The Charlotte Straker Project

Charlotte Straker House

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?	Outstanding

Summary of findings

Overall summary

This inspection took place on 7 December 2018 and was unannounced.

At our last comprehensive inspection in June 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good apart from the well-led domain which exceeded the fundamental standards.

At this inspection we found the service was good.

Charlotte Straker House is a care home that provides accommodation and nursing and personal care for a maximum of 31 older people, some whom may live with dementia.

People in care homes receive accommodation and nursing or personal care as single package 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. The service accommodated 30 people at the time of the inspection.

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

The provider's vision and values were person-centred to make sure people were at the heart of the service. This vision was driven by the exceptional leadership of the registered manager and board members

A chair person was responsible for the overall decision making together with board members within the organisation. They supported the management team and represented their views during board meetings.

The board members and registered manager had a clear vision for the organisation and service which put people at the heart of it. Staff were very well-supported by the management team. Staff were highly skilled and knowledgeable about each person they cared for and they were extremely committed to making a positive difference to each person. They were enthusiastic and believed passionately in the ethos of the service.

People were extremely well-cared for, relaxed and comfortable. Staff knew the people they were supporting very well and we observed that care was provided with great patience and kindness. The service went to great lengths to ensure people's privacy and dignity were always respected. Everyone we spoke with complimented and praised the staff team and gave examples of the outstanding care that was delivered.

There was clear evidence of collaborative working and excellent communication with other professionals to

help meet people's needs and maintain their independence wherever possible. The service was very flexible and adapted to people's changing needs and desires, enabling positive outcomes for all people. Records were well-personalised, up-to-date and accurately reflected people's care and support needs. Care was completely centred and tailored to each individual. Risk assessments were in place and they identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks.

Staff were encouraged to continue their professional development in order to progress and provide the best outcomes for people. There were enough staff available to provide individual care and support to each person. Staff demonstrated that they understood the importance and benefits of providing person-centred care

People enjoyed a varied diet. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

The staff team demonstrated a high level of responsiveness to people's individual care and support needs. People were appropriately supported in maintaining their health and they received their medicines in a safe way. They were provided with many opportunities to follow their interests and hobbies. They were all supported to be part of the local community. A wide range of therapeutic techniques were used to enhance people's well-being and provide stimulation.

There was a strong ethos for quality care which ran throughout the location. All stakeholders had input into the running of the home, their feedback was valued and used to drive forward quality service provision. People, relatives and staff were proud of being part of the home and its positive and uplifting culture. Systems and processes were extremely robust and effective ensuring that quality standards were met and exceeded. The provider was proactive in working with external stakeholders, sharing information and examples of good practice, to develop the service and support.

The service consistently strived to ensure that people had the best possible care, and that they were supported in a compassionate, dignified and safe way. The service had forged successful partnerships with other stakeholders, was actively involved in research and aimed to provide an excellent care experience for people. The service referred to best practice guidelines to formulate the type and style of care provided for people.

People using the service, their relatives and staff were confident about approaching the registered manager if they needed to. They were extremely complimentary about the provider, registered manager and the whole workforce. They recognised that their views were valued and respected by the provider who consistently used their feedback to support quality service development.

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 were kept safe as systems were in place to ensure their safety and well-being.

Staffing levels were sufficient to meet people's needs safely and staff were deployed flexibly.

There were systems in place to manage risks, respond to safeguarding matters and ensure medicines were appropriately handled.

Is the service effective?

Good

The service was effective.

Staff were highly supported to meet people's needs through continuous, pro-active and professional development of their skills. They had a very detailed knowledge of people's care and support needs.

People's rights were protected because there was evidence of best interests decision making, when decisions were made on behalf of people and when they were unable to give consent to their care and treatment.

There was evidence of collaborative working with staff and external professionals to support people's individual needs, goals and aspirations. Staff had an excellent working partnership with them.

Is the service caring?

Good

The service was caring.

People, relatives and care professionals without exception praised the caring approach of all the staff. During our inspection we observed sensitive and friendly interactions.

People's dignity and privacy were respected and they were supported to maintain their independence as much as possible. Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

A range of information and support was provided to help people be involved in decision making about their daily living and future care and support needs.

Is the service responsive?

Good

The service was responsive.

