Care UK Community Partnerships Ltd

Cheviot Court

Inspection report

Horsley Hill Square
South Shields
Tyne and Wear
NE34 6RF

Website: www.careuk.com/care-homes/cheviot-court-south-shields

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The last inspection of this home was carried out on 21 August 2014. The service met the regulations we inspected against at that time.

This inspection took place over two days. The first visit on 2 August 2016 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 3 August July 2016.

Cheviot Court is a purpose-built care home which provides personal care for older people, some of whom are living with dementia. It is registered to provide up to 73 places. At the time of this visit there were 72 people living at the home, and another person moved in during the inspection.

The home had a registered manager who had been in this role for five years. 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.

During this inspection we found a small number of care plans did not include some important details about their needs. This meant people might not receive the right support in a consistent way. We found the organisation's quality checks had already identified this as an issue and action was being taken to address this. We have made a recommendation about this.

People told us they felt safe and comfortable living at Cheviot Court. One person said, "Its nice place. We're well-looked after." Relatives also felt people were safe at the home. One relative told us, "It's absolutely safe here. It's peace of mind for us that she's cared for here."

Staff had regular training in safeguarding adults and knew how to report any concerns. A local authority commissioner told us, "We do not have any concerns with Cheviot Court."

Risks to people's safety and health, such as falls, were appropriately assessed and managed. The premises were safe, comfortable and well maintained. Staff were trained in how to help people evacuate the building in the event of an emergency.

There were sufficient staff to meet people's needs. The provider carried out checks to make sure only suitable staff were employed. Staff assisted people with their medicines in a safe way.

People who used the service and their relatives told us they felt well cared for in the home. People and relatives felt staff did a "good job". Staff told us they had good training, supervision and support. Staff said they enjoyed their jobs and were encouraged to develop their careers.

Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and Deprivation of Liberty Safeguards to make sure they were not restricted unnecessarily.

People were complimentary about the quality of the food. Their comments included "The food is very good" and "we're well-fed". Relatives said people were supported to eat and drink enough. A relative told us, "Since moving in my family member has started to eat really well and nutritiously, and their health is better because of it." Any changes in people's health were referred to the relevant health care agencies.

People had positive comments about how they were cared for. Their comments included, "Staff are canny" and "the staff are friendly". One person told us, "It's a nice place." A relative commented, "The staff are really nice and very helpful." Another relative said, "The staff seem caring."

People were addressed by the name that they preferred and staff were familiar with each person's preferences. We saw people's personal appearance was respected. People were well groomed and their clothes were clean. One relative commented, "They always keep my [family member] lovely and clean."

Relatives felt staff knew each person well. For example, one relative told us, "They understand my family member's individual quirks." In discussions staff were very knowledgeable about people's individual preferences and lifestyles.

People told us there were activities and entertainment to take part in if they wanted. The activities programme was displayed in pictures and in writing in the hallways of each unit for people and visitors to see. People also had the chance from time to time to go out in the home's minibus.

People and their relatives were asked for their views about the home at meetings and in surveys and these were used to improve the service. Each person had written information about how to make a complaint or comment and these were acted upon. People, relatives and staff felt they could approach the registered manager at any time.

People and relatives felt the home was well-run. One person commented, "The registered manager is really nice." A relative told us, "It seems well managed and efficiently run." A care professional described the service as having "good management oversight".

Staff said they felt valued and well informed by the organisation. The organisation had a number of award schemes for staff, provided fortnightly staff newsletters, carried out staff surveys and held regular staff forums.

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.

People said they felt safe living at the home and were comfortable with the staff who supported them.

The provider carried out checks to make sure only suitable staff were recruited.

The building was well maintained and safe. People's medicines were managed in the right way.

Is the service effective?

Good

The service was effective.

Staff had access to appropriate training in care and in health and safety.

The service applied Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily unless it was in their best interests.

