Roseberry Care Centres GB Limited

Lowgate 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 20 and 21 March 2018 and was unannounced, which meant the provider did not know we would be visiting. At the last inspection in January 2016 the provider had not ensured that people were protected against the risks associated with unsafe and unsuitable premises. These issues were breaches of regulation 15 (premises and equipment).

Following the inspection, the provider sent us a detailed action plan to explain how they would address these concerns. At this inspection the provider had made improvements which meant they were no longer in breach of the regulations.

Lowgate is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Lowgate provides accommodation on ground floor level for up to 42 people with residential and nursing care needs. People had a range of health care needs, including those living with dementia. At the time of the inspection, there were 40 people living at the service.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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 provider had submitted statutory notifications and had displayed its inspection rating in the service and on its website as legally required. The registered manager was held in high regard by people, relatives, staff and healthcare professionals whom we spoke with.

People told us they felt safe as did their relatives. Staff had received safeguarding adults training and told us they would have no hesitation in reporting any concerns. Where concerns had arisen, these had been addressed, which included disciplinary action towards staff when necessary.

Medicines were generally managed well with people receiving their medicines on time by trained staff. Some issues we found during the inspection were addressed straight away by the registered manager.

There was enough staff on duty at the service at all times. There were suitable recruitment procedures in place. Checks were taken before staff started in their role at the service. We have made a recommendation regarding the review of the Disclosure and Barring Service procedures in line with good practice.

Staff had received a full induction, a range of appropriate training and felt fully supported in their work at the service.

Before people moved into the service they had their needs assessed to ensure the provider could meet them. Once people moved into the service, full and detailed person centred care plans were prepared with important information recorded about people to support staff in assisting them.

Risk was identified and assessed to minimise harm to people. Where accidents or incidents had occurred, these were fully recorded and monitored for any trends forming.

Suitable checks were made on the premises and the equipment to ensure they were safe, this included all of the utilities and the building itself. Emergency contingency plans were in place in case of emergencies and the provider had recently completed a fire risk assessment to minimise risk to people even further.

People were 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.

Good quality nutritious food and suitable refreshments were available to people. Support was offered to maintain dignity and respect to those who could not fully manage themselves. This included, for example, help with meals, personal care and mobility.

People told us staff showed them kindness and were caring and we observed many examples of this throughout the inspection. this included words of comfort, positive conversations and explanations of care tasks being provided.

Outside healthcare professionals were fully involved in the service. This included district nurses, who were very positive about the service and a GP who completed regular visits. The service had been quick in responding when this was required due to, for example, a deterioration in health.

There was a good selection of activities available to stimulate people at the service run by a passionate activity coordinator. This included a range of entertainers, visits from community groups, music, church services and a selection of arts and crafts.

Complaints procedures were available and people and their relatives told us they would complain if they needed to. Any complaints or 'grumbles' had been dealt with fully and in line with the provider's policy.

The provider had a range of quality monitoring procedures in place to ensure that the service remained to a good standard. These included checks on medicines, infection control and care plans. Where issues had been identified actions were in place and the registered manager had worked or was working through these.

People and their relatives were kept at the heart of the service and encouraged to complete surveys and meetings for example. Results of any feedback were displayed on notice boards in the main reception area to show transparency by the provider.

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.

Medicines were generally managed safely.

There were enough staff to meet the needs of people at the service.

Risk assessments were recorded and monitored. Accidents and incidents were recorded and monitored for trends.

Safeguarding responsibilities were taken seriously by staff and they understood the need to report any concerns.

Is the service effective?

Good

The service was effective.

Assessments were completed before people moved into the service to ensure needs could be met.

Staff had received suitable training and were well supported in their roles.

Staff understood their role in regard to the Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards and they worked within legal guidelines.

A range of suitable food and refreshments were provided and support was given to people when necessary. Referrals to external health care professional took place if this was required.

Is the service caring?

Good

The service was caring.

All of the contacts we made with people and their relatives had positive comments regarding the caring nature of staff at the service.

People were respected and their dignity was maintained and where possible independence preserved.

Is the service responsive?

Good

The service was responsive.

People's records had been produced in a person centred way. A range of suitable activities were available to stimulate people.

People and their relatives were able to complain and material was available to show them how to do this.

Is the service well-led?

Good

The service was well led.

An established registered manager was in place who was well thought of by people, relatives and staff alike.

