HC-One Beamish Limited

St Clare's Court

Inspection report

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Website: www.hc-one.co.uk

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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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This announced inspection took place on 15 and 23 November 2017. This was the provider's first inspection since they became registered providers for St Clare's Court.

St Clare's Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Clare's Court is registered to provide accommodation and personal care to 58 people.

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.

The service provided outstanding end of life care that had a positive impact on people and their relatives at this sad and distressing time. The provider supported relatives and friends in a caring way offering practical support and accommodation when necessary. Staff provided on-going support for bereaved relatives to return to the home whenever they wished to.

There were systems in place to keep people safe. We found staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Where lessons could be learnt from safeguarding concerns these were used to improve the service. Accidents and incidents were recorded and monitored as part of the registered manager's audit process.

The provider ensured appropriate health and safety checks were completed. We found up to date certificates to reflect fire inspections, gas safety checks, and portable appliance tests had been completed. A contingency plan was in place to ensure staff had information and guidance in case of an emergency. People had up to date personal emergency evacuation plans (PEEPs) in place that were available to staff.

There were robust recruitment processes in place with all necessary checks completed before staff commenced employment. The registered provider used a dependency tool to ascertain staffing levels. We found staffing levels to be appropriate to needs of the service, these were reviewed regularly to ensure safe levels.

Medicines were administered by trained staff who had their competencies to administer medicines checked regularly. We found some gaps in medicine administration records (MAR). Medicine audits were completed regularly. Policies and procedures were in place for safe handling of medicines for staff to refer to for information and guidance. The registered manager addressed the gaps in the MAR with staff during the inspection.

People's physical, mental and social needs were assessed on admission and used to develop plans to support people's outcomes. Care records contained information which took into account current legislation and national guidance.

Staff training was up to date. Staff received regular supervision and an annual appraisal. Opportunities were available for staff to discuss performance and development.

People's nutritional needs were assessed and we observed people enjoying a varied diet, with choices offered and alternatives available. Staff supported people with eating and drinking in a safe, dignified and respectful manner. People were supported to maintain good health and had access to healthcare professionals when necessary and were supported with health and well-being appointments.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice

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People were supported by kind and attentive staff who clearly knew people well. Staff discussed interventions with people before providing support. Advocacy services were advertised in the foyer of the service accessible to people and visitors. Staff knew people's abilities and preferences, and were knowledgeable about how to communicate with people.

Care plans were individualised and person centred. Plans were reviewed and evaluated regularly to ensure planned support was current and up to date.

The registered provider had an effective quality assurance process in place to ensure the quality of the care provided was monitored. People and relatives views and opinions were sought and used in the monitoring of the service.

People, relatives and staff felt the registered manager was open and approachable. The provider recognised the value of staff and gave regular achievement awards.

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.

The provider had safeguarding policies and procedures in place. Staff understood the importance of reporting any concerns they may have had. Where lessons could be learnt from safeguarding issues these were used in improving the service.

Recruitment processes were thorough with appropriate checks made to ensure prospective staff were suitable to work with vulnerable people.

The provider had safe systems and processes in place to manage medicines. Staff were trained in safe handling of medicines and their competency to administer medicines were checked regularly.

Is the service effective?

Good

The service was effective.

People were supported to achieve outcomes with support from staff who had the skills and experience to meet their needs.

People's nutritional needs were assessed to identify any risks associated with nutrition and hydration. People had access to health care professionals when necessary.

Staff had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). People's rights were upheld and protected by the service.

Is the service caring?

Good

The service was caring.

People who used the service and relatives felt the staff had caring attitudes and treated them with dignity and respect.

Staff had genuine relationships with people, ensuring they were aware of likes, dislikes and preferences to meet their needs.

People were supported and encouraged to have personal items in their rooms to make them more homely and comfortable.

Is the service responsive?

Outstanding ☆

The service was extremely responsive.