Staff were very knowledgeable about people's needs and wishes. There was a very good standard of record keeping to ensure people's needs were met and person-centred care was provided to people that included end-of-life care.

There were varied activities, entertainment and outings to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Outstanding

The service was consistently well-led.

The management team and staff were open, willing to learn and worked collaboratively with other professionals to ensure peoples' health and care needs were met.

An ethos of involvement was encouraged amongst staff and people who used the service. Staff, people and relatives said communication was effective.

There were robust and effective quality assurance systems in place designed to both monitor the quality of care provided and drive improvements within the service.

Charlotte Straker House

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 checked 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 comprehensive inspection took place on 7 December 2018 and was unannounced. This meant the provider and staff did not know we would be visiting.

The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

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

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 11 people who lived at Charlotte Straker House, six relatives, the registered manager, the deputy manager, five support workers including two senior support workers, the cook, kitchen assistant, the activities co-ordinator, the chairperson and two board members, a visiting professional and two student nurses.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for four people, recruitment, training and induction records for three staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People were very positive about the care they received and told us they felt safe with staff support. People's comments included, "I feel perfectly safe here, just the fact people are around", "I feel quite safe", "I wake up during the night and know staff are here", "It's fine here. The staff come around every hour at night, they have their little torches and shine them to make sure everything is okay" and "I feel quite safe, you only have to ring a bell and I have a pendant to wear to call staff." One relative told us, "[Name] is safe here, they have a pendant so if they fall they can get help."

There were sufficient numbers of staff to keep people safe over the 24-hour period. There was one nurse and five support workers including a senior support worker available during the day. Overnight staffing levels included one nurse and three support staff. Staffing levels were determined by the number of people using the service and their needs. This was maintained by people's comments which included, "Yes, I think there are enough staff, I don't have to wait", "Staff are always available" and "There are plenty of staff around." Management could be contacted outside of office hours should staff require advice or support.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the person in charge. Records showed and staff confirmed they had completed safeguarding training.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. The safeguarding log showed four safeguardings had been raised since the last inspection.

Risk assessments and their evaluations were in place and reflected current risks to people. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for choking, losing weight, falls and pressure area care. The assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

People received their medicines in a safe way. Some people managed these by themselves. Staff had completed medicines training and had access to policies and procedures to guide their practice. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines.

There was a good standard of hygiene around the home. Staff received training in infection control and protective equipment was available for use by staff as required. Records showed that the provider had

arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out such as for checking the fire alarm. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances

Robust recruitment processes were in place to ensure staff were safe and suitable to work with people. People who used the service were involved in the staff recruitment process and were part of the interview panel. Recruitment files showed appropriate checks were completed before they started employment. This included proof of identity, criminal history checks, references from prior employers, job histories and health declarations. This helped to ensure only suitable people were employed to care for vulnerable adults.

Good

Is the service effective?

Our findings

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They told us they had opportunities for training to understand people's care and support needs and they were supported in their role. Their comments included, "There is plenty of training", "Supervisions happen two monthly", "Staff know their role and we work well together", "I think staff have the necessary skills and training", "I supervise some staff", "I get opportunities for professional development", "We keep up-to-date with training", "We get loads of courses" and "I have level three in health and social care."

The staff training matrix showed staff received training to meet people's needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people and this included a range of courses such as mental capacity, asthma awareness, principles of dementia care, catheter care, diets, nutrition and dementia care, diabetes, dietician updates, dignity and respect, multiple sclerosis, falls awareness, oral hygiene, person-centred thinking, Parkinson's awareness, pressure ulcer awareness, end-of-life care and bereavement.

Care provided by staff was holistic and included support for all areas of assessed need. Comprehensive assessments were carried out to identify people's support needs and safety requirements. They included information about their medical conditions, mental health, dietary requirements, safety, communication and other aspects of their daily lives.

People were supported to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, speech and language therapist (SALT) and dietician. The deputy manager told us quarterly reviews took place of all people's medical health with multi-disciplinary working with the community matron, hospital consultant, pharmacist and GP. A visiting health professional said, "We work in partnership with the staff."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that DoLS applications were clearly documented and where people were being restricted then this was done in their best interests and the least restrictive option was always considered. We observed staff demonstrated a sound understanding of their duty to promote and uphold people's human rights.

