Bewick Waverley Limited

Waverley Lodge Care Home

Inspection report

Bewick Crescent
Lemington
Newcastle Upon Tyne
NE15 8AY
Tel: 0191 490 0901
Website: www.fshc.co.uk

Date of inspection visit: 18 and 20 May 2015
Date of publication: 17/07/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

We carried out an inspection of Waverley Lodge on 18 and 20 May 2015. The first day of the inspection was unannounced. We last inspected Waverley Lodge on 9 April 2014 and found the service was meeting the relevant regulations in force at that time.

Waverley Lodge is a care home providing accommodation with nursing and personal care for up to 45 people. The service is primarily for older people, including people living with a dementia related condition. At the time of the inspection there were 25 people accommodated there.

The service had a registered manager in post, who became formally registered with CQC in May 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.

Summary of findings

People told us they felt safe and were well cared for. Staff knew about safeguarding vulnerable adults. The one alert we received since 2014 had been dealt with appropriately, which helped to keep people safe.

We observed staff provide care safely and found staff were subject to robust recruitment checks, although proof of care qualifications had not been obtained for one worker. Arrangements for managing people's medicines were generally safe, but we found recording and stock control errors. The storage of a hoist and use of the down-stairs dining room required review due to the large amount of adapted chairs and wheel chairs in use. The home was noted to be clean and free from offensive odours. The use of a sluice room for storage did not promote good infection control practice.

As Waverley Lodge is registered as a care home, CQC is required by law to monitor the operation of

the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for a DoLS. Staff obtained people's consent before providing care. Arrangements were in place to assess people's mental capacity and to identify if decisions needed to be taken on behalf of a person in their best interests.

Staff had completed relevant training for their role and they were well supported by the management team. Training included care and safety related topics.

Staff were aware of people's nutritional needs and made sure they supported with eating and drinking where necessary. People's health needs were identified and staff worked with other professionals to ensure these were addressed.

There was an activities worker employed who arranged in house and occasional outside activities. We observed staff interacting positively with people. People using the service and visitors praised the kind and caring approach of staff. We saw staff were respectful and explained clearly how people's privacy and dignity were maintained.

Staff understood the needs of people and we saw care plans were person centred.

People, their relatives and staff spoke well of the new registered manager and felt the service had good leadership. We found there were effective systems to assess and monitor the quality of the service, which included feedback from people receiving care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to medicines, infection control and staff recruitment. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not consistently safe.

People told us they felt safe and secure with the service they received. We found recruitment procedures for new staff had been followed, but qualifications were not always checked. Staffing levels were sufficient to meet people's needs safely. Staff were deployed flexibly.

There were systems in place to manage risks and respond to safeguarding matters. Record keeping and audit arrangement for medicines required improvement.

Requires improvement

Is the service effective?
The service was effective.

People were cared for by staff who were suitably trained and well supported to give care and support to people using the service.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This included policies and procedures and guidance in people's care plans. Support was provided to help people eat and drink where this was needed.

Staff had developed good links with healthcare professionals and where necessary actively worked with them to promote and improve people's health and well-being.

Good

Is the service caring?
The service was caring.

People made positive comments about the caring attitude of staff. During our inspection we observed sensitive and friendly interactions.

People's dignity and privacy was respected and they were supported to be as independent as possible. Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

Good

Is the service responsive?
The service was responsive.

People were satisfied with the care provided. An activities worker was employed to coordinate in house activities and occasional trips out.

Care plans were person centred and people's abilities and preferences were clearly recorded.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Good

Summary of findings

Is the service well-led?

Good

The service was well led.

The service had a registered manager in post. People using the service, their relatives and staff praised their approach and commitment.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service, their relatives and staff. Action had been identified to address shortfalls and areas of development.

Waverley Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 18 and 20 May 2015 and the first day was unannounced. The inspection was carried out by an adult social care inspector 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. The expert had experience of older peoples services.

Before the inspection we reviewed the information we held about the service, including notifications.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home, including observations of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with 12 people who used the service and five relatives. We spoke with the registered manager, an area manager and six other members of staff.