End of life support was outstanding. People's wishes and preferences were acknowledged with care plans developed in a person centred manner. People's relatives confirmed staff supported people at the end of their lives in an extremely compassionate manner.

People's care plans were personalised and contained information about likes, dislikes and preferences. People and relatives felt involved in care planning.

People, relatives and visitors had opportunities to complain, give comments or raise issues. Complaints were investigated and outcome letters provided to the complainant.

Is the service well-led?

Good

The service was well led.

There were systems and processes in place to monitor the quality of the service. Senior managers visited the service on a regular basis.

People and relatives felt the service was well managed with a supportive registered manager and team. The registered manager was described as open and approachable.

Opportunities were available for people, relatives and staff to meet. Meetings were held on a regular basis.

St Clare's Court

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.

The inspection took place on 15 and 23 November 2017, the first day of the inspection was unannounced. This meant the provider did not know we were coming.

The first day of the inspection was carried out by two adult social care inspectors and an expert by experience who spoke to people and relatives to gain their opinions and views of the service. An expert by experience is a person who had personal experience of using or caring for someone who used this type of service. The second day of the inspection was carried out by one adult social care inspector.

The provider submitted a Provider Information Return on 4 September 2017 as part of the Provider Information Collection. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information we held about the service and the provider. This included statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with seven people who lived at St Clare's Court. We spoke with the area director, registered manager, deputy manager, the well-being coordinator, six care workers and catering staff who were all on duty during the inspection. We also spoke with nine relatives of people who used the service.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of four people, medicine records of seven people, the recruitment records of three staff, training records, and records in relation to the management of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt the service was safe. Comments included, "Oh, I am safe in here, look at everyone we are all happy," "It's safe enough" and "You have nothing to worry about in here I'd speak up if there was."

The provider had policies and procedures in place to manage safeguarding concerns. Staff had received training in safeguarding which was refreshed on an annual basis. Staff we spoke with understood the importance of reporting any concerns they may have and told us they felt the registered manager would take their concerns seriously and act in accordance with the policy and procedure. Safeguarding and whistleblowing reporting guidance was displayed in communal areas and was accessible to visitors and people who used the service. The registered manager told us, "I make sure I walk around the home that way I can say good morning to everyone and check if everything and everyone is ok. If there are any issues we can talk about them and get them put right." This meant the registered manager was visible to people to raise issues or concerns.

We found the registered manager kept a record of all safeguarding concerns along with copies of notifications submitted to CQC. All safeguarding concerns were also reported to the local authority safeguarding team. Records of investigations carried out by the registered manager were available, these were thorough and detailed. Where contact had been made with the safeguarding team this was recorded within the safeguarding records. We asked how staff were made aware of lessons learnt from safeguarding investigations and how the service used these lessons to reduce the risk of any further safeguarding concerns. The registered manager provided copies of staff meetings and supervisions where such issues had been discussed. Actions were also entered on the service improvement plan. Where necessary disciplinary action had been taken against staff. The registered manager told us, "It is so important that we learn and I do make changes and introduce new systems to try to prevent incidents." We found the registered manager had implemented a daily medicines check to minimise the risk of medicine errors.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. For example, two references and disclosure and barring service checks (DBS). These were carried out to confirm whether applicants were barred from working with vulnerable people.

We found the provider had systems and processes in place for the management of medicines. We checked recent medicine administrations records (MAR) for seven people and found one day when gaps had occurred in recording for two people. We also found that fridge temperatures had not been recorded every day. We discussed the gaps in recording with the registered manager who took immediate steps to address the errors by speaking to staff in a staff meeting. On the second day of our inspection we reviewed three people's MAR and found no gaps or anomalies, fridge temperatures had also been recorded.

Medicines auditing completed by the registered manager for previous months also showed some gaps on MAR records. The registered manager was able to demonstrate that there was on-going auditing to reduce medicines errors and where errors were identified these were investigated and actions taken with the staff

accountable.