People were supported with their food and drink to make sure their nutritional well-being was promoted.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and helpful.

People were encouraged to make their own choices.

People were supported with their dignity and personal appearance.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A small number of people's care records did not always include important information about their needs which meant they may not receive the right support.

There was a range of in-house activities, social events and contact with the local community.

There was information about how to make a complaint in every person's bedroom. People and their relatives said they would be comfortable about making a complaint if necessary.

Is the service well-led?

Good

The service was well led.

People and visitors felt there was an open and approachable culture within the home. They were asked for their views and suggestions.

There was a registered manager in place who had been managing the home for five years. Staff felt well-informed and valued by the provider.

The provider carried out frequent monitoring visits to check the safety and quality of the service.

Cheviot 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.

This inspection took place on 2 and 3 August 2016. The first day was unannounced. This meant the provider did not know we would be visiting. The inspection team was made up of two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioning team and a range of health and social care professionals. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the service and six relatives. We spoke with the registered manager, the deputy manager, two senior care workers, two care workers, three housekeeping staff and the maintenance staff member.

We reviewed six people's care records and 14 people's medicines records. We viewed six staff files for recruitment and supervision. We looked at other records relating to staff training and the quality checks of the service.

We looked around the building and spent time in the communal areas. We joined people for a lunchtime meal. We used 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.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable living at Cheviot Court. One person said, "I feel very safe here. I couldn't manage at home. Another person told us, "It's nice place. We're well-looked after."

Relatives also felt people were safe at the home. One relative told us, "It's absolutely safe here. It's peace of mind for us that she's cared for here." Another visitor commented, "It's safe and secure."

The staff members we spoke with told us they received regular training in safeguarding adults and this was confirmed by training records. Safeguarding information was on display around the home and staff had access to policies, either via the My Care UK electronic system (there were computers on each floor for staff to access) or the paper-based policy file. The registered manager told us that safeguarding was also discussed during supervision with staff members and in team meetings. This meant staff were aware of their responsibilities to protect people from potential abuse.

The registered manager stated staff were also aware of whistleblowing and their duty to raise concerns about any poor practices by other staff. The registered manager told us any concerns would be investigated and disciplinary action taken if necessary. One staff member told us, "If I had any concerns I would be going straight to the manager."

A safeguarding file was in place which contained a log of any concerns or alerts raised and when they had been closed. The local authority logs were completed as were organisational accident and incident forms which recorded the nature of the concern, and any immediate action that had been taken. We saw investigations were completed and necessary action taken. A local authority commissioner told us, "We do not have any concerns with Cheviot Court."

Risks to people's health and safety were appropriately assessed, managed and reviewed. These included, for example, risks to individual people in relation to falls, mobility equipment, nutrition and skin care. Choking risk screening tools were completed and reviewed monthly. If this identified a person as being at risk then further assessments were completed. Falls assessments were completed and included information on the person's medicines and sensory needs as well as their mobility. Fall risk assessment tools were used to assess falls risk after any incidents and 24 hour monitoring was put in place for the person. There was a monthly log and analysis completed of falls. The registered manager recorded on the log any trends or action taken, such as referrals to the falls team, moving furniture in people's rooms and ordering new equipment such as special beds or sensor alarms.

Red dots were placed on the top part of people's doorframes to indicate they needed support to evacuate in the event of a fire. This corresponded to information on the emergency evacuation register where people had been assessed as high risk in the event of a fire. People also had emergency evacuation plans which detail the support they needed with evacuation in the event of a fire.

An emergency fire box was available near to the fire panel which included a first aid box, wrist bands, list of

people and their next of kin and doctor, high visibility vests and a torch. There was also a copy of the fire safety file which included an evacuation procedure and emergency evacuation register and personal emergency evacuation plans (PEEPs).

