Little Sisters of the Poor

St Joseph's - Newcastle

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

Overall summary

This was an unannounced inspection carried out on 20 and 25 November 2015.

We last inspected St Joseph's Newcastle in January 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

St Joseph's Newcastle provides accommodation for people who require nursing or personal care and support for up to 58 people, some of whom may live with dementia or a dementia related condition.

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

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest

Summary of findings

Decision Making, where decisions were made on behalf of people who were unable to make decisions themselves. Other appropriate training was provided and staff were supervised and supported.

People received their medicines in a safe and timely way. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed.

Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. There were a variety of activities and entertainment available for people.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

Staff and people who used the service said the registered manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service. There were effective systems to assess and monitor the quality of the service, which included feedback from people receiving care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Regular checks were carried out to ensure the building was safe and fit for purpose. Appropriate checks were carried out before staff began work with people.

Staffing levels were currently sufficient to meet people's needs safely. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were very caring and respectful. People and their relatives said the staff team were kind and patient as they provided care and support.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Staff spent time interacting and talking to people and they were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes so people received support in the way they wanted. However, not all care plans were broken down to detail the interventions required by staff to support people.

Summary of findings

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was approachable.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

St Joseph's - Newcastle

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 20 and 25 November 2015 and was unannounced. The inspection team consisted of an adult social care inspector and an expert by experience on the first day and an adult social care inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection we reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and the local safeguarding teams. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 14 people who lived at St Joseph's, three relatives, the Mother Superior of the Convent who was the registered manager, the deputy manager, one registered nurse, eight support workers including two senior support workers, the activities organiser, a domestic person, a member of catering staff, the training officer, the personnel officer, two visiting health care professionals and two volunteers. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for eight people, the training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager had completed.

Good

Is the service safe?

Our findings

People told us they felt safe and they could speak to staff. Peoples' comments included, "I am very safe here, the carers and other residents are my friends," "I feel completely safe here," "Staff are around when I need them," "I think I feel safe," "Staff are always around and they'll bring you cups of tea," "I know staff are around when I want them," "I feel safe here, thank God and the staff are lovely," "The staff are always available if you want anything," and, "I'd go straight to Mother (registered manager) if I didn't feel safe."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. Staff members' comments included, "I'd report any concerns straight away to the unit manager or the registered manager," "Nothing like that has happened since I've been working here," and, "I'd report any concerns to the nurse in charge."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place and no safeguarding concerns had needed to be raised since the last inspection.

We considered staffing levels were sufficient but should be kept under review as people who were currently more independent, on the top floor became more dependent. The registered manager told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of our inspection there were 56 people who lived in the home. The home was divided into four units and was staffed by two nurses and 13 support workers. The shift pattern was from 8-00am-3:30pm, 3:30pm-9:00pm and one nurse and five support workers from 9:00pm-8:00am. These numbers did not include the deputy manager and registered manager who were also on duty during the day and were available 'on call' overnight to provide any support and guidance when required.

Lourdes nursing unit which accommodated 17 people was staffed with one nurse and four support workers. John of God nursing unit which accommodated 12 people was staffed with 5 support workers including one senior support worker. Caroline Sheppard residential unit which accommodated 15 people was staffed by three support workers including a senior support worker. Jeanne Jugan, residential unit which accommodated 12 people was staffed by two support workers including a senior support worker who covered two floors.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. For example, "(Name) this is your Paracetamol, shall I put it in your hand.? No, alright I'll put them in your mouth for you," and, "Here's a glass of water to drink after your tablets." Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. We saw written guidance was in place for the use of some "when required" medicines. The guidance included when and how these medicines should be administered to ensure a consistent approach to the use of such medicines, such as for pain relief or for agitation and distress. We observed a staff member ask a person, "Have you any pain, would you like your painkillers.?"

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us and their training records showed they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. A staff member commented, "A nurse will do the competency checks."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included

Good

Is the service safe?

risks specific to the person such as for pressure area care, moving and assisting, smoking and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. For example, a risk assessment to maintain the safety of a person who smoked stated, “Encourage (Name) to allow papers and lighters to be removed from their bag to reduce the risk of fire.”

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with the human resource person and other members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses’ registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "There's loads of training," "We get plenty of training," and, "I've done most of the training."