We looked at a sample of records including four people's care plans and other associated documentation, medication records, three staff recruitment files, staffs training and supervision records, policies and procedures and audit documents.

Requires improvement

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe at Waverley Lodge. One person told us, "I feel safe, there seems to be enough staff, they come when I buzz if they are not busy." A relative said "No concerns about safety, really happy with this place all round." Another said "There always seems to be enough staff on." A further comment made to us was, "The girls are OK, there always seem to be enough of them."

We asked staff about safeguarding people from harm and abuse. Staff we spoke with were able to explain how they would protect people from harm and deal with any concerns they might have. They were familiar with the provider's safeguarding adults' procedures and told us they had been trained regarding abuse awareness. This was confirmed by the training records we looked at.

To support the training there were also clear procedures and guidance available for staff to refer to. This provided appropriate explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The registered manager was aware of when they needed to report concerns to the local safeguarding adults' team. We reviewed the records we held about the service and saw the one alert we received in the last year was reported promptly and handled in a way that kept people safe.

We looked at the recruitment records for three new staff members and found most of the documentation and checks required by regulation were in place for these members of staff. Before staff were confirmed in post the registered manager ensured an application form (with a detailed employment history) was completed. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions. We saw one staff member had stated on their application they held a relevant care qualification, however there was no evidence this had been seen as part of the recruitment process, and a copy of this could not be provided to us. It is important that where staff claim to hold certain qualifications these are verified as part of the recruitment process. **This was a breach of regulation 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at medicine storage, administration and recording arrangements. We saw both storage rooms remained secure during the inspection and locked cabinets and secured trolleys were used. A medicines fridge was used to store a small supply which required cold storage. The temperature of this, along with the room itself, was monitored to ensure medicines were stored in line with the manufacturer's recommendations. A supply of eye drops with a limited shelf life had not been dated on opening which meant there was a risk this could be used beyond the manufacturer's recommended time period.

A monitored dosage system (MDS) was used to store and manage the majority of medicines. This is a storage system designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. As part of the inspection we checked the procedures and records for the storage, receipt, administration and disposal of medicines. In the downstairs trolley we found two pots containing medicines that had been removed from the MDS system. We checked the administration records and saw these had been signed as administered. We noted the medication records were generally well presented and appropriately organised. Some staff signatures used to record administration were difficult to distinguish from a code used to record non-administration.

The majority of records seen were accurately complete and up to date, however some were not. We saw hand written entries were either not signed or signed by only one member of staff. This meant there was no evidence of a second staff member confirming these as being accurate. Our check of stocks did not correspond accurately to the medicines records in two cases, however the anti-coagulant and controlled drug stocks we checked were accurate. A medicine which was dispensed by the pharmacist in half tablets was not accurately recorded and stock records were incorrect. We saw a code which required staff to define the reason for non-administration was used, but no explanation had been recorded. We highlighted our findings to the registered manager who acknowledged improvements were needed and assured us

Requires improvement

Is the service safe?

immediate action would be taken to address the shortfalls we identified. **This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We noted the the home was free from offensive odours and observed high standards of cleanliness in the bedrooms and communal areas we viewed. During the two days of our inspection there were two domestics on duty and a laundry assistant. We spoke with one of the domestics, who was able to clearly explain infection control measures and the provider's policy, ensuring staff did not wear excess jewellery and false nails. They showed us the records they kept, which were maintained to monitor what areas of the home had been cleaned. They told us they had guidance to follow to ensure appropriate cleaning products were used for different tasks and also informed us; "We've recently done infection control training from the NHS. It was really good."

We observed a nurse on duty had their hands, wrists and lower arms free from jewellery and clothing, which reflected good infection prevention and control practice. We looked at two mattresses to check they were clean and the protective surfaces remained intact; which they were. The registered manager told us they had conducted a monthly mattress audit to ensure any unsatisfactory ones were identified and disposed of.