Staff and relatives told us communication was effective to keep them up-to-date with people's changing needs. Staff comments included, "We have verbal and written handovers", "Morning staff get a handover from night staff" and "Communication is very good." A handover session took place, between staff, to discuss people's needs when staff changed duty at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and well-being of each person.

Systems were in place to ensure people received varied meals at regular times. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. One relative told us, "[Name] went off their food but that's now sorted and [Name] eats well."

We observed the lunch time meal across the home. People enjoyed a predominantly positive dining experience. The meal time was relaxed and unhurried. However, we observed some people waited thirty minutes at the dining tables before their meal was served. We were told it was because people who stayed in their bedrooms were served first. People sat at tables that were well-set with tablecloths, napkins and condiments and staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts if needed, to people to encourage them to eat, and they did this in a quiet, gentle way. Staff talked to people as they helped them and as lunch was served.

The meal time was a sociable event and several people socialised before and during their meal as they enjoyed an aperitif of a sherry or a Baileys liqueur. A two-course meal was served and a choice of main meal was available. On the day of inspection, lunch served was poached salmon, salad and new potatoes and a pudding of panacotta. People ordered their food choices the day before. This process could be refined in case people forgot what they had ordered or did not want the meal when it was served. Some people commented, "We choose the next day's meals at tea time the day before", "It's at night time when we get the menu for the next day and you can get meals for visitors", and "It'll be a surprise to see what I ordered." Menus were not available on tables or in an accessible location that advertised and kept people informed of the daily food choices. We discussed with the registered manager our observations where improvements could be made. They told us these issues would be addressed.

Food was well-presented and looked appetising. People's comments included, "I can ask for something else, if I don't like what is available", "We certainly get enough to eat", "It's quite flexible you can choose something else if you don't like what is served", "There is plenty to eat, probably more than I should eat as I am putting on weight", "The food is very good" and "There are two choices and a lot of choice. At tea time, it's another cooked meal and we get biscuits or cake at eleven and in the afternoon." People were offered a choice of meal.

The home was bright and airy. The home was being refurbished and communal areas and some bedrooms had been re-decorated and flooring replaced. The registered manager told us refurbishment was on-going and there were plans to create a hairdressing salon and reception area. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms were signed for people to identify the room to help maintain their independence.

Good

Is the service caring?

Our findings

People and relatives were very positive about the care provided. Staff formed compassionate relationships with people and supported family members of people who were connected with Charlotte Straker House. Everyone that we spoke with, without exception told us they were treated with kindness and compassion by the staff who supported them and positive relationships had been developed. People and relative's comments included, "People get fantastic care", "I'm very satisfied with the care provided", "Care is A1", "It's a super home with a lovely family atmosphere", "There is a pool of talent", "The care is exceptional, both food and care. You get the impression people around you are caring people and would do anything for you", "There's a kindly atmosphere that pervades the whole place, it's a good atmosphere", "The home is first class", "Staff are very friendly", "I've seen many improvements in [Name] since they have come here, staff are very caring", "There is an openness in the home, people seem settled" and "The care is excellent."

The compliments book showed several compliments and cards of appreciation had been received commending staff for the care provided. Compliments included, "I couldn't have wished for better care", "Staff have all created in every sense of the word a wonderful place. [Name] is now so much more at peace with their situation. In particular the patient, love, care and understanding administered so freely by staff", "I want to thank staff for their kindness, patience and humour", "Staff are pro-active in making things comfortable for [Name]", "The staff team are exemplary, the very best" and "Kitchen staff went to so much trouble for [Name]'s diet on a daily basis."

The respite care placement was used as a holiday break for people and families. The registered manager told us it also provided convalescence and rehabilitative support to some people. People were referred from a variety of sources including hospital, GP, district nursing services, families and self-referrals. People were supported to regain their confidence and to maintain their independence in some areas of daily living to help them return to live in their own home. For example, to continue to manage their own medicines, for people to be fortified, nutritionally or whatever their assessed need.

People were supported to maintain their independence whenever possible and personal preferences were respected. For example, we saw that some people liked to spend time in their own rooms to follow their own daily routines. Staff understood the importance of people maintaining their independence and the benefits it had for their well-being. People's comments included, "I am usually quite independent but not at the moment", "I'm pretty much independent" and "Staff do help me, I can't dress myself and once I've washed myself I buzz and staff help dress me. At times they help if you can't walk very well." A relative told us, "[Name] has a certain amount of independence. Staff repositioned the bed to better suit [Name]'s mobility."