All staff, including night staff, attended fire safety training. This included the use of Albac mats (emergency evacuation aids) which were available throughout the building. Fire drills were completed each month, but at the same time of day each month with no night staff included in the drill. We told the registered manager about this and she stated she would make sure these were carried out at different times and would include night staff.

The home was well-maintained, decorated and furnished. Some bathrooms were being used as store rooms for equipment. We told the registered manager that any rooms being used for storage should be locked to prevent a tripping hazard and they stated this would be addressed immediately. The home's maintenance member of staff carried out health and safety checks around the premises, including fire safety and hot water temperature checks. An electrical installation condition report, gas safety check, PAT testing and LOLER certificates were all in place and in date.

We spoke with the registered manager about the procedure for accident and incident reporting. Staff completed incident forms which were reviewed and investigated by the registered manager. The registered manager also described how staff recorded and reported every infection and pressure sore as incidents. These were then analysed for patterns or trends. For example, after identifying a high number of urine infections, the home had recently started using new hydration charts to check whether people were drinking enough. There had subsequently been a reduction in the number of infections people had experienced.

People, relatives and staff felt staffing levels were safe and met people's needs, although it could get very busy at peak times such as mealtimes. One person told us, "It can sometimes seem short of staff but there's a lot of us to look after. They come when I need them to." We noted that call bells were answered promptly and people did not wait for long periods without any supervision or support.

A relative commented, "It would be impossible for any care service to have too many staff and there's never going to be one-to-one in care homes, but it seems to be safe. The buzzers (call bells) seem to be answered quickly." Another relative commented, "There's seem to be enough staff – you can see them around."

The registered manager told us that staff rotas were arranged so wherever possible the same staff members worked on each floor (although this was flexible to cover holidays or other gaps in the rota). There was a senior care worker on each floor and either two or three care staff on each unit. A staff member told us, "Everyone helps out and we all pull together when needed (to cover any gaps)." An organisational dependency tool was used as an indicator of the number of staff needed to meet people's needs. We viewed rotas for a four week period and found the staffing levels were as indicated on the dependency tool.

The recruitment records for six staff members showed that recruitment practices were thorough. These included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. A system was in place to renew DBS checks every three years.

People's medication administration records (MARs) were well maintained. A current photograph of each person was attached to their MARs to ensure there were no mistakes of identity when administering

medicines. There was also information about people's allergies, GP and date of birth with their MARs for staff to refer to.

In most cases there were clear protocols in place for people who had 'as required' and homely medicines. For medicines with a choice of dose or variable dosage time, the records showed how much and when the medicine had been given. The medicines records were completed in the right way which meant the home staff could confirm that people's medicines were being given as prescribed.

Medicines were securely stored on each floor. Senior care workers on each floor checked daily to make sure medicines were stored at the safe ambient temperature. Senior staff were designated as competent to administer medicines. All had completed training in safe handling of medicines and their competency to do this was annually assessed. Staff arranged regular reviews with people's GPs about their medicines to make sure these were still appropriate and effective.

Good

Is the service effective?

Our findings

People felt staff were capable in their roles. One person told us, "Staff do a good job for not much pay, but they look after us well." A relative commented, "Staff seem to know what they're doing and are helpful."

Records confirmed staff received necessary training in care and in health and safety. This included moving and handling, safeguarding, medicines, mental capacity and DoLS. Staff also received training in dementia, called 'fulfilling lives'. That training included some guidance on supporting people with behaviours that challenge. The registered manager told us specific training could be sourced if necessary but there were few people with these needs at this time. The commissioning officer from the local authority also described how the home had used the assistance of the challenging behaviour team to support them to care for individual people's needs if they had behaviours that challenged.

Staff told us they received suitable training and could request more if they felt they needed additional training to support their skills. One staff member told us, "The training is brilliant." Another staff commented, "The training is much more thorough since Care UK took over. I've done my NVQ 2 (a national qualification in health and social care) and am always encouraged to do more. We had group training in dementia – it was good and helps us to empathise."

