Parkside Care Limited

The Chesters Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16 and 20 June 2016 and was unannounced. This means the provider did not know we were coming. We last inspected The Chesters Care Home in September 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

The Chesters Care Home provides accommodation and personal care for up to 29 older people, including people living with dementia. Nursing care is not provided at the home. At the time of our inspection there were 25 people living at the home.

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

We found that people's care was provided in a safe, clean environment that was equipped to meet their needs. Risks to personal safety had been assessed and steps were taken to prevent avoidable harm and abuse. There were robust measures for supporting people to take their prescribed medicines safely.

The home had enough staff and people were provided with safe and consistent care. Staff were supervised and given training relevant to the needs of the people they cared for to support their personal development. Relatives were complimentary about the effectiveness of the care and many told us they had seen improvements in their family member's well-being.

People were supported to access a range of health care services to maintain and improve their health and welfare. Good nutrition and hydration were encouraged and, where necessary, staff gave assistance with eating and drinking. People told us they enjoyed the food and we observed they were offered a varied diet with choices of well-presented, appetising meals.

People and their families were involved in directing the ways their care was provided. The service protected people's rights when they were unable to give consent to their care and treatment. People and their relatives were happy with the care and had no concerns. Complaints that had been received were properly investigated and resolved.

Staff had a good understanding of people's needs and treated them as individuals. They were kind and caring in their approach and respected people's privacy and dignity. People were given the information and support they needed to make choices and decisions about their care.

People had personalised care plans for meeting their needs which described their individual preferences and what was important to them. Care was regularly reviewed and adapted in response to any changes in needs. Stimulating activities, events and opportunities for outings were provided to help people meet their

social needs.

The home had an established registered manager who provided leadership to the staff team. There was an open culture and the service worked inclusively with people, their families and staff. Good governance arrangements were in place and the quality of the service was routinely checked to ensure standards were maintained and developed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Suitable arrangements were made to minimise risks during care delivery and to safeguard people against the risk of harm and abuse.

Sufficient staff were employed to safely meet people's needs and provide them with continuity of care.

People's prescribed medicines were administered safely by trained staff.

Is the service effective?

Good

The service was effective.

Staff were given a good level of training and support to help them care for people effectively.

The service worked within the principles of mental capacity law and ensured that people's rights were upheld.

People were provided with appropriate support in meeting their health care and nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate and had developed good relationships with people living at the home and their families.

People were able to make day to day choices and were supported in expressing their views about their care.

People were treated respectfully and their privacy and dignity were promoted.

Is the service responsive?

Good

The service was responsive.

Care planning was tailored to the individual's needs and the ways they preferred their support to be given.

People were able to engage in a range of social activities and be involved in their community.

Any complaints about the service were taken seriously and were thoroughly investigated.

Is the service well-led?

Good

The service was well-led.

An experienced registered manager was in post who led and supported the staff team.

Feedback was actively sought and acted upon, enabling people and their families to influence how the service was run.

Systems were in place for assessing and monitoring the quality of the service that people received.

The Chesters 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 was 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.

The inspection took place on 16 and 20 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

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. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority that commissions the service and three external professionals who visited the home. We received one response that gave positive feedback about the service.

During the inspection we talked with seven people living at the home and six relatives. We spoke with two of the provider's representatives, the registered manager, the deputy manager and five care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at four people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person commented, "I'm safe and comfortable." Another person said, "I feel secure here." Relatives spoke highly of the safe care their family members received. Their comments included, "After years of caring I was able to go on holiday knowing that [family member] was being well looked after", "It's given me peace of mind", "My [family member] has had no falls since coming here", "The staff have a very good attitude and treat people well", and, "The home is kept immaculately clean."

The guide to the service informed people about the safeguarding process and their rights to be protected from harm and abuse. Information, including an 'Action on Elder Abuse' poster with contact details was displayed for reference. People and their relatives were asked about their understanding of safeguarding, and whether they had any concerns, at individual care review meetings. The registered manager told us they also planned to highlight the importance of safeguarding at 'residents and relatives forum meetings'.

