Premier Care Homes Limited

Picktree Court Care Home

Inspection report

Picktree Lane
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County Durham
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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

We inspected this service over two days on 2 and 3 March 2015 and the inspection was unannounced.

Picktree Court Care Home is registered to provide accommodation, nursing and personal care for up to 88 people. The service is set over three floors and is situated in its own grounds in Chester le Street on the outskirts of County Durham. At the time of our inspection there was a registered manager 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 who used the service, their relatives and friends told us they were happy and safe in the home. One of the people who used the service said, "Safe, why should I not feel safe. My room is warm and lovely and the staff are so

Summary of findings

nice" and the relative of another told us, "This is a good home. We had a good look around before [relative] came here and we were impressed with all aspects of the place".

There was clear guidance for staff on how to identify signs of abuse and how staff could report concerns. In addition we saw information regarding safeguarding on display in staff offices and were told by the registered manager that safeguarding was discussed during all staff supervisions and appraisals.

The registered manager showed the service was pro-active in terms of safeguarding and not only made appropriate notifications in relation to concerns within the service but also provided evidence of safeguarding concerns in relation to people who had received care from others.

The provider had policies and procedures in place for the storage and administration of medicines. We saw policies included instructions for staff regarding prescribed medicines, when required medicines and homely medicines, and gave staff clear guidance on the handling and storage of these. Medicines were stored in locked trolleys inside staff offices throughout the home with controlled drugs kept in locked cupboards.

We spent time looking around the service and found the service was a modern purpose built home with a high standard of decoration. All corridors were wide and free of clutter allowing people who used the service to move around freely. The entire service including, individual rooms, en-suite bathrooms and communal and public areas were clean and tidy. Specialist equipment was found to be clean and stored in appropriate areas.

All staff in the service had received training in infection prevention and control and an infection control champion was in place. Personal protective equipment was provided to staff and we saw staff used and disposed of this correctly throughout the day.

We found there were two maintenance people employed by the service and they were responsible for ensuring all repairs were carried out within seven days of them being reported. During our inspection we saw work being carried out to repair a blocked pipe which had affected one of the serveries. Although work was being carried out we found protective sheeting was used to ensure dust and dirt were kept to a minimum and people who used the service were not affected.

People who used the service, their families and staff working in the service told us they were well trained. One person told us, "You can't fault the staff" and a family member of another told us, "The staff are skilled at what they do".

The service was pro-active with training and this was provided internally by management, external training specialists, tutors and colleges. The registered manager provided us with the training matrix which detailed all the training staff had undertaken in the previous year as well as the planned training for the next twelve months. Training included mandatory areas like moving and handling, infection control and safeguarding, with additional training in more specialised areas like sensory awareness, preventing falls and fractures, oral health training and verification of death. Staff were also offered the opportunity to complete a National Vocational Qualification (NVQ) in Health and Social Care.

Some of the people who used the service had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. This was a decision made by the individual or their representative in conjunction with a medical professional, to let people know that they did not wish to be revived if they stopped breathing. Where a DNACPR had been completed we saw documents were kept in the person's care file. The registered manager told us the service has a sticker system in place which meant anybody who had a DNACPR in place had a sticker placed on their file which made it easy for staff to identify. We saw there was a diary system in place which was used to ensure updates of DNACPRs were carried out in good time and therefore meant they were renewed before the old ones expired.

We saw some people who used the service had medical conditions which meant they were unable to eat certain foods. Where this was the case we saw details were recorded in care plans. We also saw information relating to people's dietary needs was recorded in the kitchen and all recipes used included details of ingredients used and any potential allergens. This complied with Food Information Regulations which came into force in December 2014.

Summary of findings

The service had good links with the local community and we saw representatives from local churches carried out regular services. Local schools held carol services and the service had a volunteer from the local school that provided assistance to the activities team. In addition to this the service had links with local schools and colleges allowing them to offer work placements. We saw people who volunteered in the service were required to have Disclosure and Barring Service (DBS) checks carried out to ensure people who used the service remained safe.

People who used the service and their families told us staff treated them well and they were happy with the care they received. One person told us, "The home is warm and comfortable and I am well cared for, nothing is a trouble". The relative of one person told us, "They are excellent", another told us, "The staff are very respectful to [relative]".

We looked at the care records of eight people who used the service. We saw care plans were written in an individual and person centred way with detailed information about people's likes, dislikes and preferences. Care records included information about people's histories and their memories of earlier life. We also saw care records included information about people's wishes for the future and what they would like to happen in the event of their death.

Staff working in the service had received training in dignity and respect and we saw people who used the service were treated with respect at all times. Staff were observed asking people if they would like assistance with their meals and when help was requested it was given discreetly with staff sitting next to people and talking to them throughout the meal.

People who visited the service told us they felt welcome and did not feel restricted in the time they were allowed to visit. We saw the provider offered food to people's relatives if they wanted to join their family member for meals and there were a number of areas which people could use, other than their bedrooms, to have private time with their visitors.

Care plans were written and updated with the co-operation of people who used the service, their family or someone else who knew them well. Care plans were comprehensive with individual plans relating to pressure care, bathing, mobility and challenging behaviour, as well as others.

The provider had made arrangements to ensure people with sensory difficulties would be able to communicate with others and would be kept safe in the service. This included induction loops throughout the service, cue cards for people who were not able to communicate verbally and visual and auditory alarms to ensure people were aware if there was an emergency.