All newly employed staff received an employee guide which included some key information such as equality and dignity, work life balance, and employee communication. Inductions were completed which were linked to the Care Certificate any included key areas of training. Probationary period reviews were completed to ensure staff had the knowledge and competency to support people appropriately.

Senior care staff supervised some of the care staff. They had been shown how to complete this process by the registered manager and deputy manager, although at this time they had not attended formal training in supervisory management. Staff attended supervision sessions a minimum of six times a year, and we saw a supervision log which confirmed supervisions were held every other month. Annual appraisals were completed for each staff member. A new system had recently been introduced where an appraisal meeting was held six monthly to review performance. The staff members we spoke with told us they felt supported and encouraged in their career development.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. A register of DoLS applications was in place which specified when they had been authorised and if they were renewals. The registered manager said they waited for people to get used to the environment and the situation before carrying out capacity assessments and DoLS applications.

We asked if there were any people who used any equipment that restricted their liberty. The registered manager told us, "For people who lack capacity we have best interest decisions for personal care, and health. If anyone has covert medicines we have a best interest meeting with family and the pharmacy involved and the GP." They went on to explain, "No one uses bed rails. We involve the falls assessor and if people don't have mobility we used a low bed and a crash mat. If they are mobile the bed is knee high and sensor mats are in place."

The people and relatives we spoke with were complimentary about the quality of meals and the support people received with their nutritional health. People's comment included "The food is very good" and "we're well-fed". A relative told us, "Since moving in my family member has started to eat really well and nutritiously - and their health is better because of it." Another relative said, "The food is good. My family member has put on four kilos in two months which was needed."

Another relative commented, "They are very good at keeping people hydrated and fed. Staff might sound repetitive when asking someone to 'eat up' but it works because people eventually eat something."

A diet notification form was completed on admission for each person. This was shared with catering staff so they were aware of any special dietary requirements, such as soft or diabetic foods, as well as their individual likes and dislikes. People were offered a choice of two main courses before each meal but if they did not appear to want this at the time of the meal they were offered an alternative. There were written and picture menus in each dining room for people to see what was on offer that day.

People's nutritional well-being was assessed on admission and on a monthly basis. People's weight was recorded on a weekly or monthly basis depending on their nutritional risk. People had care plans about eating and drinking. Staff told us they worked as a team to support people's nutritional well-being. For example, a member of staff told us, "If people are not eating well we tell the catering staff and they provide fortified foods and snacks so we can build people up."

Staff had completed a course in 'nutrition in dementia' which included an assessment of the knowledge by a dietitian. The home had achieved a gold certificate in May 2016 for meeting 'Food First' expectations. This followed an audit by the nutritional and dietetics department (South Tyneside NHS Foundation Trust) of how people were supported with their nutrition.

People who were at potential risk of not drinking enough had hydration calendars which recorded the amount of fluid the person needed to aim for every day. A box for each day was coloured green if the amount was met or pink if they did not reach the target amount. If staff noted that the boxes were pink for three days running they would encourage the person to drink more and contact the GP for advice. In some cases this resulted in a re-assessment of the safe target amounts for the person.

The home provided one unit that was specifically for people who were living with dementia. There were lots of items of visual and tactile interest for people around this unit, such as themed areas and reminiscence artefacts. There were memory boxes outside bedrooms, and bedroom doors were painted different colours to help people to recognise their own room. There were visual signs for different rooms and coloured doors

to bathrooms and toilets for people to find their way around. There were sitting areas in corridors so people could have a rest stop if they were walking. There was a 'garden area' at the end of one corridor where large windows looked out over the front garden. This was fitted with astro-turf, plant pots and comfortable garden furniture and was a pleasant place for people and visitors to spend time together. The home used coloured crockery in the dining room to help people who were living with dementia to distinguish their food more easily. This meant the home had some specific design features that supported people who were living with dementia.