There was a programme of audits and monitoring systems in place to oversee the quality of the service provided.

People, relatives and staff had ways to feedback to the provider through a number of mechanisms, including surveys and meetings.

Lowgate Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 March 2018 and was unannounced on the first day. The inspection was carried out by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a person who specialises in a particular area of health and social care. This advisor was a nutrition nurse consultant.

Before the inspection, the provider had completed a Provider Information Return (PIR) in February 2018. 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 used this information to support the inspection process. We reviewed other information we held about the service, including any statutory notifications we had received from the provider about deaths, serious injuries or safeguarding concerns. Notifications are incidents which the provider is legally obliged to send the Commission.

Before the inspection we contacted the local authority commissioners and safeguarding teams and the local Healthwatch team. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used any information provided to support the planning process.

We also contacted, either before, during or after the inspection, a community nurse, a district nurse, the clinical commissioning group lead, pharmacy colleagues, the infection control lead for care homes, the fire service, the specialist dietician team and a range of care managers involved with the service. We used any information received to support our judgements.

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

with us.

We spoke with 11 people who used the service and nine family members/visitors. We also spoke with the registered manager, three nurses, one senior member of care staff, five care staff, the cook, the activity coordinator and a member of domestic staff. We observed staff interaction with people and looked at a range of records which included the care records for eight people and medicines records for everyone living at the service. We looked at four staff personnel files, health and safety information and other documents related to the management of the home.

We placed a poster in the reception area to inform visitors of our inspection and asked them to contact us with any feedback they may have had.

Good

Is the service safe?

Our findings

At the last inspection the provider was in breach of regulation 15 in connection with the premises and equipment. They had not ensured that people were protected against the risks associated with unsafe and unsuitable premises. During this inspection, we found the provider had made improvements and were no longer in breach of this regulation.

The provider completed maintenance checks on all equipment and the premises, including for example, electric, gas and lifting equipment which we viewed. We were made aware of some outstanding work on the heating system but this had been reported and the provider was aware and looking into.

A member of domestic staff told us, "The manager will do a walk round of the building and I also do this to check there is nothing broken in the rooms i.e. chairs. If anything is found to be broken it's recorded in the maintenance book. If there is a risk to a service user it is removed, but if it is easily fixed it's left for the maintenance man." We asked staff if there was a delay in repairs. One staff member said, "No, we are quite lucky, if carpets or anything need replaced I ask [registered manager] and she makes requests to senior managers. There is a carpet being delivered this afternoon. If anything is a trip hazard it is usually replaced straight away or temporarily repaired so that it is not a hazard until it can be replaced."

People said they felt comfortable and safe living at the service. One person told us, "I am definitely safe here, why would I not be?" Another person said, "Lovely place, feel safer than when I lived at home. They look after me very well thank you." Staff knew what to do if they had any concerns of a safeguarding nature. One staff member said, "I would speak to a senior carer on that corridor, one of the nurses or the manager if I had any concerns about anything." Another staff member said, "Yes, definitely (would report). I would go straight to the manager or if it was the weekend or the manager wasn't here I would go straight to one of the nurses." Another staff member said, "I would always respect what people say, but if they said something where I thought someone was in danger I would explain that I would have to report this to the manager, for example if someone reported any kind of abuse." We saw that a number of issues had arisen over the inspection period. These issues had been reported and immediately dealt with appropriately by the registered manager, which included disciplinary action or retraining for example.

One nurse told us, "The good thing about working here is that there is always two trained nurses on duty and [registered manager] at the end of the phone at weekends." One staff member told us, "The whole time I've been here I've never seen any agency staff. I've worked in other homes before where agency staff have been used a lot."

We observed staffing levels at the service and checked how they were calculated. We confirmed that the provider had enough staff in place to keep people safe. During the recent bad spell of snowy weather, the registered manager had managed very well to maintain enough staff to cover. This had included them staying and sleeping over at the service for a period of days while the poor weather conditions remained. Other staff had also supported this and stayed at the service with makeshift beds. We were confident that suitable arrangements and contingency plans were in place to ensure enough staff were on duty at all times.

Medicines were stored and generally administered correctly. The medicine room was clean and tidy with medicine trollies being attached to wall as required. Temperatures were monitored and unwanted medicines were stored correctly as was controlled drugs. Controlled drugs (CD) are prescribed medicines used to treat, for example, severe pain. However some people abuse them by taking them when there is no clinical reason to do and for that reason have more stringent storage requirements. We checked a sample of CD's and found them correctly logged and stored with two nurses signing for them at administration.