People were encouraged and supported to maintain and build relationships with their friends and family. There was no restriction on visiting times so that people were supported to maintain relationships that were important to them. One person commented, "I had a birthday party and there were loads of people and relatives there and the table was laid with cakes and loads of food." During the inspection visitors were present throughout the day. People were also supported to use the telephone and electronic digital equipment to keep in touch with relatives. For example, a person was supported to use Skype to

communicate with their family who live in Australia.

During the inspection there was a lively, happy and pleasant atmosphere in the service. Very positive and caring relationships had been developed with people. Staff provided care and support that was exceptionally compassionate and kind. People told us staff were very respectful. Staff interacted with people in a calm, kind, pleasant and friendly manner. Staff were not rushed in their interactions with people. They spent time chatting with people individually and supporting them to engage. One relative told us, "Staff do have time to spend with people, they are interested in people's families. It is a two-way process between staff and people

Staff showed an in-depth knowledge and understanding of people's care, support needs and routines. They had excellent positive relations with people. Staff told us that not all the people they supported were able to verbally communicate about how they preferred to receive their care and support. Staff understood and interpreted people's non-verbal communication, which enabled people to engage more with those around them. Records showed a person whose speech was affected by a stroke was provided with pictorial and written resources in consultation with the speech and language therapist to enable them to express their wishes and make choices. This was in respect of personal care and dietary needs. For another person, a picture book was used to enable a person to express their feelings and emotions.

Support plans also provided detailed information to inform staff how a person communicated. Examples in records included, "Communicates well verbally" and "[Name] can express their needs." People showed that they valued their relationships with the staff team. We observed this through people's facial expressions and body language as they responded positively to staff who were supporting them.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was accessible and was made available in a way to promote the involvement of the person. For example, by use of pictures or symbols for people who did not read or use verbal communication. A range of talking books was provided for people with severe visual impairment.

Care was provided in a flexible way to meet people's individual preferences. They told us they were asked their opinion and given choice. For example, when to get up and go to bed, what to eat, to drink and what they might like to do. Their comments included, "I choose for myself", "It's my choice what I do" and "I get up at my usual time, the time I've always been used to."

Staff all knew the importance of respecting people's privacy and dignity. Without exception we saw that where people needed support with personal care, they received such support in private. One person told us, "Doors are closed and staff knock."

People's care records were up-to-date and personal to the individual. They recorded a good level of detail in relation to people's preferences and routines. Information was available about people's likes, dislikes and preferred routines. Examples in records included, "[Name] likes sweet and savoury foods", "I like watching television, doing crosswords and friends visiting", "I like salads, not so keen on vegetables", "[Name] gets up about 8am and staff bring breakfast, has leisurely breakfast and reads the newspaper and then gets dressed" and "I wish to have a postal vote at the next election."

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, when there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in a wide range of activities. An activities programme was advertised along with available and forthcoming entertainment. An activities co-ordinator, staff and volunteers arranged activities and engaged with people to keep them stimulated and involved. People had the opportunity to take part if they wished. People's comments included, "I went to see the Christmas trees in the church competition and there were 98 of them", "If it's in my field of activity I will try to get involved", "Everyone gets a copy of the activities programme each week and there's quite enough to keep me involved", "We go on planned trips sometimes", "There's reflexology and massages. I'm having a head and shoulders massage this afternoon" and "I am one of those that's not a mixer but it's nice just to sit in the lounge. I like my knitting." Relative's comments included, "There are days away, music and there are dominoes every week", "There is a singer in at 2pm and there were craft activities yesterday" and "I bring my dog in and they do bring a pony in, it makes me laugh when it goes up in the lift."

We saw a variety of seasonal entertainment was arranged for over the Christmas period including a Christmas party, local school choir and entertainers. Activities for the week included, Christmas crafts, massage, singer, reflexology, readings, shop trolley, church visit and tree of light ceremony at the home which involved placing a memento on the tree to commemorate the life of people who had previously lived at the home. The hairdresser visited weekly and local clergy visited regularly. People confirmed activities, seasonal entertainment, parties and organised trips took place. People's comments included, "I like trips, we've had runs out and they're making arrangements for another", "We have been to Riding Mill to see a play recently", "We got to the beach in the summer and for fish and chips", "We've been to Dobbies garden centre and Hexham" and "There is an acting/drama group at Riding Mill."