The provider had policies and procedures on safeguarding and whistle-blowing (exposing poor practice) in place which were available for staff to access. The procedures were discussed in staff meetings and individual supervisions to routinely check that staff understood how to recognise and report any suspected abuse. All staff were trained in safeguarding and the registered manager and senior staff had undertaken advanced training in line with their responsibilities. The staff we spoke with were confident they would have no hesitation in reporting any concerns about people's safety.

Two safeguarding concerns had been raised in the past year, both of which were appropriately acted on and reported to the relevant authorities. The provider had introduced a policy on the 'duty of candour' and this was on the agenda for discussion at the next staff meeting. The duty of candour requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

The home had an appropriate system for the safekeeping of personal finances. Any support that people needed with their finances was documented in their care records, including arrangements for support from their relatives. Cash for personal spending was held for the majority of people living at the home. Each person's money was held individually and suitable records of transactions were kept and backed by receipts. Monthly checks of cash and balances were conducted, though we noted they were not clearly recorded; the registered manager agreed to follow this up. Full finance audits were also carried out every six months to assure people their money was being managed safely.

Staffing levels were based on the numbers of people living at the home and their needs. Staffing was also regularly reviewed by the registered manager with the directors of the company. This had led to levels being increased to four care staff on late shifts. On early shifts there were six to seven care staff, including seniors, and two care staff members at night. The registered manager's hours were in addition to these numbers. The staff team worked flexibly and provided cover for absence, enabling people to have continuity of care. External agency staff were not used. The registered manager, deputy manager and senior staff operated an

on-call system that allowed staff to get support and advice when needed. Any emergency situations were able to be escalated to the provider's representatives for further support and action.

The people, relatives and staff we spoke with had no concerns about the staffing levels. During our visits we observed that staff were well organised. They provided supervision in communal areas, checked on people in their bedrooms and had time to spend with people, engaging them in conversation and activities.

New staff had been suitably recruited. The records we examined showed all necessary pre-employment checks had been carried out. These included completion of application forms with details of employment history and training; obtaining proof of identity and references, including one from the last employer; interviews, and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. We saw application forms were designed with questions to capture the values and beliefs of the applicant, including what they felt were the most important aspects of working in care and how they would like to be cared for. Applicants were also introduced to people living at the home and any comments received, along with a summary about how they had interacted, were recorded and considered as part of the recruitment process.

Risks were assessed and steps had been taken to make sure people received safe care. Specific assessments were completed in relation to the safe use of aids and equipment. People had care plans which guided staff about how to protect their personal safety. The plans included measures for reducing risks associated with areas of care where they were vulnerable, such as maintaining skin integrity, nutrition, moving and handling, risk of falling, and the use of bedrails for safety. Where applicable, the plans incorporated advice given by health care professionals.

We viewed the home's accident and incident reporting system. Suitable records were kept and there was evidence of robust analysis. Preventative action had been taken, for instance, providing a sensor mat and a lower level bed to minimise the risks of a person having further falls. However, immediate action taken in response to minor injuries, such as provision of first aid, was omitted from the accident reports. The registered manager told us they would direct staff to complete the records more accurately in future to include these details. Other safety issues and 'near misses', for example, when a contractor had left a tool box unattended, were also reviewed to prevent reoccurrence.

We observed that the home was clean, well-maintained and free from unpleasant odours. Satisfactory arrangements had been made for maintaining a safe environment, including monthly audits of all areas of the building and grounds to check for any potential hazards. Fire safety checks and tests were carried out and staff were given instructions about the actions they must take in the event of a fire. The service had a contingency plan for emergencies and each person had an individual plan for their safety in the event of needing to be evacuated from the home.