There was also evidence that staff were given written reminders about following medicine procedures and that posters were displayed asking that staff were not disturbed when administering medicines. We saw that improvements had been made to the way the home managed the use of medicines prescribed to be administered "as required" and these were being administered appropriately.

We spoke to people and relatives to find out about their views on staffing levels and received mixed views. Comments included, "We noticed that some people required help but there were no carers available", "My [family member] sometimes has to wait a long time for assistance … it wasn't too bad when the care home wasn't full", "I don't wait if I need help it's there" and "They come when I buzz." One relative told us that they had complained about staffing shortages about two months ago. The registered manager had advised that the resident: staffing ratio was correct but they would speak with the provider anyway. The relative was unsure if more staff had been recruited. We discussed this with the registered manager who advised that staffing levels were appropriate to people's needs as demonstrated by the dependency monitoring. A dependency tool was used to decide staffing levels which was reviewed on a monthly basis. We found the staffing rotas showed the provider had appropriate numbers of staff to meet people's needs. During the inspection we found buzzers were answered in a timely manner. We found new staff had been and were in the process of being recruited.

The registered manager explained as part of the transition from the previous provider's documentation to HC One Beamish Limited records staff were re-assessing people's needs in order to transfer information. Until all risk assessments were revisited, staff were using the previous provider's processes which were reviewed and updated regularly. We found new risk assessments were in place for some people, with those admitted to the home since the transfer having the current provider's documentation in their care files. People were included in managing risk where possible. We found records were stored securely with access only to care staff.

Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls and kitchen safety. These were reviewed on a regular basis and were accessible to staff for support and guidance.

We found up to date records to demonstrate the provider ensured the maintenance of equipment used by people in the service was checked on a regular basis. Certificates were in place to reflect gas safety checks, portable appliance checks, and mobile hoist and sling checks.

The provider had systems and processes in place in case of emergencies. Staff had access to up to date Personal Emergency Evacuation Plans for people (PEEPs) as well as an up to date list of people by name and contact numbers for their GP's and next of kin. This meant staff had information and guidance in case of an emergency.

We observed the housekeeping staff kept St Clare's Court clean and tidy with scheduled cleaning plans in place. There were no odours in the home and all fixtures and furnishing were of a high standard. Infection control policies and procedures were in place. Staff received effective hand washing training and had access to a supply of personal protective equipment.

We spent time in the kitchen and found systems and processes in place to ensure the kitchen and equipment used in the preparation of food was clean and well maintained. The provider employed a head of service who was responsible for carrying out daily checks. We found records of fridge and freezer

temperatures, dry food rotation systems and cooked food temperatures to demonstrate the provider followed food hygiene regulations.

Good

Is the service effective?

Our findings

Care records demonstrated how the person's physical, mental and social needs were assessed on admission to the home and then on a regular basis. Care records contained information which took into account current legislation and national guidance when planning outcomes. For example, nutritional guidance from the NHS regarding Focus on Undernutrition had been used in developing eating and drinking care plans with an outcome of providing a nutritionally safe diet. We also found the National Institute of Clinical Excellence (NICE) Management of medicines for older people was used in developing plans to support people with their medicines.

We found the provider used technology to allow people to summon assistance wherever they were in the home. People wore pendants to summon assistance with staff carrying pagers to allow them to respond in a timely manner. The registered manager told us about a new electronic medicine administration system the service intended to introduce in January 2018. This meant the provider was embracing the move to using technology in care delivery.

People and relatives felt that staff were well trained. Comments included, "They are lovely, know what they are doing and do a good job" and "I know they do lots of training it happens here in the home."

The provider offered a comprehensive training and development programme with mandatory training which included moving and handling, fire safety, Health and Safety, Mental Capacity Act, infection control, safeguarding and first aid. Staff told us they felt supported in their role and that the training provided gave them the skills they needed to care for people. One staff member told us, "We do such a lot of training, I have attended workshops as well." Another said, "I have had training on line, I am doing the care certificate." The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We observed that staff had the necessary skills and knowledge to do their job effectively. Staff were transferring people with ease and confidence, they assisted people with their walking frames at the person's own pace enabling them to walk independently. Staff knew when to use speech, gestures or body language to communicate with people, and at a level in which they could understand.