We observed medicines being administered to people. Medicines that were in patch form had not always been applied to the skin as prescribed. We spoke to the registered manager about this and they addressed this straight away. We checked again and found staff had been spoken to and were aware of what actions to take.

At lunch time medicine was administered to one person by a nurse. The person was gently encouraged to take a drink of juice and was then fed her pudding by the nurse as it arrived at the same time. The nurse maintained continuity of care with the person and spoke to them throughout, telling them what the flavour of the cake was and encouraging them to eat it all up.

We found 'as required' medicines protocols were not always in place. 'As required' medicines are those that are taken infrequently, for example, those used for pain relief or constipation. We saw no evidence to suggest people did not receive their 'as required' medicines if they needed them because the nurses on duty knew people very well. However, it is important that information is available (dosage/frequency/why taken and expected outcome), particularly for those people who are unable to communicate their needs. We brought this to the attention of the registered manager who reviewed and updated this immediately before the end of the inspection process.

Risks had been identified and risk assessments put in place to keep people as safe as possible. Risk assessments included those for people at risk of choking, those at risk of falls and those with skin care issues. Staff had identified what they needed to do to minimise risk and what to do if risks increased, for example; referral to additional support services outside of the home environment.

Where accidents or incidents had occurred, the registered manager had ensured they were recorded correctly and they then monitored any trends which may have formed. Forms viewed also included if the incident needed to be reported to relevant authorities, for example, the local authority or the Care Quality Commission. Where an accident presented some learning to ensure it did not happen again, this was discussed with staff at morning meetings or at more general staff meetings.

The registered manager had personal emergency evacuation plans in place for everyone who lived at the service. These are used to provide guidance to emergency service should the building need to be evacuated due to fire for example. Fire drills had taken place and were done in line with best practice. The fire risk assessment for the service had just been completed and received back by the provider and the registered manager was working their way through the actions identified on it. This meant the provider had taken actions to minimise the risk of harm, should an emergency arise.

The provider also had an emergency contingency plan in place which staff would follow in times of crisis. This had worked well during recent poor weather conditions and this is discussed in the well led domain. One district nurse told us "The recent adverse weather conditions caused a few problems. I rang here and asked if they could see to one of my patients. They said they were going to…they had thought ahead, which was great."

We noted that the entrance to the service had a coded doorway entry. We noticed that a number of visitors seemed to have this code and were able to gain entry without staff. This posed a risk as visitors could enter the service unseen. We spoke to the registered manager about this who said they would address this and keep codes secure to staff only.

There were no odours and the service was found to be clean and tidy. Equipment such as gloves and aprons were available for staff to use.

The provider had recruitment procedures in place. One nurse told us, "I had to wait a while before my reference came through. My passport was used to check my identification and my registration as a nurse was checked." Another staff member said, "My DBS check was in place before starting work." We reviewed the recruitment files for four staff and this included, application forms with no employment gaps, suitable references, Disclosure and Barring Service checks (DBS) and nurse PIN numbers if applicable. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. Nurse PIN numbers were monitored to ensure they remain valid and up to date and we checked a selection to ensure this was correct. We noted that some DBS checks were older. We discussed this with the provider and best practice procedures of re-doing every three years.

We recommend the provider review their DBS procedures in line with good practice.

Good

Is the service effective?

Our findings

People thought that staff at the service had helped them to improve their quality of health. One person told us, "It's very good and they keep an eye on me. They have helped me get more mobile since I came in here too."

We asked staff if anyone displayed behaviour which challenged the service and how they managed this. One staff member told us, "We know people and know their ways and reassure people, but it's not any one person it could be anyone. We get a lot of training of how to manage these situations and you learn things yourself from what you see and what you pick up." Another staff member said, "We have received training for this. To be honest, when anyone is like that, I find it easy to calm people down. I find talking to them calmly or distracting them does the trick." This demonstrated staff knew how to manage difficult situations.

People had their needs assessed before they came to live at the service. Once people had moved in, more detailed care plans were completed and reviewed regularly to ensure that people's needs continued to be met. Care plans supported a range of needs, including those in connection with mobility, skin integrity, medicines and personal care. One staff member said, "The Deputy Manager goes through care plans and checks they are up to date but they are reviewed on a monthly basis also. If there was a change in need, such as a moving and handling change, this can be updated immediately."

