to the executive board as a new audit and assessment tool. This demonstrated that the provider organisation and manager questioned their

practice, and looked at ways of continually developing and improving the quality of the service. We found the organisation promoted and strove for continuous improvement in all aspects of the service.

Records throughout the service were well maintained and securely stored, wherever necessary.

There were good, well established links between the service and the local community. The manager told us that the fundraising committee was very active and provided the community and people who lived at the home with a range or events and activities to partake in if they wished. These included fundraising stalls at the local village fair, golf tournaments and annual cricket events to name a few. There were also arrangements in place where children from local schools visited the home and engaged with people and some children had made personalised clay models for individual people who lived at the service whom they had met.