The deputy manager told us there were very good links with the local community. Relatives and people also stated the service was involved and was part of the local community. Their comments included, "They have loads of involvement, the Methodist Church were in last week and there was a service", "Little Tinklers from the local nursery come quite often", "The home is well-supported and all local charities tend to donate to here. There is a fete which is well-attended, people go to Matfen Hall. There is a gift fair and the money raised is for Charlotte Straker" and "Charlotte Straker is very well thought of in the village and lots of villagers take an interest in it."

Relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. Information was available with regard to people's spiritual and cultural preferences at this important time and for their wishes after death to ensure their final wishes could be met. Staff worked to ensure people received a pain-free and dignified death. The registered manager told us staffing levels were adjusted so sufficient staff were available so a staff member could stay with a person, if family were not able, so the person was not on their own. There were several commendations from relatives for the care provided by staff at this time. One relative had written, "As [Name]'s life was drawing to its end the responsive staff enabled [Name] to die with complete dignity and in a peaceful environment."

People's records were maintained on an electronic system. There was a very good standard of record keeping. Before people used the service they received information about the home and an initial assessment was completed to ensure the service could meet the person's needs. Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, medicines, pressure area care, communication and moving and assisting needs. Care plans provided guidance to staff to ensure consistent care was provided to people detailing what the person could do to be involved and to maintain some independence. Consent documentation and care plans showed evidence of consultation and input from people at the service and their relatives.

Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Records showed that reviews of people's care and support needs took place with relevant people at intervals. Relatives commented when asked if they had attended any reviews, "My sister is involved and [Name]'s care plans are discussed with them" and "Yes, I know about the care plan and we are notified of any changes."

People and relatives were actively engaged in the day-to-day operation of the service. There were regular meetings and surveys to gain people's opinions about care. A record of complaints was maintained. People told us they could talk to staff if they were worried and raise any concerns. People's comments included, "I don't think I would complain, if something bothered me I'd report it to one of the carers", "I've never had any reason to", "Nothing to complain about, it's good. It is the same staff, there's not much turnover and know them all."

Outstanding ☆

Is the service well-led?

Our findings

The home had a registered manager who was experienced in managing care services for older people. They had become registered as manager for Charlotte Straker House in October 2015. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

Charlotte Straker Project is a voluntary, charitable organisation that provides residential and nursing care for up to 31 people who require nursing or personal care. One respite placement, is provided free of charge to residents of the local Tynedale community. There are eight supported living bungalows, in the home's grounds, for tenants who require minimal support. Charlotte Straker House staff do not provide support to tenants except in an emergency. The registered manager told us some people had chosen to move into Charlotte Straker House from the bungalow, when their needs changed and they had become more dependent.

The Charlotte Straker Project is part of the local community and came about due to "the determination of the community to maintain a facility of this kind within Corbridge, following the closure of the local cottage hospital in 1992." (Resident's guide 2018.)

The registered manager told us until 2016 the home had been funded by local GPs, via the NHS, for five placements specifically to provide palliative care. When the funding was no longer available the board and management, due to the need within the local community, fundraised to ensure a community respite placement within the service was available for people which may include for palliative care provision. This provision started in 2016 at the end of the NHS funded placements. The home maintained very good links and continued to work closely with the local hospice and McMillan nurses and residents and staff fundraised on their behalf.

The organisation had a very strong governance framework. There was a board of trustees and four sub committees (Strategic development committee, finance and governance committee, quality committee and fundraising committee) who supported and monitored the management team. The board of trustees met with managers every two months and sub-committee meetings took place the month after trustees meetings. People had been approached about nominating a representative to attend committee meetings and it was planned to progress this to provide direct links and promote further involvement from people who used the service. The board members had a regular presence in the home, as they monitored care provision and attended meetings and were known to people and relatives.

Various stakeholders were tasked with ensuring the organisation was meeting its objectives and that they were providing a safe and effective service for all people where they experienced the best outcomes. The board member responsible for governance told us, "An annual quality assurance plan is made available each year which has been discussed and agreed by our quality committee." Staff had received training about the changes in legislation in May 2018 and the implications for General Data Protection Regulation 2018 responsibilities.