The provider had a formal complaints procedure in place and information on how people were able to raise a complaint was in the handbook which was provided to people who used the service and on notice boards around the service.

The provider had clear values and a philosophy of care that was well advertised. People who used the service and their visitors told us the management team were happy to spend time talking with them and was seen walking around the service. One of the people who used the service told us, "I see the manager regularly and he always has a chat". The relative of another person told us, "When I arrive staff always update me on how my [relative] has been and I know what to expect. I usually have a chat with the manager as well".

Throughout our inspection we found there was a calm and relaxed atmosphere in the service. Staff worked in a caring and professional manner and people who used the service were treated in a polite and courteous manner at all times.

We spoke with the registered manager about the quality of the service provided and the building. The registered manager told us the service was decorated to the highest standards and he had invested in a number of different areas to ensure the environment was clean, safe and environmentally friendly.

The provider sought the views of people who used the service, their friends and relatives and staff members by asking them to complete surveys. Annual surveys were carried out and the results analysed and fed back to those who had completed the surveys. Results from surveys also triggered action points which were also included in the feedback.

Summary of findings

The provider was pro-active in promoting improvement and change in the care sector and this was evident by the participation in various different meetings and associations within the care sector. For example the provider is a member of the Registered Nursing Home Association and the County Durham Care Home Association.

The provider had a quality assurance system in place to ensure the care provided and the surroundings of the home were kept to a high standard. Regular room checks were carried out to ensure carpets were clean, lights were working, there was no damage to furniture, carpets or walls and the room temperature was appropriate. Further checks were carried out around the communal areas to ensure the same standards throughout.

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 safe.

People told us they felt safe in the home and staff we spoke with knew how to keep people safe and how to recognise signs of abuse.

Staff were properly trained to administer medicines and there were systems in place to ensure they were dispensed, stored and disposed of safely.

Checks were carried out twice daily to ensure the stock of controlled drugs was correct.

Good

Is the service effective?
The service was effective.

People who used the service, their families and representatives were asked to participate in planning their care.

The service had good links with other healthcare professionals and referrals were made where needed.

The environment was such that people who used the service were able to move around freely without worrying about obstacles.

The provider was aware of his responsibilities in relation to MCA and DoLS and applications were submitted in accordance with legislation

Good

Is the service caring?
The service was caring.

Staff were trained in privacy and dignity and supported people who used the service in a caring and compassionate way.

People and other professionals told us the staff were very caring and helpful.

People's end of life wishes were recorded and staff supported people who used the service and their family and friends in a way that allowed people to have a dignified death.

People who used the service and their visitors had space to spend time privately if they wished.

Information relating to advocates was displayed throughout the service and people who used the service were supported to access these.

Good

Is the service responsive?
The service was responsive.

Staff responded quickly and appropriately to people's needs.

People's future choices in relation to their care were recorded and respected.

The registered provider had a formal complaints process in place and people were supported to make complaints.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led.

The registered provider had clear values for the service and these were evident in the daily running of the service.

The registered provider had a quality assurance system in place to ensure the quality of the service and the surrounding were kept to a high standard and there was continuous improvement.

People told us the registered manager was approachable and spent time walking around the service. There was an open door policy and people were invited to comment on the service and staff.

Picktree Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 and 3 March 2015 and was unannounced. This meant the registered manager and the staff did not know we were coming.

The inspection team consisted of 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. For this inspection the expert-by-experience had expertise in elderly people

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed information we held about the service and the service provider.

This included reviewing statutory notifications submitted by the service, information from staff, members of the public and other professionals who visited the home.

During our inspection we spoke with the families of eight people who used the service, five staff and nine of the people who lived in the service. We also spoke with a GP and one of the healthcare professionals that regularly visited the home. We reviewed records that were part of the provider's quality assurance tool, tracked the cases of eight people who used the service and looked at the files of five staff employed to work in the home.

Good

Is the service safe?

Our findings

People who used the service, their relatives and friends told us they were happy and safe in the home. One of the people who used the service said, “Safe, why should I not feel safe. My room is warm and lovely and the staff are so nice” and the relative of another told us, “This is a good home. We had a good look around before [relative] came here and we were impressed with all aspects of the place”.

People who used the service were kept safe because the provider had practices in place to protect them. For example staff were given a security pass and level depending on their job role and an individual access code which allowed the provider to track that individual throughout the building and keep a record of which doors were used and at what times in the event of a crisis.

These cards also made sure that the senior staff keys (for drugs room, treatment room, CD cupboards) were not lent to other staff ensuring that only authorised access to areas was made. These cards were carried by the staff member which meant they were instantly to hand. This meant that staff were able to respond immediately without having the delay of having to find keys.

We saw the provider had cameras positioned outside lifts. We were later told that there were 40 CCTV cameras in place through the home to ensure security. We were also told that these cameras had been used to prevent crime and to respond to complaints by neighbours.