We looked in the first floor sluice room, which contained a sluice disinfector and was used to store cleaned commode pots and lids. We saw there were other items inappropriately stored there, such as continence pads, examination gloves, a person's topical medication, toiletries and a TV remote controller. The surface material for the draining rack, used to air dry cleaned items, had degenerated, exposing rusty metal, making it difficult to keep clean. **This was a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Arrangements were in place for identifying and managing risk. We looked at people's care plans and saw risks to people's safety and wellbeing, in areas such as mobilising, falling or choking, were assessed. Where a risk was identified, there was clear guidance included in people's care plans to help staff support them in a safe manner. Risk assessments were also used to promote positive risk taking and maintain people's independence as much as possible.

Staff we spoke with were able to explain how they would help support individual people in a safe manner, for example when helping people when they became anxious or agitated.

We toured the building and saw steps had been taken to maintain safety and minimise risks, such as falls from height, burns and scalds, as well as fire risks. All of the first floor windows we examined had been fitted with replacement window restrictors which could not be easily overridden. This was to ensure the risk of people accidently falling from opened windows was appropriately managed. Many bedroom doors had 'door guard' devices fitted. These were fitted so bedroom doors could be held open, but would then allow the fire protected doors to close should the fire alarm be activated. We tested water temperatures in three bathrooms and one shower. These were all within a safe and comfortable temperature range (39 to 43 degrees Celsius). Staff also kept a record of the water temperature and we saw these were all within this temperature range.

All bathroom and shower areas were clear of excess storage, such as hoists and laundry skips, allowing safe access to the washing and toileting facilities, therefore ensuring there were no trip hazards. However, we saw on the first morning of our inspection a hoist being left in the general corridor near the sitting room (upstairs) at 10am. This was still in the corridor at 1.15pm. Because of it's proximity to the shared toilets was a possible this presented a trip hazard to people using these facilities.

We observed mealtime support, and when people were being moved into the room at lunchtime, we saw there were two people in large support chairs, four in wheelchairs and six in ordinary dining chairs. No one was transferred from wheelchairs into dining chairs and it was difficult to manoeuvre the large chairs through the small room. The kitchen door was propped open by the last table at which two people were sat; one in a large support chair and another in a wheelchair. The wheelchair cut across the open door to the kitchen. This made moving through this area difficult and we saw kitchen staff and carers had to weave their way through. All store rooms were locked to prevent accidental access to hazardous products. We saw the upstairs dining room floor had a non-slip treatment, which further reduced the risk of slips should food or drink be spilt.

Requires improvement

Is the service safe?

We recommend the provider reviews mealtime and equipment storage arrangements to ensure the safe use of equipment.

We were shown fire safety, maintenance and water safety log books. These prompted the handyperson to review the safety of key parts of the service on a regular basis. Checks included regular reviews of hot surfaces, alarm call systems, window restrictors, wheelchairs, tall furniture, and so on. Water temperatures were also checked and water draw down in vacant rooms to reduce the risk of legionella bacteria forming in unused areas of the home.

We spent time during the inspection observing staff care practice. Although busy, we saw staff had time to chat with and build positive relationships with people, in addition to carrying out other care tasks and duties. People using the service and their relatives made positive comments about the staff. Those staff we spoke with expressed mixed views about staffing levels. One staff member said, “When there is two of us on we have a carer for one to one but she might not be able to help us. At mealtimes when the buzzer goes and we need two of us, that leaves no one else.” They went on to express the view, “Not enough of us to do everything, you get called away to the buzzers and you have to leave someone in the middle of helping them eat.” Another staff member said, “We are still safe but getting a bit pushed now, especially upstairs (dementia unit); it is so demanding. There’s not quite enough time to do everything as you should.” In contrast a different worker said’ ”It's OK. Our one to ones (one upstairs one down) are only funded 12:30 to eight, so that will help at mealtimes as we couldn't manage them and the floor.” Another person we asked said staffing levels were safe, although a different worker cautioned, “Up here at the moment it’s ok. If we got more service users we’d need more (staff).”