Prescribed medicines were ordered on a monthly basis. The registered manager told us the supplying pharmacy provided an efficient service, including same day delivery of medicines needed outside of the monthly cycle. The home used a 'biodose' system, whereby the majority of solid and liquid medicines were dispensed in sealed units. Pre-printed medicine administration records (MARs) were provided which contained a photograph of the person to help avoid errors, and a picture and description of each medicine so they could be readily identified. We observed that medicines were neatly stored in a designated, secure room and within the medicines trolley. Medicines separate to the biodose system, including those prescribed to be taken 'when required', were clearly recorded with the date of opening, to keep check on stocks and expiry dates.

All medicines were administered by senior staff who we saw were trained every three years and had an annual assessment of their competency. Senior staff informed us that the biodose system worked well. They told us each person had a medicines care plan for their individual requirements which they followed. We saw that care plans included directions for prescribed nutritional supplements and where medicines were to be given in dispersible form. Senior staff said they closely monitored any regular refusals or difficulties in taking medicines and, when necessary, requested GPs to carry out medicines reviews. None of the people living at the home had medicines which were authorised to be given covertly (disguised in food or drink). We examined the MARs and the register of controlled drugs (medicines liable to misuse). The records were correctly completed, with no gaps, confirming medicines had been given as prescribed. Weekly medicines audits were undertaken to check for any discrepancies and ensure that people had received their medicines safely.

Good

Is the service effective?

Our findings

Relatives praised the effective care provided, particularly in terms of their family members' improved health and well-being since they had come to live at the home. They told us, "My [family member] was sent back here from hospital for end of life care and has made a miraculous recovery", and, "My [family member] is as well as they have been in years." Another relative told us their family member was of a great age and prone to a particular health problem. They said, "They've kept [family member] well, including building up their weight and feeding them when necessary."

Records showed that new staff had been given induction training to prepare them for their caring roles. They then undertook the 'Care Certificate', a standardised approach to training for new staff working in health and social care. All staff were provided with a range of safety-related mandatory training and other topics relevant to the needs of people living at the home. A training matrix was kept with an overview of all courses which had been completed. This demonstrated that mandatory training was either up to date, or refresher training had been booked. Other training completed included dementia awareness, challenging behaviour, person-centred thinking, equality and diversity, human rights, falls training, and caring for people with Parkinson's Disease. Further training sessions were organised over the coming months, including record-keeping, care planning, and risk assessment. The majority of care staff had also achieved health and social care qualifications.

We saw that all staff had received individual supervision every three months and an annual appraisal. These were currently provided by the registered manager, however training had been organised for senior staff with a view to a delegated system being introduced.

Staff confirmed they were given regular training and were supported in their personal development. Senior staff told us they were confident in fulfilling their responsibilities. Their comments included, "I get plenty of training", and, "We get training all the time and can access e-learning courses. One of the directors is a trainer and they're here quite often." This director was present during the inspection, delivering training for staff on death, dying and bereavement. They told us they felt it was beneficial for staff to have as much face-to-face training as possible.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the service worked within the principles of the MCA. Staff had been trained in the MCA and DoLS to understand the implications for their practice. Mental capacity assessments had been carried out and at the time of the inspection 19 people had DoLS in place. Supporting documentation was on file and

there was a system for monitoring DoLS expiry dates. Information had been gathered about any power of attorney arrangements to ensure people's representatives were fully involved in important decisions about their care and welfare.

We observed that staff were mindful of seeking people's permission before any support with care was provided. Where able, people were consulted about and asked to give their consent to the sharing of personal information, being photographed/having photographs displayed, and the use of equipment required to assist in their care delivery. The registered manager advocated that people who had DoLS in place should not be unduly restricted and encouraged them to go out of the home, either accompanied by staff or relatives.

The home had a policy of not using excessive control or restraint with people with distressed or challenging behaviours. We were told staff used diversional techniques and sought to gain people's co-operation. This was confirmed by our observations. Input and advice were also obtained when needed from specialist mental health care services.

People's weights and body mass index were checked monthly. The registered manager told us they were introducing a full nutritional assessment tool that identified other malnutrition risk factors. Some people had been referred for further assessment and support from dietetic services.
Care plans were devised for meeting people's dietary requirements and we saw staff monitored food and fluid intake where necessary. Information about promoting good nutrition was also displayed in the dining room.