There were policies and procedures in place which related to safeguarding and the potential abuse of people who used the service. There was clear guidance for staff on how to identify signs of abuse and how staff could report concerns. In addition we saw information regarding safeguarding on display in staff offices and were told by the registered manager that safeguarding was discussed during all staff supervisions and appraisals. The provider told us they had developed and implemented safeguarding incident forms which allowed safeguarding incidents to be accurately recorded, responded to and reviewed to ensure best practice was achieved. They told us they felt that these safeguarding forms made staff think about the outcomes and any potential need for change and went far beyond merely recording the incident. We were also told that any “potential incident” was also recorded to ensure management were kept abreast of daily life within the Home. The provider thought that having clear communication channels led to clearer and better communication and found that since the introduction of both of these forms the home and staff were more proactive in reviewing incidents and creating management plans to minimise the chance of the same problem occurring. The provider told us that staff at Picktree Court took a robust and proactive stance in all safeguarding areas to protect the safety of the residents. These safeguarding referrals included referrals associated with NHS discharges, NHS care, Clinical Commissioning Group commissioning practices, Durham County Council equipment provision, North East Ambulance Service responses and communications, 111 service and Out of Hours service.

The registered manager showed the service was pro-active in terms of safeguarding and not only made appropriate notifications in relation to concerns within the service but also provided evidence of safeguarding concerns in relation to people who had received care from others. For example one person had been transferred from another care service and the way in which the transfer had been made resulted in the person being put at risk. The registered manager made a formal complaint to the other service and a referral to the local safeguarding authority. In addition steps were taken to ensure the person was made safe and risks relating to the transfer were minimised

We spoke with five staff employed in the service and found they were all able to identify different types of abuse and tell us in detail how they would report any suspicions of abuse. We looked at the files of five staff employed in the service and found all of them had received training and regular updates in safeguarding. All these things meant people were protected from potential abuse because staff were trained to recognise the signs.

We spoke with the registered manager about the use of restraint and asked about the policy the service had in relation to this restraint. We were told by the registered manager restraint was never used in the service and staff had been given training in alternative ways to deal with behaviour that challenged the service. This meant people were protected from the risk of harm because physical interventions were not used.

We looked at the provider’s recruitment and selection policy and found prior to starting work in the service, potential staff were required to complete an application form which covered education and employment histories

as well as qualifications and experience. In addition people were required to attend an interview and give the names of two people who could provide a reference. We saw references were obtained and verified and comprehensive notes were kept of interviews. Where people were offered employment in the service a Disclosure and Barring Service (DBS) check was carried out. DBS checks are carried out to help the provider keep people who use the service safe and to ensure that people were not barred from working with vulnerable adults. We also saw evidence of new staff being subjected to a probationary period which was reviewed after three months when a decision was made to end or extend the probation, or even terminate the person's employment.

The registered manager told us a dependency tool was used to assess the number of staff required to meet the needs of people who used the service. This was used in conjunction with the registered manager's personal knowledge and experience and input from staff working the floors so that dependencies were correctly allocated and aligned with staff skills. This meant additional staff were brought in to provide assistance where people's care needs were higher. Staffing levels were regularly reviewed to ensure changes to people's needs were managed. We were shown how staffing levels had been calculated and for the month of February we saw that the care hours required meeting people's needs were 506 however, an additional 243 hours had been provided. During our visit we noticed that there were plenty of staff visible and we observed them inter relating well with the people who lived at the home. The provider also told us that staff had to clock in for duty with their unique hand print. This allowed the provider to audit proposed staff levels against actual staffing levels and eradicate any short falls and provide a clear audit trail as to who was on duty at any one time.

The provider had policies and procedures in place for the storage and administration of medicines. We saw policies included instructions for staff regarding prescribed medicines, when required medicines and homely medicines and gave staff clear guidance on the handling and storage of these. Medicines were stored in locked trolleys inside staff offices throughout the home with controlled drugs being kept in locked cupboards. We looked at the Medicine Administration Records (MARs) and found they had been completed in accordance with guidance and records were accurate. Stock levels of controlled drugs were checked twice daily by two members of staff and a record of the medicines in stock was recorded in the controlled drugs book. We looked at the topical medicines and liquids that were held and found these were dated to show staff the date items were opened and this in turn meant they were able to ensure items were not used past their expiration date. We looked at the open stock and saw it was all within its expiration date. The provider showed us examples of audit tools used which identified that the deputy manager and care supervisor were required to regularly complete thorough reviews and audit checks of the medication process and procedures. These included stock checking, missing signatures, transcribing systems, stock returns and compliance with policy and current legislation and best practice. We also saw that risks were assessed for one person living at the home who chose to manage their own medicines ensuring that they retain some independence.

We spent time looking around the service and found the service was a modern purposed built home with a high standard of decoration. We were told that the building was zoned from a design perspective. This allowed safe disconnection of water, electric and gas to specific and discreet areas. This meant that in the event of an emergency or planned maintenance people living at the service need not be subjected to loss of power or electric as isolations were completed in small areas as appropriate, leaving people in the remainder of the building free to enjoy full access. All corridors were wide and free of clutter allowing people who used the service to move around freely. The entire service including, individual rooms, en-suite bathrooms and communal and public areas were clean and tidy. Specialist equipment was found to be clean and stored in appropriate areas. We were told that the home had both auditory and visual fire alarms and a mist suppression system in place. Having both auditory and visual systems in place would benefit people with different sensory impairments. The provider told us that the fire safety systems were highly praised by the local fire brigade and were described as 'in excess of the norm.'