One person's bed was not at the correct setting for comfort and to protect them from pressure damage. The setting was changed immediately upon discussion with staff, although we confirmed no harm had come to the person. The registered manager said they would review their checking procedures to ensure this did not happen again.

The provider's induction was in line with the Care Certificate. We asked staff about their induction process. One member of care staff said it was effective and commented, "Yes, it was a period of three days where I was supernumerary and worked alongside other staff. I was given a mentor and had an induction check list and tasks were ticked off as they were completed."

Staff training was generally up to date and provided staff with knowledge to support them in caring for the people who lived at the service. This included for example, falls awareness, safeguarding adults and medicine training. One staff member told us, "I've done all the in house training; safeguarding, DoLS (Deprivation of Liberty Safeguards), dementia awareness, end of life, moving and handling, equality and diversity, nutrition awareness and food hygiene. I have done everything on my training matrix, but I don't have to do training for care planning." One nurse told us, "[Registered manager] does all the other training; she's very good at that."

Staff told us they received good support from their line manager, including the deputy manager, nurses and registered manager. One member of staff said, "I get supervision quite regular, I would say every couple of months. Sometimes it could be more if there is anything new that needs to be discussed." Another staff member said, "Yes. The management have been brilliant and have supported me with things that are going

on in my personal life as well as here." A further staff member said, "Yes, very well supported. That's why I like working here."

Handover discussions took place at every staff change. We sat in on part of two handovers and found staff passed on important information about each person who lived at the home. This ensured that all staff had this information before starting their shift. The handovers gave staff an overview of how people were and if there were any particular appointments or other arrangements they needed to know about or things they needed to do for people. We saw that one person's form of hoist had been discussed, including their choices and preferences. One staff member said, "There is good communication in the home."

A district nurse told us, "Communication is very open, only yesterday someone presented with an infected joint…they approached me and I got the GP out." A local GP completed regular visits to the service. The district nurse told us, "It's great, when the GP visits, people's health concerns can be nipped in the bud before they turn into something worse. Not sure how long it has been like this, but having the GP attend like that is very good."

People had access to health care professionals when needed. For example, there had been good contact with a diabetes nurse, community matron and a GP, regarding fluctuations in on person's blood sugar levels regarding their diabetes management. One staff member told us, "If it is dietary changes such as a change in swallow, we get SALT (Speech and Language Therapy team) in to assess the client for eating."

The registered manager and staff were aware of their responsibilities and followed correct procedures regarding the Mental Capacity Act 2005 (MCA). 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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any applications had been made to deprive a person of their liberty. 21 people were subject to a DoLS which had been applied for and authorised (or awaiting approval) via the local authority. These were all in order and correctly applied for and monitored.

Staff understood the importance of allowing people choice and gaining their consent. Where consent was not possible due to a lack of capacity, best interest decisions had been made with family, GP's, staff and other healthcare professionals involved. For example, one person received covert medicines which had been recorded fully and correctly by all involved. The registered manager was in the process of updating paperwork to ensure that any decisions made in people's best interests were in place and fully recorded.

The service held copies of the lasting power of attorney (LPA) for people on their care records when this was the case. (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. One decision that had been made on behalf of one person was not clear if the family member had LPA over health decisions as well as finance. We spoke to the registered manager about this. They said they would review the process and make sure that staff were aware and copies were always kept on people's care records.

There was a good selection of balanced nutritious food and a range of refreshments available to people living at the service, including a water station in the main dining area. The kitchen held good quality products, including double cream, full fat milk, fresh fruit and vegetables and home cooked cakes and pastries. There was also a selection of proteins, with adequate carbohydrates as recommended in the governments 'Eat Well Guidance'.

People thought the food was good. One person said, "The food is lovely but too much…I am putting weight on, but no complaints though. It's magic." Another person said, "The meals are smashing." One of the kitchen team served dessert and went around the tables asking if people had enjoyed their meal. People seemed to know them and gave complimentary responses throughout.

We observed picture menus were used on display boards as well as written menus on each dining table, with very clear and bright colours. People were offered choices. One person was having a late breakfast said, "I am very good. No complaints. All the girls are very good…do anything for you." People were encouraged and supported throughout mealtimes. One member of care staff sat with one person through their entire meal, feeding them with encouragement. The person smiled throughout and seemed to really relate to the staff member.