Good hydration was encouraged, with different hot and cold drinks being provided at mealtimes and regular drinks rounds in between, with snacks. For example, lemonade, squash and water were offered to people in the break during an exercise activity. The drinks round in the afternoon included homemade cake, chocolate biscuits and milky coffee. Prepared fresh fruit was also regularly offered. Jugs of sugar-free squash were provided in the lounge areas throughout the day and to people who spent time in their bedrooms. We were informed that the squash, which was available in a variety of fruit flavours, had been purchased as it was designed to be highly concentrated in flavour and beneficial in stimulating the taste buds.

Information about each person's food and drinks preferences was recorded and passed onto the catering staff. We observed that the cook had daily contact with people and worked very flexibly to accommodate their needs and requests. There was a four week cycle of menus which was balanced, varied and provided choices of meals. People chose their meals on the day and menus were displayed. Special diets were able to be catered for and at present diets for people with diabetes were provided. We saw that meals were well presented, looked appetising, and were of good portion size. People could choose where to take their meals and staff were attentive during mealtimes, giving support and encouragement to eat, where needed.

People and their relatives were very complimentary about the food provided. They told us, "The food is extremely good", "Everything is really nice and beautifully presented", "The food is very good. I've put on weight", and, "We get lots of choice. Even if we're having sandwiches there's always lots of different fillings." Relatives also praised the cook and care staff, telling us how well they worked together in persevering with encouraging people to eat well. One relative commented, "I can't believe how good [family member's] appetite is now. When they were at home we were very worried."

People had care plans which indicated how staff would support them in meeting their physical and mental health care needs. Documentation about future care, including decisions not to be resuscitated, and people's wishes in relation to care at the end of their lives, were in place.

We saw that people were supported to access a range of health care services and contact with other professionals was recorded in their care records. The home worked with four GP practices and had established arrangements for people to receive podiatry, optical and dental services. District nurses visited regularly and had acquired equipment, such as pressure-relieving mattress, to support people's care and treatment. Referrals were made to other health care services as needed. The registered manager told us a care assistant had recently taken on a champion role and attended the first meeting with the Gateshead Vanguard Care Home Programme. This was a joint venture with health partners aimed at providing a more co-ordinated and multi-disciplinary approach to health care for older people in the area.

Good

Is the service caring?

Our findings

People told us they had good relationships with the staff and were happy with the support they provided. One person said, "You couldn't ask for better. We're all treated very well." Another person commented, "All the staff are very nice with me. They're all nice and kind."

People's relatives spoke highly of the caring approach of staff. Their comments included, "It's a demanding job but the staff are always patient and very caring", "The staff are brilliant, very hard-working and patient", and, "They treat people well and are very kind." A person's advocate told us they had always observed that people looked comfortable and well cared for when they visited the home. They described the staff they had come into contact with as being kind, respectful and caring towards people.

Some relatives explained they had chosen the home for their family members based on their positive impressions when they had visited. They told us, "We waited for a vacancy as it was the best home we viewed", "My [family member] moved here earlier this year and has settled very well", "It's a nice, homely environment. My [family member] was moved to a ground floor room that was newly decorated", and, "My [family member] has blossomed since coming here. We know we've found the right place." One relative added, "When my [family member] was in hospital they wanted to be back here, back to their home."

Each of the relatives we talked with emphasised the individual attention they felt the staff provided to their family members. A staff member told us, "It really is a 'home from home'. We're able to get to know people well. Some staff have worked here for years so there's lots of continuity." We observed that attention was paid to detail in relation to people's grooming and appearance. People wore clean, co-ordinated clothing, accessories and jewellery and had been supported with hairdressing and nail care.