Relatives told us people were supported with their health care needs at the home. Throughout the care records we viewed there was evidence of involvement with other health and social care professionals. These included, for example, involvement from Speech and Language Therapy (SALT), dieticians, physiotherapists, the falls team, opticians and psychiatry.

Good

Is the service caring?

Our findings

People told us they got on well with staff. Their comments included, "Staff are canny" and "the staff are friendly". One person told us, "It's a nice place." A relative commented, "The staff are really nice and very helpful." Another relative said, "The staff seem caring."

The home was over three floors and each floor had a different atmosphere which was influenced by the people who lived there. For example the ground and top floor were quiet and relaxing, and the middle floor was lively and active. On all floors there was a good relationship between the people who lived there and the staff. Staff told us they usually worked on the same floor so they could get to know people individually and people could get to know them. One relative commented, "The staff seem to know my [family member] very well and make every effort to support her in her own way."

Relatives told us people were treated with dignity and respect. People were addressed by the name that they preferred and staff were familiar with each person's preferences. We saw people's personal appearance was respected. People were well groomed and their clothes were clean. One relative commented, "They always keep my [family member] lovely and clean."

We saw instances where staff explained what they were going to do before supporting people, for example before helping them out of a chair or assisting them with food. We saw staff got down to eye level to reassure and comfort someone who was becoming anxious. We saw people were supported in an unhurried way and at a pace that the person could manage, for example at mealtimes and when walking. A care worker told us, "We try to make it as homely and lovely as possible. All my colleagues are caring, although we may show this in different ways."

People were encouraged to make their own decisions and to remain as independent as possible. For example, some people had chosen to have a key to their bedroom door. People chose to spend time in different parts of their unit, for example some people enjoyed sitting in the entrance hallway socialising with visitors. Other people preferred spending some time in the privacy of their own room.

People who were able to comment said they made their own choices. For example one person said, "I come and go as I want. There are plenty of activities if you want to join in. I like to spend time in my room – it's a lovely, bright comfortable room. I am very satisfied, warm and comfortable."

A staff member commented, "We always try to offer people choices, like menus and activities."
The care records for people living with dementia included details about their individual preferences and how they could make daily choices, such as what to wear. For example, one person's care plan about personal hygiene stated '(Name) is able to choose her own clothes daily. (Name) likes to wear trousers with a matching twin-set and a scarf to match her top. Also likes to wear fluffy socks with slippers in the home and shoes outside.'

People and relatives felt they were kept informed and involved. One relative commented, "There's lots of

information around so we always know what's happening." There were residents' meetings every two months and people were encouraged to make suggestions about what they would like to do and make any comments about the service they received. It was good practice that a monthly newsletter was placed in every bedroom so people and relatives had information about any forthcoming changes and social events.

Staff told us they got satisfaction from supporting the people who lived there. In a recent survey by the provider which was completed by 61 staff members, all of them stated that they felt proud of the work they do. One staff member, who had won an award following votes from residents and relatives, commented, "I feel really valued by the feedback from people and their relatives – it's a real morale boost."

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records to check that these reflected people's needs and provided guidance for staff to support people in the right way. The care plans identified people's needs such mobility, nutrition and personal hygiene. Care plans were up to date and reviewed at least monthly, but four of the 74 people's care plans did not include important information about people's specific care needs and others were contradictory. This meant people may receive inconsistent or inappropriate care.

One person's care records contained conflicting information about the number of staff needed to support them with their mobility. Their care records indicated their 'current situation' was for two staff to transfer the person from wheelchair to dining chair, but the actions were recorded as needing assistance from one member of staff. Also this person's care plans did not specify how to transfer the person. Another person's care plan about personal hygiene stated the person had "healthy skin", but staff had told us the person continuously scratched their skin which had caused an infection.

A person's care plan about personal hygiene stated 'staff to assist' with getting washed and dressed and getting out of bed. But there was a lack of detail about the nature of the assistance the person needed or what elements the person could manage themselves.