We observed the lunch time dining experience in different parts of the service, including the dining area, lounge area and where people had chosen to eat in their bedrooms. On some occasions we found that different staff supported people with their meals and it felt a little 'task orientated'. We spoke with the registered manager about this and they said they would look into this.

Staff used the Malnutrition Universal Screening Tool (MUST). MUST is a five-step best practice screening tool to identify adults, who are malnourished, at risk of malnutrition or who are obese. Staff had identified weight loss in one person and had provided appropriate intervention, including fortifying foods and drinks. This person had increased their weight by three kilogrammes. GP's and dieticians had been kept informed of the weight loss and the action staff were implementing.

Outside people's bedrooms were memory boxes which were filled with important items special to each person. For example, one box held pictures and another held certificates and details of previous employment in the armed forces.

We asked the activity coordinator about her role and what has changed. They said, "I came here about nine years ago with no training…came into with a pack of cards, dominoes and a couple of quiz sheets. At that time most of the people were residential, but over time we have a mix of people now and some with dementia. We have reminiscence afternoons where we use some of the things from the Reminiscence Kitchen and have lovely conversations comparing things in the 'old days' to now." The Reminiscence Kitchen was full of a variety of equipment and furniture which would have been used in the 1920-1960 or thereabouts.

We observed people sitting in lounge areas with refreshments, watching and listening to the television, reading newspapers and chatting with staff. We noted the television also had subtitles on for people who had impaired hearing.

The service was comfortable, light and airy, and remained homely. The outside area was well laid out with plans to further develop it. There was a garden room in the middle of the outside space which had been decorated to replicate a beech scene. We were told this area was open in the warmer weather for people to use. We saw one person sitting outside in the warm spring sunshine and later we asked them if they had

enjoyed doing that. They said, "I like to sit outside for some fresh air if the weather is okay…lovely out there today."

Although the premises was a little dated in parts; the provider had a continuous redecoration programme in place. Handrails were a different colour to the main walls to help people living with dementia differentiate between the two. Signage was in place to also help people move around the building and locate bedrooms, toilets and other communal rooms better.

Good

Is the service caring?

Our findings

Throughout the inspection the team observed acts of kindness with staff providing care in a compassionate and sympathetic way. Staff were attentive. We observed one member of care staff reassuring a person who had become distressed. We overheard them telling the person that 'everything was alright'. This person was then supported back to their room with words of comfort throughout. We overheard thoughtful staff comments such as, "How are you feeling today, you a bit better [person's name]?"; "How do you fancy a bit of this (food) [person's name]…it's your favourite" and "I think your [relatives name] is coming today…that will be nice."

We observed a number of moving and handling procedures taking place. Staff spoke to the person throughout, including, "Are you comfortable"; "We are just going to put this round you [person's name], is that okay" and "Are you okay [person's name], we are nearly there."

People's comments about the care provided at the service included, "I am quite happy - everyone is very welcoming and amicable"; "I am looked after well. I get tea and biscuits regularly. Nurse comes on a regular basis for my feet and get help with shower and baths. I have no problems. I have everything I need"; "I didn't like it at first, but was soon made to feel welcome by everyone…really good"; "It's very friendly in here. It's not too big either. I had respite here, liked it and have been here ever since. [Registered manager name] is great. I really like the music" and "The staff are really nice. They will sit and talk to me which I really like and shows they care."

Relatives told us, "Everyone seems very nice, very friendly and helpful"; "The staff know him so well and treat him well…caring. I know he can be difficult" and "We are quite happy with the care we have seen since coming in. My brother (who lives locally) tells us the care is very good. The manager is very good; we have spoken to her a lot since we have visited with no complaints."

Friends of one person said, "We love coming here to visit. There is always something on and our friend is so well looked after."

When speaking to the activities coordinator they mentioned how caring the staff team were; in particular the registered manager who was "very hands on." They also said, "The staff are great, they have done sponsored walks to raise money for the activities and some of them bring in their children, as the residents love to see children… its brilliant."

One staff member said, "I think the carers really care here, everyone all joins in and everyone helps including domestic and kitchen staff."

There were no restrictions about relatives visiting times. They could come whenever they wanted. Relatives could also have a meal with their family member if they wished as long as they let the staff know to enable additional food to be made available.