The home had a number of measures designed to manage and minimise the spread of infection including separate washing machines and driers for soiled and infected items. Each floor of the building had a laundry area which housed coloured laundry bags which enabled staff to separate people's clothes, bedding and soiled linens and put them into a laundry chute to the basement. All dirty linen was washed on special sluice cycles which cleaned and

Good

Is the service safe?

disinfected. This meant the risks of contamination being transferred between materials was minimised. All staff in the service had received training in infection prevention and control and an infection control champion was in place. Personal protective equipment was provided to staff and we saw staff used and disposed of this correctly throughout the day.

We found there were two maintenance people employed that provided seven day a week cover. They were responsible for ensuring all repairs were carried out within seven days of them being reported. This meant that the service was able to ensure that repairs were responded to immediately reducing the impact of broken or malfunctioning equipment on people who lived or worked at the home. During our inspection we saw work being carried out to repair a blocked pipe which had affected one of the serveries. Although work was being carried out we found protective sheeting was used to ensure dust and dirt were kept to a minimum and people who used the service were not affected

We looked at the care records of eight people who used the service and found they all contained risk assessments that were directly linked to care plans. Where a potential risk was identified an appropriate risk assessment was carried out to determine how to manage the risk while allowing the person to maintain their independence. For example one person had difficulty swallowing their medicines but they wished to continue taking the medicine in the prescribed format. We saw, as part of the risk assessment, evidence that advice had been sought from medical professionals and an agreement was reached that the person was able to take their medicine with a spoon full of yoghurt, which it was believed would assist the person to swallow the medicine more easily.

People who used the service were given the option of having a staff assistance pendant. This was worn around people's necks and gave people the ability to summon staff help whenever and wherever it was needed. This meant that help was able to be summoned easily at all times and it also enabled people to be independent of the call bell system.

All of the people who used the service had emergency evacuation plans in place. Plans were used to assist staff and emergency services to effectively organise the evacuation of the service and gave information which related to people's individual mobility needs and the level of assistance they would require, any mobility aids and any other relevant information. For example one person was found to have behaviour that may challenge the service and would respond better if a member of staff were to assist them.

We saw there was a whistleblowing policy in place which meant staff were able to raise concerns about other staff and their practices. We asked staff if they were aware of the whistleblowing policy and if they knew how to raise a concern. Staff told us they did know of the policy and believed any concerns would be quickly and properly dealt with by the registered manager. We saw evidence that a member of staff had previously raised concerns and this had resulted in an investigation being carried out.

We also found the registered manager had raised concerns with Care Quality Commission regarding someone who had been supplied by an employment agency to work a shift in the service. This meant staff were supported to raise concerns without fear of persecution or reprisals.

Good

Is the service effective?

Our findings

People who used the service, their families and staff working in the service told us they were well trained. Comments made included, "You can't fault the staff", "The staff are skilled at what they do" and "As far as I am concerned the staff are skilled at what they have to do and are very respectful to my dad".

Staff working in the service were provided with training in order to help them carry out their roles effectively. The registered manager told us staff were required to complete an induction when they started working in the service. Staff inductions covered a minimum period of twenty hours; these hours were supernumerary meaning that training hours did not detract from care hours provided. The induction process was based on 'skills for care' induction principles but adapted to give a more in depth and personal approach. Potential staff were required to pass their induction and sign an acknowledgement to say they have completed the induction and understood their role and the aims and objectives of the service.

The service was pro-active with training and this was provided internally by management, external training specialists, tutors and colleges. Specialist training was provided by a local hospice and NHS personnel including district nurses and GP's. The registered manager provided us with the training matrix which detailed all the training staff had undertaken in the previous year as well as the planned training for the next twelve months. Training included mandatory areas like moving and handling, infection control and safeguarding, with additional training in more specialised areas like sensory awareness, preventing falls and fractures, oral health training and verification of death. Staff were also offered the opportunity to complete a National Vocational Qualification (NVQ) in Health and Social Care. Staff we spoke with confirmed they had received training and told us if they wanted to undertake other training that would help them carry out their role more effectively they would speak to the registered manager. We looked at the files of five members of staff and found they all contained certificates to show training had been carried out. We also found evidence of training being regularly updated. Some of the people who used the service had difficulty with communication and vision. In order to ensure people were cared for in an appropriate way staff were offered additional training associated with these specific needs. This included basic sign language and awareness of visual and hearing impairments. All these measures meant staff were properly trained to carry out their roles and to meet the diverse needs of the people who used the service. Regular updates were provided ensuring staff were using the most recent guidance. The provider told us that staff were encouraged to plan their future professional development with senior staff being put forward for team leadership NVQs on top of their NVQ 3. Staff were not encouraged to do training work when on shift as this was felt to detract from care hours on that shift which would reduce the quality of care provided to people.

The registered manager told us staff working in the service had regular supervisions and appraisals. We found the registered manager had scheduled time for four supervisions throughout the year and these included discussions with staff, observing practice and group sessions. The staff files we looked at contained detailed information relating to the supervisions held and any improvements required. Appraisals were held annually and were used to discuss staff performance over the previous twelve months and what aspirations they had for the year ahead.

The provider told us that they regularly reviewed notices and communications from organisations such as National Institute for Health and Care Excellence (NICE) and Care Quality Commission (CQC). The provider was also a member of the Registered Nursing Home Association (RNHA) which they said was a valuable source of relating to issues that were in vogue and best practice consideration.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We spoke with the registered manager about MCA and DoLS. The registered manager was aware of their responsibilities and told us that all staff received training in these areas and were aware of people's rights in respect of both. We saw evidence that applications had been submitted in relation to DoLS and authorisation for the deprivation of people's liberty.