We spoke with the registered manager about staffing levels. Their view was that staffing levels were safe. They told us about arrangements for monitoring staff levels using a dependency rating tool and indicated staffing levels would be adjusted as occupancy and people’s needs changed. There was a staffing rota in place to help plan staffing cover and this showed there was a consistent level of staffing planned ahead.

Good

Is the service effective?

Our findings

People we spoke with and their relatives made positive comments about the effectiveness of the service, including about the food and arrangements for accessing health care. One person said, “The food is good; well it has to be for me, I used to be in food preparation.” Another person remarked, “The food is OK, I am on a soft diet now, but I would love a steak! You can't really purée that.” A further comment was simply, “The food is fine.” With regard to health care one person said, “I see my GP if I need; all sorts of health people are coming and going.” A relative noted, “The GP comes in if needed, (name) has had a couple of infections but they have been on them pretty quick.” Another relative said, “They are quick at letting me know if there is anything wrong.” Another relative made positive comments about the way staff worked to encourage their family member with personal care and compared this service positively with the experiences at a previous service.

We asked three staff members about the training they had received and looked at how the provider trained and supported their staff. Staff told us about the training they had received and this was confirmed by the records we examined. We found staff were trained in a way to help them meet people’s needs effectively. For example, new staff had undergone an induction programme when they started work with the service. All staff were expected to undertake key training topics at clearly defined intervals. Topics covered included health and safety and care related topics, including dementia awareness elements. One staff member said the on-line training was ‘fine’ but said they would like more face to face training too. Another staff member said, “I enjoy doing the training, I’ve done diabetes and fire training which was taught.”

Staff we spoke with told us they were provided with regular supervision and they were supported by the management team. A staff member told us, “I’m well supported.” Records confirmed regular supervision meetings took place and these provided staff with the opportunity to discuss their responsibilities and to develop in their role. We saw records of these meetings contained a detailed summary of the discussion and also a range of topics had been covered. Staff told us handover meetings were held and key points recorded in ‘hand over’ records. Again, this was confirmed by records we looked at. This process ensured staff were kept well informed about the care needs of the people who used the service.

Staff training included awareness raising of the Mental Capacity Act 2005 (MCA). The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the MCA and the associated Deprivation of Liberty Safeguards (DoLS) with the registered manager. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure decisions are made in people’s best interests. DoLS are part of this legislation and they ensure where someone may be deprived of their liberty, the least restrictive option is taken in a person’s best interests.

Staff spoken with told us they had received training on the DoLS and staff had access to on-line information on the MCA and DoLS.

We looked in three people’s care plans and saw people’s capacity to make decisions for themselves was considered as part of a formal assessment. These were recorded on documentation supplied by the authorising authority (Newcastle City Council).

One of these people was subject to a DoLS. The registered manager had notified us of the outcome of this application.

We looked at how people were supported with eating and drinking. The people we spoke with told us they liked the food provided. We observed the meal time on the first floor and saw staff were attentive and responsive to people’s needs and people were given sensitive assistance to eat their food. One to one support was seen to be carried out by several staff, who engaged with people at the table, making the meal time a social experience. Time was taken to provide explanation when people were assisted with eating. One person who was not able to use cutlery was given finger foods, which ensured they remained independent and minimised spillages. On the ground floor the menus on walls and in the meal rota book did not relate to what was served at lunchtime. People were offered a choice of two courses but not what was displayed. We saw tea trolleys being brought round on both floors. There was a selection of hot and cold drinks, biscuits, little cakes and yoghurt's. People requiring fortified drinks had theirs made up separately from their

Good

Is the service effective?

own tins. There were cups, mugs and appropriate feeding cups. The unit for people living with dementia also had brightly coloured cups and plates. We did not see any fruit, either on trolleys or in the communal rooms. We also did not see any jugs of water or juice in communal areas. There were some jugs in rooms but not all.

People's nutritional needs were assessed and their preferences were individually recorded. We saw advice had been sought from a speech and language therapist about what foods were appropriate for people, for example when they needed a soft diet. The input of the dietitian had also been arranged, where people were at risk of malnutrition. We noted staff had maintained food and fluid charts when people had been assessed as having a nutritional risk. The amount of food and fluid had been totalled to help monitor people's intake and ensure they were receiving sufficient food and fluid.