A program of appraisal and supervision sessions was in place for staff. Staff told us that they received good support from the management team both in relation to day to day guidance and individual supervision. This ensured people received care and support from staff with the appropriate support, training and skills to meet their needs.

Care plans identified people's specific dietary needs. We found the chef had information about people's specific diets such a soft or diabetic diet. Diet notification sheets were kept up to date with a copy given to the kitchen staff for their guidance. A rolling set menu was provided, however the chef was able to prepare other choices for people if they did not want or like what was on the menu. A pictorial menu was available for people with communication needs. We found people's cultural needs were meet as part of their

nutritional care plans. For example, to ensure the provision of a specific type of food.

Where people required a pureed diet we found this was prepared using an innovative method in which food was blended but prepared in such a way that it appeared like a normal meal. The chef showed us the pureed food they had prepared for the lunch time meal, the food looked like vegetables and chicken even though it would dissolve once in the mouth. This meant the provider was using innovative methods to provide food for people who needed specialised diets. By serving meals which were pleasing on the eye it encouraged those who may have reduced intake.

People were offered a healthy varied diet. We observed people having lunch in the dining room. Tables were set with cutlery, crockery and condiments. People were offered pea and ham soup with bread and butter followed by a choice of meat, egg and salad sandwiches, chicken goujon's with potato wedges and garlic mayonnaise. People appeared to enjoy their meal, and were offered an alternative if they did not want the set menu.

Where people required their food and fluid intake recorded we found records were not always completed correctly. No target amount was recorded which meant staff were not clear on the amount a person required to ensure they were hydrated. We discussed our findings with the registered manager who advised this would be addressed. On the second day of the inspection we checked food and fluid charts again and found the recording was improved. People now had a target fluid intake recorded which had been reviewed on a daily basis. Where the person was at risk of poor fluid intake a check list for symptoms of dehydration for staff guidance formed part of the intake chart. Food charts had been amended to include the quantities eaten for example, ¼ or ½ teaspoon or none, where people required specialised diets this was also included on the food intake chart as an additional prompt.

During lunch we spoke to one person, who commented, "The soup is beautiful…. it could be a wee but warmer though." They also mentioned that, "Food comes disguised with a funny name." We asked them to explain what they meant and they told us, "I am not accustomed to all this fancy food, I don't like it. I prefer simple foods like pie and mash," They commented that they could ask for an alternative if they didn't like what was on the menu. Another person told us, "The food is lovely, I enjoy every meal put in front of me,"

Relatives we spoke to gave mixed views about the food stating, "Food has fancy names and people don't know what it is for example beef cobbler …. People like old fashioned meals like plain old egg and chips", "Food's too fancy, people are given chicken parmesan. Why can't they have food like meat and potato pie", "Food names should be what people understand", "Food is lovely, my mum always gets a choice of what she wants to eat" and "Food looks very nice, my [family member] loves cornflakes, I had to buy her a bigger cereal bowl." We discussed the comments with the registered manager about the "funny names" given to meals. The registered manager advised this could be addressed by adding a descriptor to the menu to explain what the meal consisted of. We found on the second day of the inspection this was in place. The registered manager told us, "We took on board all the comments and have put things in place. It's about being open and transparent we are here for the people who live at St Clare's it's about providing the best care for them."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked capacity to make decisions, MCA assessments and best interest decision meeting records were available. The registered manager kept a matrix to identify who had a DoLS in place, when it was granted and where one has been requested along with date. Emails were available to demonstrate that the registered manager had maintained contact with the DoLS team for updates.