Care plans included information regarding DoLS and there was also evidence of mental capacity assessments being

carried out. Where people were found to lack capacity we saw evidence that discussions regarding care were held with family, friends or advocates in order to establish what was in the person's best interest. For example one person who was deemed to lack capacity was able to have a flu vaccine however this could not be given without consent and therefore a discussion was held with a family member in order for them to decide if this was reasonable. The decision was recorded in the person's care file and the appropriate consent was obtained allowing the administration of the vaccine. The provider gave us an example of how the home was part of a review where a person living at the home and subject to a DOL authorisation, was able to have this removed and be facilitated back into the community to live the life they wished to live. This process was only able to be completed once it was agreed that the plans and structures were in place for the person to be safe. This process involved overnight stays, week holidays and required the co-operation of staff and management .This demonstrated that the staff and management of the home had worked closely with other healthcare professionals to ensure that the goals of a person living at the home had been achieved.

Throughout the day we saw staff interacting with people who used the service. We saw staff asked people if they would like help with tasks and also what help they would like. For example, one person was walking to the dining room and we saw a member of staff asking, "Can you manage or would you like me to help?" This meant people were given the choice about receiving help.

We looked at the care files of eight people who used the service and found they contained care plans which had been written with direct input from them or their representative. Care plans contained detailed information which allowed care staff to understand the needs of the people they supported. For example, all care files contained information relating to people's bathing preferences which included water temperature, toiletries, time of day and the sex of the person assisting them. Some of the people who used the service had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. This was a decision made by the individual or their representative in conjunction with a medical professional, to let people know that they did not wish to be revived if they stopped breathing. Where a DNACPR had been completed we saw documents were kept in the person's care file. The registered manager told us the service has a sticker system in place which meant anybody who had a DNACPR in place had a sticker placed on their file which made it easy for staff to identify and ensure that peoples wishes were followed. We saw there was a diary system in place which was used to ensure updates of DNACPRs were carried out in good time and therefore meant they were renewed before the old ones expired.

The registered manager had made arrangements for people who used the service to access other healthcare professionals like podiatrists, dentists and opticians. Regular visits were scheduled to ensure people's wider healthcare needs were monitored. In addition we saw the service had close links with the local GP and visits were carried out daily by a member of the practice. We spoke with a GP who was visiting the service on the day of our inspection. We were told the registered manager and members of the practice worked closely to give people the best service. The GP we spoke with told us one of the biggest problems they faced was not having access to people's medical records and in order to give a more effective service they were working together to establish secure computer access that would allow GPs to access these. The provider told us that the GP service was being offered and had accepted the home's offer for securing access to people's NHS medical records (EMISWEB) while on site at Picktree Court. This would allow

GPs to remotely check results of samples and review medical histories. Picktree Court also had a community matron aligned to the home to supplement and support the GP service. The home had also implemented regular meetings with the GP practice and local pharmacy to streamline the ordering process for people's medicines. The provider told us they had managed to achieve a one week saving in the ordering process, which in turn reduced waste, ordering times and ultimately led to a reduction of missing medications. This process had required a change in system for the surgery, the pharmacy and the home.

We looked at the menus of meals the service provided and found they offered people choices which were healthy and nutritious. We saw some people who used the service had medical conditions which meant they were unable to eat certain foods. Where this was the case we saw details were recorded in care plans. We also saw information relating to people's dietary needs was recorded in the kitchen and all recipes used included details of ingredients used and any potential allergens. This complied with Food Information

Good

Is the service effective?

Regulations which came into force in December 2014. These regulations mean information must be available for all meals and allergenic ingredients. We also saw evidence that people were referred to dietitians or speech and language therapists if there was a concern about their weight or they had problems swallowing. Where referrals were made we found the provider had acted on the recommendations made and provided people with fortified or soft diets to ensure people received the correct care and their weight was appropriately managed. Catering staff had been trained via Durham County Council's Focus on under-nutrition team. The training covered fortification, soft / pureed diets, presentation of food and understanding risk categories for residents.

People who used the service were encouraged to eat their meals in the dining rooms however if preferred they were able to eat their meals in another area During meal times we saw food was transported from the kitchen to individual serving areas on each floor via dedicated lifts. The trolleys that were used to transport the food were plugged in when they reached the correct floor in order to keep meals hot. We saw people who used the service had chosen their meals from the menu the previous day but prior to serving staff asked people if they were still happy with their selection. We saw that those people who required help with eating were given that support. Food served was of a good portion size and looked appetising. We saw that people who chose to eat in their rooms had trays taken to them however; we noticed that not all trays were covered. We also saw that drinks were served morning and afternoon along with fruit and biscuits. People told us, "I get a choice and there is always plenty" and "The food is always hot and tasty and if I want more then I can."

People's care files had a space which staff would complete if anyone had specific religious or cultural needs. At the time of our inspection we saw people from other cultures using the service however they had not requested any specific adjustments or needs.

Shift handovers were carried out at every change and as well as verbal handovers staff were required to read a daily log book for the floor they were working on and sign to say they had read and understood the information recorded. We saw the shift handover included general information regarding people who used the service and individual areas of risk or concern. For example where someone was identified as being at risk of malnutrition discussions around their daily intake took place. These measures helped ensure people who used the service received care that was effective and reflected their personal needs.