There was an ethos of continual improvement and keeping up-to-date with best-practice across the organisation. There was a comprehensive programme of staff training to ensure staff were skilled and competent. Staff members told us they had been encouraged and supported to access accredited and professional courses and their training had been sponsored by the organisation. For example, the deputy manager was finishing a chartered management degree and they then planned to complete a level five course in leadership. Other heads of department such as the office manager and housekeeper had enrolled for team leading at level two.

The management and staff team were outward looking, and had formed links with other organisations such as local charities, churches, universities, colleges and schools. These included Healthwatch and Northumbria University. Positive comments had been received from first year student nurses at Northumbria University who had been on placement at the home. They were very complimentary about the guidance and mentoring they had received from management. Their comments included, "I have enjoyed my placement here and have learned a lot", "The staff and management have been very welcoming and helpful", "Your staff team exemplify the very best of what it means to care" and "Thank you so much for showing me such kindness and patience whilst I was on placement. You have given me a great start to my nursing career." The deputy manager told us the service planned to provide mentoring and placements in the future for student nurses at different levels of their training, this way the service also kept up-to-date with best practice and clinical developments.

Staff members were champions and had lead responsibility for an area of interest and they promoted best practice within the home. Staff representatives were members of agencies and attended CQC Conferences, Infection Control Resident Champions Meetings Northumberland County Council and providers meetings and Care North East Northumberland (CNEN) Meetings. The management team worked collaboratively with the local Urgent Care Teams, Advocacy services, commissioning teams, the local hospice, NHS resources and Older Person's Mental health teams. The chairperson told us, "Direct access pathways have been developed to allow some residents to transfer directly from Charlotte Straker to Hexham General Hospital, our local hospital, therefore avoiding a lengthy journey to Cramlington hospital for initial assessment. This provides an improved patient experience and links well with our local GP practice."

The management team were motivated and clearly passionate about making a difference to people's lives. This enthusiasm was also shared with the rest of the staff team we spoke with. Staff received training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs and interests. People were supported to continue with memberships of committees that they belonged to before they moved into the home such as the Woman's Institute (WI), political affiliations and church committees.

Resident meeting minutes also showed people were consulted and they were listened to. People's suggestions were actioned in a timely way. For example, more organised trips and gender specific activities were taking place, people who had asked to be involved in staff interviews were now on the interview panel and people had been consulted about colours for the re-decoration that had taken place in some lounges and dining rooms. Feedback from resident meetings fed into the committee meetings.

The provider and management team were committed to providing a service that was consistently high quality and continues to develop in a way that evolves and includes people. People were involved in staff recruitment, they received training in topics such as infection control, safeguarding and other areas to increase their awareness. The provider had considered how people, relatives and staff were meaningfully involved in making decisions about how the service was designed and run. Relatives were consulted regarding not only how their relatives care was to be developed, but also how to drive continuous

improvement in the service. Opportunities were provided to meet in the home and such meetings were used as opportunities to consult with them on a variety of topics. For example, menus, events and activities, refurbishment and feedback on service provision.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of daily, weekly, monthly, quarterly and annual checks. They included the environment, health and safety, medicines, infection control, finances, safeguarding, complaints, personnel documentation and care documentation. Regular, two monthly visits were carried out by a board member. They checked the environment, spoke to people and the staff and checked a sample of records regarding the standards in the service. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits.

Staff told us staff meetings took place regularly and minutes of meetings were available for staff who were unable to attend. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff meetings also discussed any incidents that may have taken place. The deputy manager told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated. For example, any medicines errors that had taken place.

The management team told us about the business contingency arrangements that had been triggered when the power supply had surged in the home during the summer. The electric supply had surged and then gone off and emergency arrangements had been put in place to ensure people were supported and appropriately cared for. Action plans prepared by the management team showed any lessons learned were put in place if required.

The registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out to people who used the service, staff and relatives. The provider's survey for 2018 showed comments were overwhelmingly positive about the care and support provided by staff and the quality of the service. All relatives and professionals told us people who used the service were at the heart of the service. The management team at Charlotte Straker House showed their passion and commitment to ensure a person-centred culture whereby people who used the service were at the heart of everything they did.