People's dignity and privacy was respected and maintained. When we asked about this, one staff member told us, "If I'm cleaning in the corridor and a door is shut, I will always knock before entering, or if I open a door and a service user is on the toilet, I would close it and return later. I do support people to the toilet and close doors to maintain privacy and cover people over to respect their dignity. Another staff member said, "We close the door, not shout things about people and if people have an accident not to make a big deal about it." In the reception area was information to let people and their relatives know that the registered manager was the dignity champion. The dignity champion held responsibility to ensure staff maintained people's dignity and, for example, passed on best practice to all staff.

We observed staff helping people to remain independent. One person could not manage to cut up their food, so staff intervened to support them after they asked if the person wanted help. The staff checked they could manage and then left them to eat the food on their own, which they managed very well. Another person was unable to rise from a chair and asked staff to help them. Once this action had been completed, the person walked off slowly to their bedroom with the support of their Zimmer frame, being watched by the same staff member. The staff member clearly recognised the importance of allowing people to remain as independent as they could be.

Staff were aware of the importance of securing personal data and information. One nurse told us, "Confidentiality is discussed regularly at morning 'Hub' meetings. We have note books, but we are asked to use room numbers or initials when writing notes about service users."

Another staff member said, "Communication is important so if people are able to communicate what they prefer, it's best to ask individuals what they prefer themselves. I respect that everyone is different and that people have different beliefs."

In the reception area and in other parts of the service, we found a variety of information to support people and their families. This included, for example, leaflets and printouts of services in the local area, equality and diversity information, infection control newsletters, what safeguarding measures were taken and who to contact, how to contact the provider and which staff were on duty (which included pictures). We were not made aware of anyone receiving support from advocacy services at the time of the inspection, but the registered manager had information available should that be required.

Good

Is the service responsive?

Our findings

Changes in people's care and support needs were discussed within the service to ensure their changing needs continued to be met. One nurse said, "We make sure any change is communicated throughout the team and that it is discussed at handovers. If it is diet related, such as someone being prescribed thickener, it would also be recorded on the MAR sheets (medicine administration record sheets) and the kitchen would be given this information. The kitchen also have records of what kind of diet a particular person requires such as a soft diet."

One relative explained how their family member had fallen and how responsive the registered manager had been. They said, "The [registered] manager could not have been more supportive. She already had equipment in his room to alert them if my dad got out of bed, but they have put a different type of alarm in now. They have all been great."

One relative told us how responsive staff had been and said, "My dad has an unusual sleep pattern and can be awake for 20-30 hours then sleeps for two to three days. When he is awake the carers keep him with them, where possible, during the night. They ensure he has drinks etc. when needed. During the days he sleep's for two to three days, they have to wake him for drinks and food as he is diabetic. They tell me he is grumpy but no problem at all."

One family member said, "When I chose this home I really liked the manager and there was a mix of residential and dementia. The staff have made a huge difference to my mother. Recently there was a visit by a micro zoo. I couldn't believe it, but they got people talking who I had never seen talking, when asked if they wanted to hold a beetle…Great."

The activities coordinator showed us records kept about each individual at the service called, "This is me." These documents held personalised information about people, including a picture of the person and person centred information about what they liked, disliked and about their background.

Care records were person centred. One person's care plan stated they had a sweet tooth, and would spit food out if they didn't like it as they could not communicate any other way their feelings. Documents explained what a pureed diet was and importantly what it was not for this person.

One person had a very detailed PEG care plans in place which included all the essential elements of; turning the PEG, cleaning the PEG, what to do if PEG falls out, what angle the person was to be positioned, with an explanation that failure to keep this position may cause aspiration pneumonia and the feeding regime. A PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We were told by the registered manager that they were continuing to work on care plans to ensure they were as person centred as possible.

Care staff knew that changing needs required a quick response. One member of care staff said, "Care plans

are kept in the nurses office and these are available to staff. If there is a change in need, care plans are updated by the nurses. It's important that any of the carers report if they notice any changes, as moving and handling can change all the time."

The activities coordinator said, "The manager and other staff are so supportive with the activities…always on hand to help." There were many activities for people to join in with should they so wish. We saw a list which included, singers, exercise, quiz (with appropriate questions for everyone), scrabble, 'Pamper and Poetry' session, various entertainers, puppets, ponies and visiting dogs and other animals. Where people liked to stay in their bedrooms, the activity coordinator spent time with them. Staff told us some of these people liked to have their nails painted and one person liked to watch 'westerns' in the privacy of their own room too. The activity coordinator said, "He [person who liked westerns] has a variety of DVD's to play." Each person had a record of what activities they had participated in, and we could see that everyone who wished to take part, had.