Picktree Court is a purpose built home that has incorporated all modern design features that took into account sensory impairments and needs of older people. For example private and communal rooms were spacious and all bedrooms were fully equipped with access points for HD Sky TV with Freeview, DAB radio and telephone sockets providing access to phone and internet usage. Corridors were designed to allow easy wheel chair access. Each of the three floors had a number of lounge areas. Some of the lounges had televisions in place and some did not, allowing people who lived at the home choice to have access to quiet communal areas rather than having to stay in their private rooms for peace and quiet. All lounge areas had induction loop systems in place to assist people who had hearing difficulties and alarms alerted people through both visual as well as sound stimuli. People told us, "It is good because I can hear much better."

Dining rooms were located on each floor and we saw that they were spacious allowing good wheel chair access. The provider told us that fire panel, fire suppression and nurse call facilities had been designed and installed as discreet units which only sounded or flashed on the floor they were related to rather than throughout the whole building. This meant that calls for assistance would be responded to in a timely manner.

The home provided nursing care and to support this they had available a range of equipment to meet people's care and nursing needs. For example four fully electric hoists, three electric stands, fall sensor chair and bed pressure mats, exit sensors and remote wireless pendants etc.

People also had access to secure external gardens which included smoking areas.

Good

Is the service caring?

Our findings

People who used the service and their families told us staff treated them well and they were happy with the care they received. One person told us, "The home is warm and comfortable and I am well cared for, nothing is a trouble". The relative of one person told us, "They are excellent", another told us, "The staff are very respectful to [relative]".

The registered manager had clear ideas on how people who used the service should be treated and worked to the principle of 'would you do that to your own parent'. The registered manager told us one of his relatives lived in the service and was so confident of the staff and their caring attitude; staff were not informed of the person's identity.

We spent time observing staff and the way they interacted with people who used the service. Throughout the inspection we saw staff treated people with care and compassion. For example we saw one person walking around in a confused state and becoming distressed. We saw a member of staff speaking kindly to the person, reassuring them and guiding them to the area they wanted to be. From conversations we heard, we found staff knew people and were able to talk to them about their families.

We looked at the care records of eight people who used the service. We saw care plans were written in an individual and person centred way with detailed information about people's likes, dislikes and preferences. Care records included information about people's histories and their memories of earlier life.

Where appropriate care records also contained details about any representative's people had acting on their behalf. For example some people had independent advocates and others had Lasting Power of Attorney (LPoA) in place. This is a legal document which the person in question had used to appoint another person to act on their behalf for things like finances or health and wellbeing. We saw full details were recorded including the names of the people on LPoA and which areas they had authority to act in. This meant the provider was able to adhere to the wishes of people who used the service.

People who used the service were able to make choices about their care and were able to express their views. Regular meetings were held for people who used the service and their relatives or representatives. We saw meetings were planned and notice boards throughout the service gave details of the date, time and agenda for the next meeting. We saw minutes of the last meeting held and found people's comments were recorded and responded to during the meeting. In addition we found action plans were drawn up to deal with people's suggestions, comments and concerns.

We saw evidence that people were supported to make decisions about their care. For example one person had been given specific dietary advice. Despite this assessment we found the person had chosen not to follow this and had made the decision to continue with normal meals. We found evidence in the care record that discussions had been held to ensure the person was aware of the potential risks. Details of the person's decision were recorded and staff were made aware of this.

Staff working in the service had received training in dignity and respect and we saw people who used the service were treated with respect at all times. Staff were observed asking people if they would like assistance with their meals and when help was requested it was given discreetly with staff sitting next to people and talking to them throughout the meal. We saw staff knocked on doors before entering rooms and asked people who used the service and their visitors if they were okay and if they needed anything.

We found all rooms in the service, including communal rooms and people's bedrooms were fitted with induction loops. This allowed people who used hearing aids to hear more clearly. One of the people who used the service told us, "It's so good because I can hear much better".

Staff in the service usually worked on the same unit during all their shifts allowing staff to get to know the people they cared for. One member of staff told us, "Working this way gives us responsibility and a sense of pride if we do well". If it was felt more staff were required on another floor, they were occasionally asked to help in other areas and staff told us this helped them to 'keep in touch' with others.

Throughout the service there were noticeboards which were used to display information to people who used the service and their visitors. Information included details about meetings that were arranged, meals and activities. In addition we found information about advocacy services were displayed and also details about other organisations people may find useful.

People who visited the service told us they felt welcome and did not feel restricted in the time they were allowed to

Good

Is the service caring?

visit. We saw the provider offered food to people's relatives if they wanted to join their family member for meals and there were a number of areas which people could use, other than their bedrooms, to have private time with their visitors.

We also saw care records included information about people's wishes for the future and what they would like to happen in the event of their death. For example some people had expressed a wish to remain in the service until their death and others had said they wished to be transferred to hospital. We also saw there were details of people's funeral plans and their preferred funeral arrangements including hymns, readings and the place they wanted the service to be held. We also found relatives were able to stay overnight in the service and were supported throughout the time their family members were receiving end of life care. The provider told us they had utilised their training, links with the local hospice and existing experience to develop end of life care / palliative care to proactively manage residents' wishes. We were told that the home had been working with the local GPs to implement advance care plans, emergency health care plans and DNACPR's to ensure residents' needs and aspirations were met and planned for in advance.