One relative told us, "At home my [family member] was depressed. They just wanted to sleep and had no interest in anything. Now we can see a major difference. They're more lucid, eating well and enjoying the company of the staff and the other residents." Another relative told us, "I've hit the jackpot with this place. I'm very happy with the care and they've worked miracles. The staff have managed to get [family member] in the bath regularly, to eat in the dining room and I know they're cared for with real dignity." We observed that staff often spent one to one time with this person and were sensitive to their needs when they appeared to be distressed. For example, a staff member brought the person a blanket when they complained of feeling cold, and sat with them helping them with a drink and offering them chocolate to eat. Another relative told us, "Everything is very flexible here, there's no set routines. People can have a lie-in and have their meals later if they want."

We received comments from an advocate who represented a person who was subject to Deprivation of Liberty Safeguards. They told us the person had initially been unhappy to be living at the home though was now reasonably settled and happy. They said the person had told them they felt well cared for, safe and that, "Staff do their best". The advocate also told us that a particular staff member had supported the person to go shopping in their favourite store in Newcastle, when they were off duty.

We saw that visitors were welcomed by staff, offered drinks and asked if they wanted to stay for a meal. At mealtimes we observed that people were offered choices of meals and other options. For instance, we heard a staff member offering three flavours of yoghurt or fruit and ice-cream as alternatives to the hot pudding. We observed that staff were very patient towards a person who was reluctant to eat, suggesting various foods they might like to try until they decided upon something they were able to enjoy.

Serviettes were provided and some people chose to wear aprons to protect their clothing from any spillages. Some people were given food served on crockery designed to aid independent eating, or used plateguards. Space in the dining area was limited when everyone was seated, making it somewhat difficult for staff to comfortably support people with their meals. This was remedied by the use of folding seats, though we noted that one staff member stood over a person whilst assisting them to eat their meal. We raised this as a learning point with the registered manager to follow up. The issue of staff wearing blue plastic gloves throughout the mealtime was also discussed and agreed to be an unnecessary practice.

We observed that staff worked in an unhurried way with people and there was lots of engagement and positive interactions. Staff took a pride in their work, with one telling us, "We care for people as we'd want our own families to be cared for." Those staff we talked with demonstrated a good understanding of people's needs and gave clear accounts of how individuals preferred to be supported.

The registered manager told us they had taken on board guidance from Stirling University to make the care environment more dementia-friendly. This had included new signage in the home to help people identify areas and rooms, non-patterned flooring, increased lighting levels and use of red toilet seats in the communal toilet areas. We saw that people had 'Remember I'm Me', (a laminated chart with a summary of the person care), on the back of their bedroom doors. One person we talked with told us they had been involved in completing this and said, "I'm very pleased with it; it tells the staff all about me and what they need to know." Care plans also guided staff about respecting privacy and helping people to retain their independent skills.

An informative guide to the service had been developed that informed people about what they could expect from living at the home. This included a clear commitment to involving people and their representatives in decisions about their care, and supporting people to access advocacy services where needed. Leaflets from the Department of Health (DoH) about Independent Mental Capacity Advocates and decision-making were also provided in the home.

A range of useful information was displayed for people and their visitors to refer to. This included details of external agencies which provided support for older people and the last Care Quality Commission inspection report. The home was signed up to the DoH 'dignity challenge' (that sets out how care services should respect people's dignity). Leaflets about this were on display along with guidance on the ways the challenge could be adopted in different aspects of people's care.

People and their relatives confirmed they were encouraged to express their views about their care and the service in general. This was done in a variety of ways including during individual care review meetings, 'residents and relatives forum meetings', and completing surveys about the quality of the service.

Good

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. Their comments included, "I can ring the call bell and the staff come straight away", "They [staff] tell me about the activities and what's going on", and, "You only to have to ask and the staff will do their best to give you whatever you want."

We observed that staff took time to talk with visiting relatives, giving them updates about the care of their family members. A relative, who lived out of the area, told us they often telephoned the home between visits. They said, "I always get a full report from the staff. I know they take care of my [family member] and that they're very well looked after." A relative also commented positively about how staff had prompted the GP to carry out a review of their family member's medicines. This had led to a reduction in the amount of medicines they were previously prescribed, which the relative felt had been beneficial to the person's well-being.