During the inspection a harpist visited the home and we were told they had performed with royalty. We found this was extremely calming on the people who listened and later staff commented on how people had responded positively. A quiz was also organised, with questions about which film stars played roles in particular films from years gone by. This was also enjoyed by everyone joining in.

We discussed people's religious and cultural needs with the activity coordinator. They said, "We have the Catholic church and Methodist church come in once a month. We arrange the lounge so that people can light a candle if required and sing hymns. We put 'quiet' signs up during this time." We observed this in practice as a religious service took place with ten people gathered to take part. People were given sheets of paper with hymns on to join in if they so wished. These sheets had larger print so that people could see them better. One person particularly enjoyed singing and robustly sung all of the hymns, thoroughly enjoying the service. One person who lived at the home was from a religious background. They told us, "I am quite happy being in my room for worship." Although we observed them participating in the service held. We also observed priests visiting the home to offer their support to one person in particular.

People and their relatives knew how to complain. One relative said, "Never had to make a complaint. The manager is great and very hands on. I can talk to her or any of the staff any time." Complaint procedures were on display in the service. Minor 'grumbles' were discussed in staff meetings to ensure they were addressed. All complaints had been dealt with fully and in line with the provider's policy and procedures.

Many compliments had been received from people who had lived at the service or from relatives; in particular where their loved ones had passed away. Some of the comments we had permission to use included, "I know Nanna was my family, but she was also a part of the Lowgate family for so many years" and "Every one of you without exception tried to help us feel at home. I enjoyed your liveliness and the patience you have shown in dealing with challenging situations." One positive comment written by the ambulance service included, "Has ECP + DNR to avoid hospital. Nurses are wonderful and are going to care for her tonight." ECP is an 'emergency care plan' and DNR is a 'do not resuscitate form'.

Advanced decisions had been made about how people wished to be treated, including having emergency health care plans (EHCP) in place. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems. An EHCP was in place for one person with instruction that they did not want to go to hospital for any health concerns except for a fractured bone. The EHCP was completed corrected with GP's signature and family awareness.

People received responsive end of life care in a caring and kind manor. A district nurse told us, "A resident

deteriorated. The GP was brought in. They [nurse and care staff] took the lead and supported me in the process. I would say that people have been very well cared for when they reach that stage of their life. I have never had any cause for concern about anyone at the end of their life as staff here treat them extremely well." One person had been supported to return to their own home to end their days as this was their wish. The service had worked with volunteers in the person's community to enable this to occur and ensure they had enough support in place. We saw many cards which had been sent to staff at the service for looking after a relative who had sadly died. Cards thanked staff for providing dignified and caring treatment at this very sensitive time. We also noted on the reception information board that one staff member had been commended for providing, "Compassion she showed at a service users end of life."

A number of people at the service had 'do not attempt cardiopulmonary resuscitation' (DNARCPR) forms in place. These forms are directives for staff to follow in the event of the person's heart suddenly stopping beating. Forms we viewed were appropriately completed and authorised and staff were aware of the importance the instructions be followed. One nurse told us, "A list is on the board to remind us, but all forms are kept in people's files. The last thing we would want to do is perform CPR on someone where it shouldn't be done."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. The registered manager is a qualified nurse and had worked at the service since 2008, becoming manager in 2012. The registered manager was available during the inspection and supported the team throughout.

One nurse told us, "I think we have a good manager and that it shows. The staff are happy in their work, I wouldn't work here if I wasn't happy and you get fond of all the residents. I worked in the NHS as a midwife and it was so stressful and this is much better." One staff member said, "This is the nicest home I have ever worked in and I have moved around a lot of homes especially when I worked with the agency." Another staff member thought the registered manager was 'rare' and said, "The manager has been very supportive when I've had to take time off work. You can approach her about anything and she will try and help."

One staff member told us, "I just think it's a very friendly environment here, the staff tend to like each other. The clients are also a really nice group of people; no one day is the same and there is always loads of activities going on." Some relatives mentioned that quite a number of staff had worked at Lowgate Care Home for many years which they felt was positive.

A district nurse told us, "[Registered manager name] is a very good manager. What you see is what you get. She will get her pinny on and do personal care. There is good leadership here."