This meant that this pre-work allowed the majority of residents to die in their preferred place of care with reduced hospital admissions. The home utilises the National Gold Standard Framework (in end of life care) which identified 80% of people died within the home, which showed effective pre-planning in end of life care.

The provider told us either the registered manager or deputy manager plus care staff attended all funerals of people who passed away while under their care. This was to provide that personal touch and pay their final respects. We were also told that family gatherings including funeral wakes had been facilitated within the home. This enabled families to remember their loved ones in their preferred setting.

Good

Is the service responsive?

Our findings

People who lived at Picktree Court told us they received care that was good and responsive to their individual wishes and needs. The relatives of one person told us, "We're always kept up to date with any concerns about [relative]."

The registered manager told us they always tried to be responsive to people's needs and when new people came to the service they made arrangements to ensure people had the correct equipment and support. We saw people's care plans were reviewed every month with additional updates completed when people's individual needs changed. We saw specialist advisors were contacted when there was a change to people's needs and recommendations were recorded and acted upon. We saw there was a good working relationship between the service and other healthcare professionals who spent time with people in the service. We spoke with one of these professionals who told us, "They're very good, very caring". We also spoke with the relative of one person who told us when their relative left hospital they were unable to walk and the registered manager had worked with staff and specialists to improve their ability. We saw the care plan for the person reflected this and were told by the relative, "[Relative] was unable to walk in hospital and when I met with the manager here he said they would do their utmost to get [relative] back on his feet and they did. I was so pleased".

Care plans were written and updated with the co-operation of people who used the service, their family or someone else who knew them well. Care plans were comprehensive with individual plans relating to pressure care, bathing, mobility and challenging behaviour, as well as others. Care plans provided staff with information about the assistance people required and how they preferred to receive assistance. For example, one person had been found to be at risk of pressure sores and advice had been sought from another healthcare professional. We saw recommendations had been made to protect the person which included the completion of a body map, regular positional changes and new mattress. The care plan showed all of these had been implemented and a progress record was also completed. This meant people were given the level of support they wanted and needed.

Risk assessments were written and directly linked to people's care plans. We saw areas where people's safety may have been compromised were identified and steps were taken to minimise the risk to people whilst allowing them to take calculated risks and maintain their independence. For example, one person wanted to manage their own medicines. We found checks had been carried out to ensure the person had the ability to manage their medicine and saw a risk assessment had been completed to determine the risk to others and what the risk to the individual would be. We found regular reviews were carried out to ensure the person was still capable. This meant people were supported to take measured risks and lead an independent life.

Some of the people who used the service had medical conditions that meant regular tests were required to ensure their conditions were appropriately managed. For example one person had been diagnosed with diabetes and had daily checks on their blood sugar level. Staff were trained to monitor the levels and to recognise when they were too high or low and were able to help the person manage their condition. We also saw people were taking medicines which had to be closely monitored to ensure they did not have an adverse effect on people's health. Again regular testing was carried out and the results were recorded in care plans. We saw the prescribed level of medicine was adjusted according to what the test results were and the MAR charts were annotated to show what people should be receiving. We also found people's weight was monitored and food and fluid balance sheets were put in place for some people. If any concerns were identified referrals were made to specialists and we found people were supported to attend appointments and follow recommendations. This meant staff were able to respond to people's changing needs.

Care records showed health assessments had been completed by other services and where people had been transferred to or from other services details of the care provided was kept in people's care records. For example where people were discharged from hospital a copy of the discharge record was kept. This gave staff essential information in case of any concerns. In addition where people were transferred from the service to other healthcare providers comprehensive notes were provided to ensure all relevant information was provided. This meant people were able to receive consistent care when they were transferred between services.

Good

Is the service responsive?

During the inspection we monitored staff and how they responded to people and call bells and people's requests for assistance. We saw staff responded to people when they saw them, asking how they were and when asked for support we heard staff asking what help people would like. We also found people's call bells were answered quickly and staff took time to help people in the way they preferred. The provider told us the nurse call system was linked into a computer system that allowed detailed analysis, reporting and management of data. They said they had used this to find out staff day and night response times, averages number of calls per shift etc. These statistics allowed the provider to plan safe and responsive care staffing levels. We were told it also allowed person specific care plans and care support to be developed based on factual evidence of calls made by any individual and the time that care staff take in attending to and supporting that person.

The provider had made arrangements to ensure people with sensory difficulties would be able to communicate with others and would be kept safe in the service. This included induction loops throughout the service, cue cards for people who were not able to communicate verbally and visual and auditory alarms to ensure people were aware if there was an emergency. Staff had also undergone training with the County Council Sensory Awareness team to enable them to meet people's needs.

The provider had a formal complaints procedure in place and information on how people were able to raise a complaint was in the handbook which was provided to people who used the service and on notice boards around the service. We spoke with the relatives of eight people who used the service who told us they knew how to make a complaint but at the time of our inspection none of them had found it necessary to raise a formal complaint. People who used the service also told us they knew how to make a complaint and that staff working in the service were able to sort out little problems. The registered manager showed us the complaints register for the service and we found all complaints were recorded and investigated in line with the complaints procedure. Where possible written responses were provided to anyone that made a complaint.