Staff told us the home promoted support for people to maintain contact with their family and friends. For example, one person had regular Skype calls with relatives who lived overseas. Skype is a computer programme that allows video and telephone calls to be made over the internet. Arrangements had been made for the person to use this to enable them to take part in a forthcoming family celebration.

People's needs had been assessed prior to moving in and we saw the registered manager had provided written confirmation that the home could meet the person's needs. People were able to have a trial period at the home, if they wished, before deciding whether to stay permanently. A checklist was completed to confirm that the admission process had been followed correctly.

The individualised care that people received was reflected in the way their care was planned. One page profiles had been drawn up which gave staff good information about what was important to the person, what those who knew the person liked and admired about them, and how staff could best support the person. Separate information was recorded about preferred routines, gender of carer, food and drinks, social interests and voting. Some people also had life story books with photographs which had been well put together with the support of families.

Detailed and personalised care plans were in place which addressed all identified needs. These included support with personal care; diet; senses and communication; mobility; oral health; foot care; personal safety; continence; mental state and cognition; social interests; and family involvement. We saw that care plans recorded how the individual preferred their care to be given and what they could do for themselves. For example, a person's 'sleep care plan' specified that a small night light was to be kept on, and their preference for their bed to be made up with a duvet and a fleece blanket on top. Another person's plans indicated those areas of personal care they were able to do independently.

There was evidence that care plans had been updated, for instance, where a person's needs had changed since their admission to the home. All care plans were regularly evaluated though entries were variable, with some not reporting on the person's progress and whether the care given had been effective. This was

acknowledged by the registered manager who assured us they would direct staff to record more focused evaluations.

Staff recorded reports of people's ongoing care and welfare which were supplemented, where applicable, by other monitoring records. We saw, for example, that positional changes and food and fluid intake charts were completed for a person who was cared for in bed. Handovers took place at each shift change to ensure staff were given up to date details about each person's welfare.

Individual care was reviewed at meetings, which the person and their relatives were invited to attend. In addition to discussing current care plans, those present were given the opportunity to comment on the main principles that underpinned the care provided. These included respecting privacy and dignity, offering choices, enabling independence and upholding the person's rights. We saw a number of relatives had given positive comments at reviews about their satisfaction with the care.

Information was advertised outside of the main communal areas about the social activities on offer, forthcoming events, and the availability of wireless internet in the home. There was also a large display of photographs that showed people and the staff participating in different activities and themed events. The lounge area and outside decking were decorated with England flags in support of the Euro 2016 football.

Relatives told us, "There's always plenty going on in the way of activities and taking people out", and, "They celebrate events and there's lots going on for people to join in with or just watch if they want to." The registered manager explained that two staff were planned to take on lead roles involved with 'Oomph' (a social enterprise dedicated to enhancing the well-being of older people, including provision of fun activities). All care staff were involved in providing activities. We saw they followed a varied programme of daily activities and that every month there was entertainment, a celebration or event and an outing. Outings were arranged according to suggestions from people and included trips to the beach, the Angel of the North, and shopping in Newcastle and the Metrocentre.

We observed different activities took place during our visits, which staff led enthusiastically and people clearly enjoyed. These included a gentle exercise session with music playing and activities generated from the 'Daily Sparkle', an interactive newsletter produced by the company. The newsletter was read out by staff and covered a range of topics with prompt questions to encourage conversations and reminiscence. For example, we heard people talking about where they had holidayed when they were younger and sharing their memories of fashions and shopping in a local well-known department store. This was followed by a quiz and a sing-along. We also saw that staff spent one to one time with people, doing jigsaw puzzles and giving manicures.