Some staff told us they had worked at the service for several years. One staff member commented, "I love working at St Joseph's, I've been here for years." All staff said when they began work they had completed an induction. They said they had the opportunity to shadow a more experienced member of staff when they began work. Staff members' comments included, "I love it here. I'm doing my induction at the moment," and, "I had an induction and did training when I started." This ensured people had the basic knowledge needed to begin work. The training officer told us new starters studied for the Care Certificate as part of their induction to equip them with some of the required skills to work with people.

The training officer told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as, end of life care, dignity, mental capacity, diabetes, nutrition and well-being, distressed behaviour, dementia care, vision awareness, effective communication, Parkinson's awareness, pressure area care and mental health awareness. Several staff had obtained or were studying for a diploma in health and social care previously known as National Vocational Qualifications (NVQ).

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "I do supervisions with some support workers," "Mother Superior (the registered manager) does my supervision," and, "I think my supervision is due." Staff told us they were well supported to carry out their caring role. One staff member commented, "I'm really well supported." All staff said they had regular supervision to discuss the running of the service and their training needs. They said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal which was checked after six months to review their work performance. A staff member commented, "Nurses and the management team carry out the appraisals with staff."

Staff told us communication was effective. A staff member commented, "Communication is very good. We're a good team," "Communication is good amongst the staff," "Communication has really improved," "Staff have been here a long time so know people well." We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. A formal verbal exchange of information took place about all people to ensure staff were aware of the current state of health and well-being of each person. Staff told us the diary and communication book also provided them with information. Staff members' comments included, "Handovers take place between the nurses and senior support workers and the seniors pass the information to the other support workers," "We make sure the staff read the care plans when they come on duty if there have been any adjustments," "We write in the report if someone is feeling down and miserable," and, "Care plans are vital." We did note recent staff meeting minutes for one unit reminded staff to look in the communication book, "as messages were being missed."

Relatives told us they were kept informed by the staff about their family member's health and the care they received. Relatives' comments included, "I'm kept informed about (Name)'s health and if there's any change in their condition," "They (Staff) are very good at keeping me up to date," and, "Staff will let me know about (Name)."

Records showed the health needs of people were well recorded. Information was available in their records to show the contact details of any other professionals who may also be involved in their care. Care records showed that people had access to a General Practitioner (GP), dietician, speech and language therapist and other health professionals. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. For example, the psychiatrist and mental health team. One person commented, "The doctor would be called if I had a problem."

We spoke with the General Practitioner and the specialist nurse who were responsible for the clinic that took place at the home each week. They told us it had started

approximately six weeks previously and was working well. Both said staff were caring and communication was good. We saw they had their own consulting room at the home but they told us they also visited people in their bedrooms when required. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us three applications were authorised and other applications were in the process of being completed for people. More training was being provided for staff to ensure the assessment process was understood.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. Records contained information about the best interest decision making process, as required by the MCA. Best interest decision making is required to ensure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Information was available to show if people had capacity to make decisions and to document people's level of comprehension.

We were informed an application was made to the Court of Protection with regard to a person who needed support in relation to decision making. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused to receive assistance with personal care.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. The chef told us they received information from nursing staff when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce.

A four week menu was in place and an alternative to the main meals was available. For example, on the day of inspection lunch was, tomato soup, followed by poached cod in parsley sauce with vegetables or macaroni cheese and grilled tomatoes and apple pie and custard or ice cream. We saw the food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received "excellent" food. Their comments included, "The food is lovely", "I can have cooked breakfast every day if I want, you just can't grumble about the food here or the restaurant," "Not bad as food goes, I don't eat as much as I used to," and, "I have good food." Hot and cold drinks were available throughout the day. We saw arrangements were in place so people could also get their own drinks and snacks from the kitchen on each unit as they wanted.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts to monitor people's daily food and fluid intake.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were all positive about the care provided by staff. Comments included, “Staff are marvellous,” “Staff make you feel so welcome,” “I can ask for anything,” “I’m very happy here, the people are lovely,” “It’s a homely place,” “I love being here it’s like being part of a big family,” ”I have a very happy relationship with the carers, they are all very polite, I don’t know how they keep it up all day,” “Staff are all very jovial and friendly,” “Mother Superior says we all live as a family here,” “Staff will come when you want them, they’re efficient in that way,” “It’s really nice here, I have everything I want and I think I am very lucky to live here,” “I have good company, good food and warmth, the carers and residents are my friends,” “The staff are fantastic they couldn’t be more helpful, I haven’t seen a grumpy face around,” and, “It’s very good here.” A relative commented, “(Name) is being very well looked after,” “They even do the laundry and it comes back perfect.” A volunteer commented, “I used to visit a relative here and as I enjoyed visiting so much I’ve come back as a volunteer.” Several cards of appreciation from relatives were also very positive about the care and compassion shown by the staff. A comment included, “There are no words to express to you and the community how much I thank God and you for the loving care you gave to (Name).”