A kitchen assistant was able to inform us about those people who needed specialised diets, needed thickened fluids or who had particular food preferences.

We looked at how people were supported to maintain good health. Records we looked at showed us people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. People's healthcare needs were considered within the care planning process. We noted assessments had been completed on physical and mental health needs.

From our discussions and a review of records we found the staff had developed good links with other health care professionals and specialists to help make sure people received prompt, co-ordinated and effective care. We saw from looking at people's care files a summary information sheet had been compiled, which provided information about medical conditions and a description of needs. The sheet was provided to hospitals on admission to effectively communicate people's needs and wishes and to ensure continuity of care.

Good

Is the service caring?

Our findings

People using the service and their relatives told us they were treated well. People were observed to be relaxed and comfortable and they expressed satisfaction with the service. One person told us, “They look after us; the girls are kind.” They went on to say, “My family can come in, no problem.” A relative said, “We are very happy with this place, we looked at a couple of homes but (our relative) preferred this one. The girls are very caring, very good to them. I am happy with my relative being here, I can come and visit any time, I work shifts and sometimes I come in at eight or nine at night, but I can still visit.”

We observed many gentle and caring interactions between staff and people using the service. Staff were accepting hugs or kisses from residents and used touch appropriately to provide reassurance and help people feel calm and valued. Staff appeared to know all the likes and dislikes of the people using the service, such as at meal times. Staff seemed to know everyone by name and spoke with people gently and calmly. We saw thank you cards had been posted on a notice board, expressing people’s gratitude at the care provided by staff.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. Staff were knowledgeable about people’s individual needs, backgrounds and personalities. They explained how they involved people in making decisions, such as when drafting care plans, which was confirmed in the records we looked at. We observed people being asked for their opinions on matters, such as meal choices and they were routinely involved in day to day decisions within the service.

On arrival we saw two people’s care files were left out in a downstairs lounge as staff had been working on updating people’s care records. When we returned shortly afterwards these had been removed to ensure confidential information was not accessible to others.

People said their privacy and dignity were respected. We saw people being prompted and encouraged considerately. Staff were observed to be consistently attentive, friendly and respectful in their approach. We did not observed any instances of people receiving personal care within public areas. Staff we spoke with were able to clearly explain the practical steps they would take to preserve people’s privacy, for example when providing personal care and knocking and awaiting a reply before entering a person’s room.

Good

Is the service responsive?

Our findings

We asked people and their relatives whether the service was responsive to their needs, whether they were listened to and if they had confidence in the way staff responded to concerns and complaints.

A relative said, “I’ve never had to complain.” They went on to discuss a care issue raised with the manager and concluded, “They had to get the GP in to get it right, but they did it and it's alright now.” Another relative said “It's better than it used to be; a lot cleaner. We were not so sure at first but we are happier now.” Another person said, “The new manager is very approachable, they tell us everything.”

We observed several instances of staff being responsive to people’s various requests, such as when using their call alarms and when they were mobilising (moving around) or becoming agitated. Other aspects of the service were responsive, and a relative told us they felt involved in the provision of care; confirming communication between staff and family was good.

We looked at a sample of people’s care plans to see how staff identified and planned for people’s specific needs. We saw a needs assessment was received from the local council’s social work staff, and people’s needs were assessed before a service was provided. From the information outlined in these assessments individual care plans were developed and put in place to ensure staff had the correct information to help them maintain people’s health, well-being and individual identity.

Care plans covered a range of areas including; diet and nutrition, psychological health, personal care, managing medicines and mobility. We saw if new areas of support were identified then care plans were developed to address these. Care plans were reviewed regularly. Care plans were sufficiently detailed to guide staffs care practice. The input of other care professionals had also been reflected in individual care plans and these documents were well ordered.