The home had a complaints procedure that people were aware of. None of the people and visitors we spoke with expressed any concerns about the service. A relative told us, "I've no complaints at all." A log of complaints was maintained with details of whether they included safeguarding issues and where concerns had been reported to external agencies. Two complaints had been received in the past year, both of which were appropriately responded to. One complaint had been thoroughly investigated by one of the company directors. This had led to an action plan being devised and a follow up visit to check that staff were adhering to practice guidelines before the complaint was closed off as being resolved. A number of compliments and thank you letters and cards had also been received which praised the management and staff for their care and compassion.

Good

Is the service well-led?

Our findings

The home had an established registered manager who was experienced and qualified in managing care services for older people. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager said they were well supported in their role by the provider and company directors, and that meetings with their peers from the provider's other two care homes were being introduced. They told us they subscribed to a range of care industry and related publications and kept up to date with best practice and initiatives. These included membership of the Care North East Provider Association and links with the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

Some of the people living at the home knew who the registered manager was and described them as "Nice", and, "A good lady". Relatives told us, "The home is very well-run", "I've been impressed with the manager and staff", "The manager and staff are 'spot on'", "I've recommended this home to other people", and, "I have total confidence in the staff and management." An advocate who visited the home told us, "I think that the service is well-led. I have always been made welcome and kept informed of any changing needs of the person I support by the manager and the senior staff team."

We observed there was a good team ethos and staff told us they felt well supported in their roles. Their comments included, "I love working here, it's such a friendly place", "The manager is very approachable", "[Name] is a very good manager", and, "It's a very good company to work for. It's a family business and they're very supportive. The directors often call in and they always talk to the staff during their visits." Records showed that the directors also represented the provider at meetings with staff and with people and their relatives.

Bi-monthly staff meetings took place which were chaired by the registered manager and were well attended. The minutes of the last meeting showed these forums were used for meaningful discussion about employment and practice issues. The topics covered included mental capacity, equality and diversity, and health and safety. A proposal to look at changing shift patterns had been discussed which was followed up by a survey with staff to consider their opinions.

A director told us staff were valued and offered a range of employee benefits. These included a pension scheme, seasonal bonus, reasonable adjustment of duties, and use of an employee support helpline and a corporate pass to Beamish Museum. All meals and drinks whilst on duty were provided free of charge to staff. The possibility of introducing an 'employee of the month' reward was being considered.

The registered manager told us they aimed to work inclusively with people and their families, enabling them to influence the service. A suggestions box was available and residents and relatives forum meetings were held to consult people about the running of the home. At the last meeting we saw relatives had expressed their appreciation to all of the staff. There had been feedback about activities and events, the meals, any

complaints or concerns, and discussion on the proposed extension of the home. Opportunities to suggest any improvements were given and these were acted on. For example, the cook had responded to a person's request to have more Yorkshire pudding and sausages which they had followed up by including toad-in-the-hole in the menus. A talk had also taken place from a person from the Alzheimer's Society to raise relatives' awareness of the needs of people living with dementia.

Surveys were carried out to get the views of people living at the home and their families. We saw people were asked to rate their satisfaction with the staff, service provision, the environment, communication, safety, and the overall quality of the service. A summary of the survey findings for 2016 showed that all respondents were either 'very' or 'extremely' satisfied with the quality of the service. Surveys had also recently been introduced to obtain feedback from professionals who visited the home.

A schedule was followed, using different methods to assess the quality of the service. This included auditing care plans, finances, safety, medicines and staff training; completion of staff supervisions; and monthly visits to the home by the directors. Comprehensive reports were made of these visits which included comments from people, relatives and staff, reviewing records, and checking the environment. The directors set clear actions for any improvements needed and reviewed the progress of these being implemented at their next visit.

The registered manager described their vision for the future of the service and planned developments. Building permission had been approved for an extension to the home, increasing the numbers of beds, and it was anticipated that work would begin in 2017. Care staffing levels were planned to be revised as occupancy increased. Other plans included moving the external laundry facilities into the home; continuing to build on making the environment more dementia-friendly; encouraging more people to take part in daily household tasks and activities; and promoting the use of life story books with family and friends.