We observed the atmosphere was calm, relaxed and tranquil. We saw staff engaged with people in a quiet and compassionate way. People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people appeared relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, when they offered assistance to people as they moved to the dining table for lunch or when a staff member offered a person a choice of drink at coffee time.

We saw that care was provided in a flexible way to meet people’s individual preferences. For instance, people told us they could have a bath when they wanted, they could choose where they wished to eat and they could get up and go to bed when they wanted. One person said, “I like to get ready for bed quite early and watch television in my room, staff will bring supper to me in my room.”

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people’s needs and preferences which showed they knew people well.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Staff treated people with dignity and respect. We saw they knocked on people’s doors before entering their rooms and staff ensured any personal care was discussed discreetly with people. We observed that people looked clean and well presented. One person commented, “The staff are very fussy, if I have a stain on my blouse they will offer to help me get changed.” Some people sat in communal areas but most preferred to stay in their own room. Some people had their doors open and we saw staff stopped and had a chat as they passed by. A relative had commented in a recent card of appreciation, “What impresses me is the way staff treat everyone with dignity. It is heart-warming to see.”

We observed the lunch time meals on the units and in the restaurant. In all areas the meal time was relaxed and unhurried. In the restaurant the atmosphere was pleasant with a ‘buzz’ of conversations taking place between people. On the units where some people had their meals televisions were turned off, with people’s permission, and relaxing background music was played depending upon people’s preferences. For example, in one dining room the music was more contemporary to another where classical music was played. People sat at tables set with tablecloths, napkins and condiments. Specialist equipment such as cutlery and plate guards were available to help people. People sat at tables set for three or four and staff were available to provide help and support to people. Staff addressed people by their preferred name or title. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to

Good

Is the service caring?

eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served. People were served a three course meal that looked appetising. Staff worked well together and they did not appear rushed. The plates were cleared before serving the main course and staff asked people if they had finished before their plates were removed.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told no one at the service was using an advocate as most people had relatives. Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. The registered manager told us if necessary a more formal advocacy arrangement would be put in place. Advocates can represent the views of people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

Care was provided from a large, vibrant yet serene environment which had many facilities for people to use. A chapel was on the premises and daily mass took place that people could attend, supported by staff if required. If people were unable to attend the 'live' mass it could be played on television in their room if they wished to follow it. Arrangements were in place so people were able to receive 'Holy Communion' if they could not get to chapel. A tea/ coffee bar was available that provided drinks each day in the morning and we observed many people congregated there with their friends and visitors after mass. One person commented, "I visit other residents and enjoy meeting friends in the dining room." The home was similar to a hotel in some respects and the atmosphere was easy going with people moving around the home as they wished. For example, people could choose to eat in the restaurant or remain on the unit and have a meal in the kitchen or dining room or in their bedroom. There was a craft room, several lounges, a shop and a well–stocked library with a wide range of fiction and non-fiction reading materials. There were large, well-maintained gardens where a balcony and decking area had also been created.

People confirmed they had a choice about getting involved in activities. An activities board on the ground floor advertised sessions for the week that included poetry recitals, baking, sensory sessions, tasting and smelling, arts and crafts, yoga and choir practice. Other activities included, board games, quizzes and pamper sessions. Regular entertainment was available which included singers and concerts. A mini bus was available and when the weather was fine trips had taken place to Alnwick, the coast and country. An activities organiser was available during the week and volunteers carried out activities when they were not available. Most people commented there was plenty to do if they wanted. Peoples' comments included, "I have been out on a few day trips, we went dancing once," "There's plenty to keep you entertained and lots of birthday parties," and, "The carers take me to town fortnightly, but I can come and go as I please." One person commented, "There isn't much going on at week-ends." We discussed this with the registered manager who acknowledged the volunteers and activities person were not available at week-ends. They said it would be addressed to ensure some activities were available at that time.