Another person's eating and drinking care plan stating the person could be disruptive during meal times. There was a description of the person's behaviour and the care plan stated that staff were to move the person out of the dining room so they could finish their meal just outside the dining room or in their bedroom. But the care plan also said to take the person's meal to where they would like to have it, either the bedroom or lounge. This contradicted the earlier statement which was that the person was to finish their meal outside of the dining room or their room. The person also had a risk assessment about choking. We spoke with the deputy manager about how staff observed the person if they weren't in the dining room. They said, "They are either in their bedroom with their family or just outside the dining room so we can see them." We noted this detail was not specified in the care plan or the risk assessment.

This person also had a care plan for psychological needs which stated the person could become hostile during care intervention but this did not include any details about the behaviour the person could display. We saw in other records that the person could attempt to hit and bite but there were no specific strategies for staff to follow to distract or divert the person. This meant staff did not have written guidance to support the person in a consistent way.

When people's needs changed this was not always recorded in people's care plans. For example, staff told us that one person had an acquired infection that meant they had to remain their bedroom for the foreseeable future. There was no reference to this in their care plans or any care records. Another person had the involvement of the dietician which stated the person needed a high protein, high energy diet with food fortification due to weight loss. This information wasn't recorded in the person's eating and drinking care plan nor was it on the diet notification sheet.

When we reported these gaps the registered manager told us these care records would be updated immediately. After the inspection we were also provided with information that showed how these gaps had already been identified by the organisation's own monitoring checks and confirmation that these had been addressed.

We recommend that the service considers its system of review of care records in order to address any changes in a timely way.

Other people's care records were more descriptive and included personalised information about how people preferred to be supported. For example one person's care plan about personal hygiene included details of their favourite brand of hand soap, bubble bath, deodorant and the moisturiser that the person liked to use.

Relatives felt staff knew each person well. For example, one relative told us, "They understand my family member's individual quirks." In discussions staff were very knowledgeable about people's individual preferences and lifestyles. People had documents titled, 'My life story' in their care records which provided information about their background such as their family and special memories. This helped staff to understand people's life history and what was important to them, even if they were no longer able to communicate this.

A monthly mini-review was held each month about each person which included comments by the chef, activity staff and housekeeper. In this way all staff teams were aware of each person's current well-being.

People told us there was always something going on which they could choose to take part in if they wanted. One person commented, "There are plenty of things to do and we go out from time to time." The home had a minibus and people described going out for a run along the coast and for ice-creams.

The home employed two activities staff who covered five days a week. There were information posters and pictures on display boards around the home informing people of the activities for that week as well as forthcoming entertainment and social events. These included music and singing sessions, games, arts and crafts, reminiscence chats using old newspapers, quizzes and cinema events. Other activities included visiting pet therapy, singers and a monthly library day for book exchanges.

One relative told us, "It's busy and sociable on the dementia unit. My [family member] enjoys being involved in all the activities and the activity staff is lovely with them." Some people on this unit enjoyed caring for dolls or soft toys and were engaged with looking after, cuddling and feeding them.

Hairdressers were visiting on both days of this inspection and people were enjoying pamper sessions and a chat with the hairdressers. Care staff had set up foot spas in one lounge and were helping people to have a pamper session while they waited for their hair to set. Staff were also preparing for the home's summer fayre the following weekend.

The home was sited in a housing estate with a range of local shops nearby. People told us they could be supported by staff to go to shops or could ask staff to pop out for items. The home also promoted links with the local community. For example on the first day of this inspection a local vicar and wife led a service with music in one unit. On the second day a new 'crèche' session was held by the home for the first time. Local parents had been invited to bring their babies and young children into the home to meet the residents and enjoy some games. People commented afterwards how much they had enjoyed watching the children play.