To monitor people’s needs, and evidence what support was provided, staff kept daily progress notes. These offered a detailed record of people’s wellbeing and outlined what care was provided. Staff also completed a daily handover record, so oncoming staff were aware of people’s health and immediate needs and forthcoming appointments. We looked at records of care plan reviews and saw comments were meaningful and useful in documenting people’s changing needs and progress. The language used was factual and respectful. Records also focussed on people’s strengths and were positively worded.

We spoke to staff about personalised care. We found staff had a good knowledge of the people using the service and how they provided care that was important to the person. The staff we spoke with were readily able to answer any queries we had about people’s preferences and needs.

We saw visitors coming and going freely, which meant people were not isolated. Visitors appeared to know staff well and were made to feel welcomed. There was an activity worker employed who said, “We have a minibus every Thursday though that is limited. We have a trainer in chair exercises once a fortnight and entertainment when we can.” We observed items to touch on walls upstairs and appropriate pictures and reminiscence items such as wartime memorabilia and films from the post war era. Downstairs there were newspapers and games for people to use.

We looked at the way people’s views were sought and complaints managed. People using the service and their relatives told us they were aware of whom to complain to and expressed confidence that issues would be resolved. Most said they would speak to the registered manager or a nurse if they had any concerns. A copy of the complaints procedure was clearly available in a public space. We reviewed the records of complaints received and saw there was one complaint received which was in the process of investigation.

Good

Is the service well-led?

Our findings

People we spoke with told us they were happy at the home and with the leadership there. A relative said, “It has improved a lot recently. The new registered manager has made a difference, you see her about and you can talk to her, the staff seem happier too.” Another relative said “The girls are caring, the management is very approachable.” A care worker said, “I love working at this place but sometimes it's hard to enjoy working when your flat out.” Staff told us the service was, ‘well managed’ and praised the manager for her open style and changes they had made. A staff member said to us, “You can speak with the manager. I’d recommend it here.” Another described the registered manager as ‘approachable’ and the service as ‘well managed.’

At the time of our inspection there was a registered manager in place. Our records showed they had been formally registered with the Commission in May 2015. The registered manager was present and assisted us with the inspection. They walked round with us for part of the inspection and appeared to know the people using the service, their relatives and the staff well. Records we requested were produced for us promptly. The registered manager was able to highlight their priorities for developing the service and was open to working with us in a cooperative and transparent way. They were clear about their requirements as a registered person to send CQC notifications for notifiable events.

The registered manager told us their philosophy for the home was to develop care that was person centred and to create ‘a nice and homely environment, for people to be treated with dignity and respect.’ The registered manager stated they were keen to encourage staff to work on people’s life stories. This was to help staff understand more about the people using the service and to get relatives involved in the care. The registered manager also highlighted that staff were attending Pearl training (Positively Enriching and Enhancing Residents' Lives); a model of specialised dementia care training, focusing on people’s experience of care. The registered manager highlighted their commitment to encourage staff learning and they told us about links which had been developed with the local ‘Tyne and Wear Care Alliance’ as well as those with clinical practitioners to obtain training, advice and support for staff in areas such as oral health and eye care.

We saw the registered manager carried out a range of checks and audits at the home. We also saw that they reported back to the provider organisation via an ‘on-line’ system on a regular basis. Reports, detailed any complaints or compliments received, incident reports or accidents, sickness levels and staff training completed. We looked a recent customer satisfaction survey. We saw practical steps had been taken to address areas for improvement suggested by the respondents, such as those relating to the building. We saw 92% of people would recommend the home and the remaining 8% were undecided. The registered manager told us, and people confirmed, they regularly walked around the home to check on things and see how people were.

The registered manager told us since they had taken up post there were a range of meetings either recently progressed or planned. These included relatives meetings, a health and safety meeting and a quality and clinical governance meeting. Care staff confirmed a meeting was also planned for them in the near future. We saw copies of minutes from some of these meetings, although some were waiting to be typed up.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not complied with the proper and safe management of medicines. Regulation 12(2)(g).** **The registered person had not assessed the risk of, prevented, detected and controlled the spread of infection, including those that are health care associated. Regulation 12(2)(h).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The following information was not available in relation to each person employed – information specified in Schedule 3 (6).**