Staff understood their roles and responsibilities. One nurse told us, "The manager does tasks but each nurse has a role of responsibility; mine is nutrition. I check that people are hydrated and that people who need help get it and I monitor weight loss and complete records on a monthly basis."

Recent bad weather had meant that some staff were unable to get to the service when their shift was due. The registered manager confirmed that both herself and a number of other staff stayed over at the service for a number of days until the weather subsided and rostered staff were able to travel in. Nurses and care staff confirmed this was the case and one said, "We are a good team, that rotten weather proved that. [Registered manager name] stayed which just goes to show how much it means to her to make sure everyone is okay." Staff at the service had also utilised the support from local farmers to help get into work. The registered manager organised for uniforms to be laundered at the service and makeshift sleeping arrangements made to accommodate staff, including using her own office as a bedroom for herself.

The registered manager was very visible in the service. She completed walk-arounds of the service at regular intervals. People knew her as did relatives. One person said, "[Registered manager name] is lovely." A number of relatives commented on how responsive the registered manager was and how they thought she ran a "tight ship". One relative told us, "Whenever I have had any issues, she has been able to sort them out. Never major things but she treats everything seriously and takes on board comments." Another relative said, "She is very good, I feel the service is well led with her in charge." A third relative said, "I am part of the relatives group and last year I made a couple of observations. Nothing major, but I was listened to and I was confident they (management) would look into them (Minor issues)." A fourth relative said, "My mother has

not been well in the last couple of days but we are very happy with the care she is receiving. We liked this home as it has a low turnover of staff and the manager actually listens to you. I am confident my mother is being looked after by caring people".

Meetings for staff took place regularly. There were standard items on the agenda which included safeguarding. Other items for discussion were wide ranging and included, supervision, use of telephones, staff morale and employee of the month. Employee of the month was an incentive where nominations were received for a particular staff member who had 'gone that extra mile' or completed some good work. Staff were presented with a £10 voucher and a certificate. Actions were noted during staff meetings and timescales given for completion. We noted that the registered manager had followed up actions at the next meeting, particularly those not fully completed.

Audits and monitoring checks were completed to monitor the quality of the service provided. These included checks of medicines, care plan audits, and monitoring of all departments within the service (kitchen/domestic etc.). Where issues had been identified, they were followed up with actions and who was responsible for their completion.

People and relatives felt included in the running of the service and felt informed. Information was shared with people and visitors including, for example, a key performance indicator dashboard produced in February 2018 which was displayed in reception. This showed, for example, various information on audits, how people's weight was monitored and pressure damage in the service.

A satisfaction survey had been completed in February 2018 which showed people and relatives were either very satisfied or satisfied with the service. One person was noted as asking for shelves in their room and this was organised for them via the maintenance person. This survey information was displayed on notice boards for all people and visitors to see. A recent staff survey had been sent and in a meeting staff were reminded to complete this with the results expected back soon. We saw that the 2017 staff survey had contained mostly positive responses. Surveys had also been received from healthcare professionals involved in the service and these were recorded as either very satisfied or satisfied with the service provided (mostly very satisfied).

We discussed turn charts with the registered manager. Turn charts are documents which show how many times a person requires to be moved at particular times of the day or night. The moving helps prevent skin damage. We found that a small number had not always been completed fully. The registered manager was already aware of this and was working with staff to address this shortfall.

The provider representative visited the service on a regular basis. We viewed a very recent visit by the director of operations and compliance. Their report was very detailed with a number of actions for the registered manager to follow up and complete. We noticed they had identified some of the same issues as the inspection team had. The registered manager said they were working through the issues raised.

The service worked in partnership with other services and the local community, including for example, supporting a project called 'Supporting Excellence in End of Life Care in Dementia (SEED). This was conducted through a local surgery and we saw a letter thanking the service for playing part in the research. The WRVS (Women's Royal Voluntary Services) had visited the service and given a talk to people living there. Local schools had also been involved with the service and visited at Christmas for example. The registered manager was involved in meetings which took place in the Hexham area with other providers. Although they told us these meetings had 'slowed' down, they were hoping they would restart again soon and were in contact with the manager who organised them.

The registered manager was fully aware of their responsibilities and had submitted statutory notifications which they are legally obliged to, to the Commission. Notifications are incidents which occur at the service, for example, deaths, incidents involving the police and safeguarding concerns. They had also displayed their most recent inspection rating both on their website and within the service as also legally required.