Staff understood the importance of supporting people to make as many of their own decisions as possible. We observed staff supporting people to make decisions regarding whether they wanted to have a shower or what activities they wished to attend and what they wanted for lunch using gestures, facial expressions and body language. One staff member used show and tell when offering different flavours of juice, this made it much easier for the person to make a decision.

Care records confirmed people had access to external health professionals when required. Records detailed visits from district nurses, community matrons, speech and language therapy and GP's. People also accessed the dentist, chiropody and opticians. We found hospital appointment letters in people's care files and associated daily records detailing the visit and outcome. Where people were admitted to hospital staff ensured details of their care and support along with current medicines were given to the ward or department to ensure medical staff had the information they required to continue support.

The home was a new building with a high specification in terms of facilities for people. En-suite rooms were available with showers and toilets which were easily accessible for people. Specially designed baths were available for those who required support to access the bath along with spacious wet rooms. Facilities were large enough to accommodate wheelchairs and other mobility equipment. Signage was in place to support people with orientation. Corridors were spacious with several communal areas with comfortable seating where people could spend time together or have private time if they wished. People had access to a safe enclosed garden which again was accessible for those using mobility equipment.

The provider had developed the areas in the home for people living with a dementia. We found tactile items for people, such as twiddle muffs, therapy dolls and items from the past which stimulated conversation. A twiddle muff is a knitted hand muff with items attached inside and out. It is designed to provide a stimulation activity for restless hands for people suffering from dementia. Doll therapy can be a very effective way for a person living with Alzheimer's or any kind of dementia to decrease stress and agitation.

Good

Is the service caring?

Our findings

People and relatives told us they felt the service was caring and were positive in their views and opinions. Comments included, "My [family member] is very happy here…can't fault the staff at all", "Staff always make sure that they are together especially at meal times", "My [family member] is treated with dignity and respect" and "Staff go above and beyond care." We found many written positive compliments had been made about the service. For example, "This is a lovely caring well decorated home. Manager and staff are friendly, and welcoming toward both resident and their families. Very professional, varied healthy diet, [family member] loves staying here and is making lots of new friends, is a friendly caring home.

The atmosphere in the home was pleasant and welcoming. The administrator welcomed visitors to the home, it was clear they had a good relationship with relatives and knew them well. During both days of the inspection we spent time in the communal areas and found staff encouraged people to join in the activities which were going on. We observed people obviously liked to sit together and staff knew this. People spent time together chatting and having a coffee or tea in the communal areas. We saw a group of people playing bingo in the main communal area, one person was calling the numbers and staff supported others so they did not miss the numbers. There was great excitement when one person got a line and then a house. The registered manager also joined the group and it was clear people knew him well by the humorous banter between them.

We observed staff asking people what they wanted to eat in a respectful manner speaking clearly. People's dignity was respected by staff asking if they wanted a dignity tabard to avoid food spillage. There were enough staff assisting with lunch and people didn't have to wait a long time before their food was brought to them.

Staff addressed people by their preferred name and were very friendly and caring towards them. It was a quiet but pleasant atmosphere with staff chatting to people. Staff worked well as a team and were professional in their work being very kind and respectful while giving individualised care and attention to everyone.

Where necessary we saw staff crouched down to maintain eye contact, rather than standing over people. Staff waited for people to respond and used a range of actions during communication such as hand gestures, facial expressions. Staff explained options which were available to the person and encouraged them to make their own decisions. For example, what they preferred a bath or shower.

People were cared for by staff who knew their needs well. Staff were able to describe how they supported people. For example, always making sure [person] had their glasses on, making sure [person] had their walking frame close. Staff told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, or asking if they wished to spend time alone. Comments from people included, "Staff always knock on the door before they come in" and "When carers leave me on the toilet they always wait outside until I am ready."

We found care plans were in place to meet communication needs. Staff had taken time to speak with family members to gain information in putting together a support plan which enabled staff to give people the opportunity to make their views known. For example, speak clearly and give [person] time to respond and [person] has a soft voice.