The activities organiser told us of other links with the community whereby local university and school children volunteered and carried out beauty sessions, sat and talked individually with people and baked cakes with people if they wanted to be involved.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, activities of daily living and moving and assisting needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, wound care, mobility and falls and personal hygiene.

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "I like one Weetabix and six or seven prunes," and, "(Name) likes a glass of wine at night."

Although care plans were in place and detailed people's care and support needs they were not all consistently written to give staff specific information about how the person's care needs were to be met. Some of the care plans were not broken down to give staff information about instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not all detail what the person was able to do to take part in their care and to maintain some independence. However, because staff knew people well, they were able to deliver care in the way the person wanted. The registered manager told us this would be addressed. Care plans were up-to-date and they were reviewed monthly and on a more regular basis, if a person's needs changed. Staff told us they were responsible for updating designated people's care plans.

Good

Is the service responsive?

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Detailed information was available to help staff provide care and support. This was important when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information about their life history, likes and dislikes which gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. It was also respected if people did not wish to share information about their previous life. For example, one person's care plan stated, "If (Name) chooses not to share information about themselves it is up to them." Information was also available with regard to their wishes for care when they were physically ill and to record their spiritual wishes or funeral requirements. This information was important as well as the health care information that was available about people's wishes at this important time in their lives.

Regular meetings were held with people who used the service and their relatives. The registered manager said meetings provided feedback from people about the running of the home. July 2015 meeting minutes showed the discussions about the evening menus and the suggested action taken to improve them. We saw later menus incorporated peoples' suggestions for the evening meal. We saw the meetings were an opportunity for people to give feedback about the care they received. Comments from people included, "A vote of thanks for the alterations that have been carried out around the home."

People said they knew how to complain. Comments included, "I know how to, but I haven't needed to." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and we saw no complaints had been received since the last inspection.

Good

Is the service well-led?

Our findings

A registered manager was in place who had been registered with the Care Quality Commission (CQC) since 2011.

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. The culture promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making. Comments from people and other professionals included, ""Brilliant leadership," "Care is compassionate," "Real sense of community", and, "Person-centred care."

The registered manager did not run the home in isolation but encouraged people's links with their religion and former lives if they wished. We were told of an inter-generational project they had encouraged within the home to link the youth of the local communities and older people. It recognised older people, as valued members of society, had a wealth of experience to share with younger people. The registered manager had encouraged the home's links with a religious initiative within the Catholic diocese looking at the future of the traditional Catholic community due to the reduction in the number of vocations to the priesthood. Younger people visited the home to hear people's views and experiences and arrangements were being made for people from the home to visit the 'youth village' to meet younger people who shared the same Catholic values. Therefore people were encouraged to give their views and ideas about the future and to remain part of a community which they had belonged to before they moved into the home.

The atmosphere in the service was friendly. Staff said they felt well-supported. Comments included, "I feel well-supported," "We work as a team," "Mother (registered manager) is always available," and, "The manager has been to see me at night, when I was on duty."

Staff told us staff meetings took place monthly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed health and safety, risk assessments, medicines management and the needs of people who used the service. Meeting minutes were made available for staff members who were unable to attend meetings. Three monthly health and safety meetings took place with representatives from different departments.

We were told regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Records showed a person who had fallen more than twice was referred to the falls clinic. Significant incidents and accidents were also discussed and audited at health and safety meetings in case other action was required. For example, any changes to the environment.

Records showed audits were carried out regularly and updated as required. Daily audits included checks on medicines management. Weekly checks also took place that included health and safety, environment, fire safety and documentation. Monthly audits were carried out and they included health and safety, documentation and risk awareness. The registered manager told us a separate audit was carried out by a staff member from the compliance department of the organisation to provide an independent view of the service. Their two monthly visit was to audit a sample of records, such as care plans, health and safety documentation, laundry, kitchen and staff files. They also spoke to people and the staff regarding the standards in the service. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. The human resource person told us an annual audit of human resource files took place.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and visiting professionals. Surveys results were available for 2015. Findings from the survey were positive. Comments included, "(Name) couldn't be in a better place. Has made friends and remains incredibly happy," "We (family) are delighted with all aspects of care provided by St Josephs," "We cannot thank everyone enough for the care my mother receives. It is exemplary," and, "Extremely clean, never any unpleasant odours."