The provider employed an activities team who were supported by care staff and occasionally volunteers. Planned activities were shown on notice boards in the service which enabled people who used the service and their visitors to plan and participate in these. Activities included pamper sessions, arts, sing-a-longs and also occasional outings.

Good

Is the service well-led?

Our findings

The provider had clear values and a philosophy of care that was well advertised. People who used the service and their visitors told us the management team were happy to spend time talking with them and were seen walking around the service. One of the people who used the service told us, "I see the manager regularly and he always has a chat". The relative of another person told us, "When I arrive staff always update me on how my [relative] has been and I know what to expect. I usually have a chat with the manager as well".

At the time of our inspection the service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager is supported by an assistant manager and care supervisor. The managing director also took an active part in the running of the home.

The registered manager told us there was an open door policy in the service. This meant people who used the service, their family, friends and representatives were able to speak with them about any concerns. In addition to this the registered manager or another member of the management team regularly spent time walking around the service and talking to people.

Throughout our inspection we found there was a calm and relaxed atmosphere in the service and staff worked in a caring and professional manner and people who used the service were treated in a polite and courteous manner at all times.

We spoke with the registered manager about the quality of the service provided and the building. The registered manager told us the service was decorated to the highest standards and they had invested in a number of different areas to ensure the environment was clean, safe and environmentally friendly. For example, there was an air source heating system in place which used external temperature to heat water up to 50 degrees without using any other energy source. This system was also used to provide hot and cold air to air conditioning units throughout the service. We also saw there was a system in place for collecting rainwater and this was used to flush toilets. The provider had also installed a mist suppression system which was used in case of a fire. The system was a state of the art design which reduced the amount of water used and reduced the amount of oxygen in the room helping put fires out quickly. In addition the system isolated the area affected so the disruption to people who used the service was minimised. In the kitchen the provider had installed special ovens which were made to ensure the nutritional content of food was kept to the highest possible standard and a dishwasher that disinfected all the contents when it washed.

Regular meetings were held for people who used the service and their visitors. We saw meetings were scheduled every month and an agenda was available prior to the meeting which meant people could decide if they wanted to attend the meeting beforehand. We looked at the minutes of previous meetings and found concerns raised in these meetings were discussed and action points were made and assigned to a member of staff to deal with. We also found previous actions were discussed in subsequent meetings to ensure they had been dealt with appropriately.

The provider sought the views of people who used the service, their friends and relatives and staff members by asking them to complete surveys. Annual surveys were carried out and the results analysed and fed back to those who had completed the surveys. Results from surveys also triggered action points which were also included in the feedback. We looked at the results of the last staff survey and that of the last relatives and service user surveys. Comments about the care provided included, 'Love everyone in the home', 'Safe clean environment', and 'The food is perfect'. Each survey contained both positive and negative comments. Comments from staff members included, 'I think it's a great care home', 'Nice friendly environment, staff are very supportive' and 'There is a good variety of training to help me with my job'. In addition we found some suggestions from people who used the service and staff working there. These included, 'Maybe more outside activities', 'More social events evenings and weekends' and 'More food choices at supper'.

The provider was pro-active in promoting improvement and change in the care sector and this was evident by the participation in various different meetings and associations within the care sector. For example the provider was a member of the Registered Nursing Home Association and the County Durham Care Home Association. In addition the provider has given input to North Durham Clinical Commissioning Group relating to reviews and development

Good

Is the service well-led?

of strategies like end of life care and older person care model. In addition the provider has worked with a local hospice to develop a mutual arrangement of support. The provider worked with other organisations to ensure that national standards and best practice were met. In addition the registered manager told us they kept up to date with legislation and best practice by using various sources including the National Institute of Clinical Excellence, Registered Nursing Homes Association and the Care Quality Commission. Updates were passed on to staff through training and supervisions. This meant the service was always caring for people in line with best practice.

We saw the provider had an effective system in place to ensure there was an appropriate number of staff on duty and there was a good balance of knowledge and experience.

The provider had a policy in place for staff who wanted to raise a complaint. The provider's whistleblowing policy allowed staff to raise concerns about other people working in the service, or their professional practice. We saw staff were supported throughout the process with additional support available via a legal employment law network which the provider was a member of.

The provider had a quality assurance system in place to ensure the care provided and the surroundings of the home were kept to a high standard. Regular room checks were carried out to ensure carpets were clean, lights were working, there was no damage to furniture, carpets or walls and the room temperature was appropriate. Further checks were carried out around the communal areas to ensure the same standards throughout.

Contracts were in place for the maintenance and repair of lifts and medical equipment. We found portable appliance testing and fire safety equipment was checked and tested regularly. In addition we saw regular detailed internal audits were carried out for various areas like infection control, medications and catering.

We looked at the records the service held in relation to accidents and incidents that happened in the service. Staff recorded all incidents and the management team used the information to monitor and investigate incidents to see if there were any trends or patterns. In addition if there were patterns to incidents the provider was able to take action to reduce the risk of them recurring. Staff were then informed of any changes that had been implemented in response to these incidents

The service had good links with the local community and we saw representatives from local churches carried out regular services. Local schools held carol services and the service had a volunteer from the local school that provided assistance to the activities team. In addition to this the service had links with local schools and colleges allowing them to offer work placements. We saw people who volunteered in the service were required to have DBS checks carried out to ensure people who used the service remained safe.