We found all staff wore a name badge containing something interesting about them. By doing this the provider had developed a method of starting conversations with people and relatives and to give the opportunity for people to interact with staff. For example, Steph, cat lover.

We found people had detailed life history booklets. By gaining information about people's lives staff used the information to ensure they knew people's likes and dislikes. Staff felt it was important for people to maintain contact with friends and family and supported people to maintain relationships by facilitating visitors to spend time with their loved ones. We heard staff asking people if they wished to have their visit in private or to remain in the communal areas.

Rooms were tastefully decorated and contained photographs, ornaments and furniture which had been brought in by family or friends. This meant the provider understood people's need for home comforts and to still have things that meant something to them in close proximity.

The registered manager recognised the possibility that people may require the support of an advocate. They told us, "We would always contact them [social workers] if need be." We found information was readily available in the reception area for people, relatives and visitors about independent advocacy.

Outstanding ☆

Is the service responsive?

Our findings

We found the service provided an excellent standard of end of life care by incorporating National institute of Clinical Excellence (NICE) End of life care for adults March 2017 into care planning. We found plans included pain and symptom management. Personal preferences were acknowledged and detailed in care plans so staff could deliver care in the way the person had requested. For example, keep the bedroom window slightly open and curtains are to left open during the day so [person] can see out. One staff member was the dedicated end of life champion for the home. The role of the champion was to keep up to date with best practice and communicate this to staff through team meetings and ensuring the provider displayed posters and information for staff. The provider had end of life training as part of their electronic training system which staff were completing.

The registered manager told us, "Staff provide an excellent level of care not only for residents but also to relatives." We found numerous compliment cards and electronic comments to demonstrate how staff had shown a caring and sympathetic approach. Relatives described how such an upsetting situation was made more manageable due to the support given by all staff. Staff displayed, "care, kindness, dignity and dedication", "loving care and peace of mind" and "exceptional care", "exemplary personal care and attention to the family "and "the care St Clare's Court gave my [family member] has been outstanding".

We spoke to a relative whose family member had recently died. They wanted to come in to speak to the inspection team about the excellent care that they and their family member had received from staff. They told us how the staff and registered manager had supported them as a family. A room was made available to them to rest and sleep so they could remain at the home for 24 hours a day allowing special time with their family member. They were kept informed of everything during this time by the GP and staff. Their family member died comfortably and peacefully cared for by kind, thoughtful and very caring staff who showed respect and dignity. They told us, "The funeral cortege left from the care home and all staff were very respectful at this very sad time, I am very welcome to visit the home whenever I want."

We found the chef played an important part in the support to people and families. They told us how meals were prepared for relatives. The chef told us, "We always make sure we offer something to eat, sandwiches or a meal, cups of tea or coffee and a chat even if it's five minutes in the corridor."

We looked at one person's end of life care plan and found it contained their wishes and preferences, completed with the person, relatives and staff. The care the person requested was detailed and personalised for staff to follow. Records were kept of all interventions for end of life care and symptom control including the administration of medicines to relieve pain and distress. Personal care records showed staff carried out positional changes, mouth care and personal hygiene care. We saw records of GP and community nurse involvement with staff requesting visits when necessary. The provider had a system of providing mouth care for people at the end of life which was not as intrusive as sponge mouth swabs. The bubble machine is used with liquids such as juice or mouthwash, once switched on the bubbles it produces are placed on a spoon and used to freshen the person's mouth.

The registered manager told us, "We would always try to have somewhere for relatives to stay, or just to have a rest. It's important to make time to look after the family." The registered manager had put together an overnight bag for relatives. Staff attended people's funerals and the service sent condolence cards to families. Bereaved relatives were welcomed back to the home to visit whenever they wished to visit.

People and relatives felt staff were very supportive to people's individual needs and focused on person-centred care. Comments included, "My [family member] likes to have his meals in his bedroom and staff respect that. They do ask him though if he wants his meals in the dining room….he can go to bed and get up when he wants", "I know how I want to be looked after and talked to them about that" and "I have everything I need here, they [staff] always ask me what I want to do."