People and relatives said they found the registered manager approachable and would feel comfortable about discussing issues with her. It was good practice that in every bedroom there was there was written information about how to make a comment or complaint. This meant people, relatives and visitors were encouraged to provide their comments about the service and had the contact details of who to discuss complaints with.

There was also clear complaints policy guidance for staff about how to process and manage a comment or complaint. The registered manager kept a log of each complaint and a written report of how these were investigated and any action taken. In each report we saw the complaint was taken seriously and an outcome was reached. In some cases this did not show whether complainant was satisfied. The registered manager told us she would add this information straightaway.

Good

Is the service well-led?

Our findings

People and relatives felt the home was well-run. One person commented, "The registered manager is really nice." A relative told us, "It seems well managed and efficiently run." A care professional described the service as having "good management oversight".

The registered manager had been in the post for five years. All the staff we spoke with said the registered manager was open and approachable. They felt the service was "well-run". One staff member said, "I can always talk to the manager and feel I could raise any issues with her. Another told us, "I feel the manager listens and passes any issues we have on to the organisation for action."

People had opportunities to comment on the home at bi-monthly residents' meetings and their views were taken on board. For example at a recent residents' meeting some people had said it would be better if there were more activities at weekends because the activity staff did not work then. As a result the registered manager was looking at additional resources to support this. In the meantime care staff said they were trying to provide more at weekends such as cinema sessions.

The provider carried out annual surveys of people's satisfaction with the service at Cheviot Court. The results of the most recent residents' survey in 2015 were on display in the home on a 'you said, we did' poster. The main action from that survey was missing laundry. As a result the home now held monthly 'lost items' day where people can see all the clothing that has not been claimed to see if theirs is amongst it.

Relatives were also asked for their views via satisfaction surveys. The most recent survey for 2016 had been completed by eight relatives. The results calculated an average of 84% satisfaction with the home with very high scores in hygiene, cleanliness, quality of food and capability of staff to provide the right care for their family member.

Staff told us and records confirmed that they had opportunities to give their views about the service at regular staff meetings. Meetings were held with the registered manager, senior staff and staff team to discuss the organisational standards that were expected. Staff said they felt the organisation was continuously developing improved ways of working, for example the new hydration charts.

Staff also commented that communication had improved between the different teams in the home. Some staff had additional roles such as infection control lead and dementia care champion. It was intended that these staff members took responsibility for keeping up to date in relation to current best practice or initiatives relating to those areas. Several staff had worked at the home for some years and told us they were "proud of the home" and enjoyed their work.

Staff said they felt valued and well informed by the organisation. The organisation had a number of award schemes for staff, such as 'Gem of the month' and 'residential care services' awards. The provider produced a fortnightly staff newsletter with information and hot care topics such as hydration over summer and window restrictor safety. There was a weekly information bulletin for all staff on the Care UK computer

system. This provided updates about guidance, policies that had been reviewed and any new legislation.

The provider held a staff forum with representative from each of its services called 'Colleagues Voice'. The representative's details were on display in the home so staff could give them their views to raise at the forum. The registered manager said she felt supported by the organisation, especially by regional and clinical development managers. The registered manager had opportunities to attend a regional meeting for managers each month.

The registered manager and key staff carried out a number of in-house audits to continuously check the safety of the service. These included audits of kitchen safety, night time care, activities, medicines and infection control.

The provider had a robust quality assurance system to monitor the safety and quality of the care service provided to the people who lived there. A clinical governance manager carried out monthly quality outcome reviews. These were thorough audits of the care service which were based on the five questions asked by the Care Quality Commission, for example is the service safe, effective, caring, responsive and well led.

The regional manager also carried out monthly audits of the quality of the service. The audits included any identified shortfalls with actions and timescales for completion. For example, this had included a check of care plans which identified the gaps in care plans we found during this inspection. This was listed as an action for improvement. In this way the provider had effective systems to monitor and develop the quality and safety of care at this home.