We saw the provider had a plan in place for the re-assessment of some people's needs in order to develop care plans using HC One Beamish documentation. This process was on going and we found some people had new care plans and some remaining on the previous provider's documentation. In all instances we found people had care plans which were personal to them, that included information on maintaining people's health, likes, dislikes and their daily routines. For example, what time they preferred to go to bed or get up. The plans set out what people's needs were and how they should be met. These included identifying potential risks to the person and management plans were devised to minimise these risks such as, mobility and risk of malnutrition.

The service responded to people's spiritual, religious or faith needs as part of the assessment and care planning process. People were supported to have access to different religious or faith groups. For example, visits from local clergy. We also found cultural preferences regarding people's dietary choices were also included in care planning.

We found care plans were reviewed on a regular basis so staff had access to detailed up to date information to support people's specific needs and preferences. Where possible people and their relatives had been involved in the development of care plans. Daily handovers were used by staff to ensure they were kept informed of any recent changes in a person's needs.

We were shown a file containing daily activities and meaningful moments. Each person within the care home had a specific page which illustrated their daily activities log, which on the date of inspection was up to date. We found daily entries covered a wide range of activities. For example, decorating Christmas baubles, playing dominoes, knitting, darts and baking cakes. One entry showed that a person spent time folding the washing as this was their job when they were younger and they enjoyed the activity.

We found the service had purchased an electronic device called 'Alexa'. Alexa is a voice-activated technology innovation that can be helpful to people living with dementia. People can ask the device questions and get an answer thereby assisting with memory as well as involving them in the use of new technology. The registered manager told us, "They absolutely love it, and have had so much fun with it." People also used an iPad to look at times gone by. The home had a 'Gardening Club', one person spent a lot of time in the garden potting plants and doing light general garden maintenance. They told us, "I enjoy working in the garden, it keeps me occupied and gives me something to do. [Well-being co-ordinator] takes me out to buy plants for the garden. We have been looking for plants suitable to grow in winter." Staff supported one person to attend a local centre to use the hydrotherapy pool, which provided exercise as well as a recreational activity. People were helping staff decorate an old fashioned sweet cart, we saw this was partly painted.

We asked people and relatives what they felt about the activities provided in the home. Comments included,

"My [family member] prefers not to get involved in any activities, he likes to sit in his room but the carers always pop in and chat to him", "I think there is a lack of activities during the day, there are two part-time activity coordinators but only do activities for an hour on the morning and an hour on the afternoon", "I enjoy everything they put on, bingo is my favourite" and "I have been making pumpkins for Halloween and making poppies for Remembrance Sunday." The well-being coordinator told us, "We have just heard that we got third prize for pumpkin competition held by a local retailer and won a voucher. I have just told the people who took part and they were chuffed to bits."

We saw the home had a 'One Proud Home' file which showed photographs of people being involved in the community. We found photographs of one person's celebrations with the local police for his service as a sergeant. We also observed the local school 'Sugar Hill' attending the home to show people their guitar and singing skills. There were many photographs of people making Christmas cards for the local nursery.

The care home had a '3 Wishes' initiative and we saw lots of photographs of people's wishes being granted for example, going out to have ice-cream, eating fish and chips, going to the town to do some shopping. Staff took a drinks trolley round on a Friday with alcoholic and non-alcoholic drinks for people, known as 'happy hour'. One person told us, "I enjoy a drink, just a little one."

The provider had a complaints policy and procedure in place. We found the registered manager kept records of all complaints. We saw copies of investigation notes along with copies of the registered manager's outcome letter to the complainant. Investigation notes were thorough and detailed.

Good

Is the service well-led?

Our findings

We found the registered manager had been registered with CQC since June 2017 and was passionate about St Clare's Court and proud of the care and support the staff provided. We observed their interaction with relatives and people and found this to be friendly, engaging and professional. The registered manager was experienced in supporting older people and people living with dementia. They worked alongside staff which allowed them to observe the care and support that was provided. This showed us the registered manager led by example in his role and was not restricted to the administrative side of management.

People and relatives we spoke to had positive comments regarding the registered manager. They told us they were very approachable and visible in the home. Comments included, "He's lovely, always a smile", "Around all the time, nothing is too much trouble" and "Oh, they are great." People told us they would have no hesitation in speaking to the registered manager if they had a concern or a worry. One person told us, "He listens."

The registered manager told us the provider had an open door policy in terms of access to the managers, this meant people who used the service, their relatives and other visitors were able to speak with them at any time. Staff we spoke with were clear about their roles and responsibilities. They felt supported in their role and told us they were able to approach the registered manager or to report concerns.

We found the registered manager used various methods of gaining feedback about the service and was constantly reviewing how improvements could be made. They visited the home outside of normal working hours (late at night and early in a morning) to support staff and monitor the quality and safety of the service. Records were maintained of visits and used as part of the quality assurance process. The registered manager told us, "I come in early or stay late to thank the night staff, it's important to let them know they are valued. I couldn't wish for a better team."

We found the provider had a system called Cornerstone to monitor the quality of the service, the last overall audit score was 91%. The system covered all aspects of service delivery including audits of medicines, infection control, and care records. The audits also provided evidence to demonstrate what action had been taken if a gap in practice was identified and when it was addressed. The provider had a rolling service improvement plan where audit findings were actioned. We found where actions were completed these were reviewed as part of the quality assurance system.

The registered manager had identified concerns with medicine management and had put in place additional checks to reduce the risk of reoccurrence. During the inspection we identified some gaps in recording on people's MARs and fridge temperature recording. The registered manager reviewed their audit processes and addressed this in a timely manner by arranging a flash meeting and supervision with staff. The registered manager told us that an electronic medicine system was being introduced from January 2018 with the aim of making medicines administration easier and safer.

The area director visited the home on regular basis. We found monitoring reports from their visits contained

actions for the registered manager. Where actions were needed these were addressed and signed off as completed. The area director told us, "This home has received a score of 9.9 on Carehome UK. I am so pleased for [registered manager] and the staff, who work incredibly hard." Carehome.co.uk is a web based platform used by the public to place reviews about care homes.

People who used the service, relatives and staff told us they had regular meetings with the deputy manager and/or registered manager. We found minutes of meetings contained suggestions and queries raised during meetings. Action plans were in place from meetings to demonstrate how the registered manager looked into concerns or issues. One such concern was around car parking, relatives felt the car park was not big enough for staff and visitors. We discussed this with the registered manager who advised that car parking had been discussed with senior management as this was not something they could influence in the home. Car parking was available at the front of the home, with a place to drop off or collect.

We found accidents and incidents were recorded and uploaded onto the HC One Beamish portal within 24 hours. The system sent a report to senior managers and the health and safety team for auditing purposes. Where action was needed a plan was sent to the registered manager. The registered manager told us "The audits and analysis drive improvements in keeping people safe."

The provider also ran an award scheme for staff who went above and beyond. We saw that staff, relatives and people nominated staff for these awards. We saw photographs of staff receiving their certificates from the registered manager. Some of the comments made about staff were, "Always showing kindness", "Going out of their way to help and support, she cares for [person] as if he was her own father," and "Is more than a maintenance man, he would do anything for everyone, he brings a great atmosphere to the home and is always smiling."

The provider had a comprehensive set of policies and procedures which were easily accessible for staff if they wished to refer to them. The registered manager told us, "Policies and procedures are reviewed regularly to keep up to date with legislation and best practice. We receive emails when policies are updated."

The registered manager worked in partnership with the local authority commissioners and safeguarding team and the clinical commissioning group (CCG). We also found links with local community services and schools.

The registered provider ensured notifications were submitted to CQC as part their regulatory responsibilities.