HC-One Limited

Grosvenor 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?	Good

Summary of findings

Overall summary

This inspection took place on 8 September 2016 and was unannounced.

Grosvenor House is registered to provide nursing and personal care for up to 50 older people. The home comprises of large single bedrooms with en-suite facilities and has a range of amenities including lounge areas, a dining room and hairdressing room. All floors can be accessed by a lift. At the time of our inspection 29 people were using the service.

The service is required to have a registered manager, and at the time of our inspection there was a registered manager in post. They had registered with the Commission in April 2014. 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 had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm.

The registered provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. The registered provider had systems in place to ensure there were sufficient staff available to keep people safe and meet their needs.

Medication was appropriately stored, administered and recorded on medication administration records. Staff responsible for administration of medication had received training and the provider completed medication audits and staff competency assessments. This showed that there were systems in place to ensure people received their medication safely.

Staff completed a range of training to help them carry out their roles effectively, and there was a schedule for refreshing this training when it was required. Staff received supervision and appraisal to support and develop them in their roles.

The registered provider sought consent to provide care in line with legislation and guidance. Staff had completed Mental Capacity Act (MCA) training and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had accessed a range of healthcare services where required, such as GPs, podiatrists, community physiotherapists and a consultant neurologist. People were supported to receive adequate

nutrition and hydration and we received positive feedback from people and visitors about the quality and variety of food available. Care plans contained information about people's nutritional needs and preferences, and this information was also available to staff in the kitchen.

People told us that the staff who supported them were kind and caring. People also reported that they felt their privacy and dignity were respected. We saw that interactions between staff and people who used the service were warm and friendly. Support was provided to enable people to practice their religious beliefs and visitors were welcome at any time.

Care plans were reviewed monthly and contained information about people's needs, routines and preferences. Staff were also able to demonstrate a good understanding of people's needs and preferences. The home employed an activities co-ordinator and there was a range of leisure and social activities available to people.

There was a complaints procedure in place and people who used the service told us they knew how to raise a complaint if they needed to. People also had opportunity to raise concerns or give their views in residents meetings and through a 'resident of the day' review process.

There was a quality assurance system in place, which included a range of audits and surveys conducted by the registered manager. There was evidence that systems in place had resulted in actions being identified and addressed where required.

Feedback about the management of the service was very positive and comments from staff indicated there was a person-centred and supportive culture at the home.

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.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to respond to any concerns. Risks to people were appropriately assessed and managed.

The registered provider used a robust recruitment process and appropriate checks were completed before staff started work. This ensured that people were supported by staff who were considered suitable to work with vulnerable people.

There were good systems in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received an induction, regular refresher training, supervision and appraisal.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People were supported to ensure they received sufficient food and drinks. They also had access to healthcare services, where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring and that they had positive caring relationships with the staff that supported them.

People we spoke with felt that staff respected their privacy and dignity, listened to their views and promoted their independence.

Support was provided to enable people to practice their religious beliefs where applicable.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and detailed care plans were in place to enable staff to provide personalised care. Staff demonstrated a good understanding of people's individual needs and preferences.

A range of social and leisure activities were available.

There were systems in place to manage and respond to complaints and concerns, and to listen to the views of people using the service.

Is the service well-led?

Good

The service was well-led.

Feedback about the management of the service was consistently positive and staff were provided with the support they needed to deliver the service effectively. The registered manager promoted a positive, open culture.

There was a quality assurance system in place, which enabled the registered provider to monitor the quality of the service provided.

Grosvenor 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 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 8 September 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from North Yorkshire County Council's quality and monitoring team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with four people who used the service and three visitors to people who used the service. We also spoke with three care staff, a nurse (who was also the clinical lead for the home), a chef, an activities co-ordinator, an administrator and the registered manager. We looked at four people's care records, three people's medication records, four staff recruitment files, staff training files and a selection of records used to monitor the quality of the service.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Grosvenor House, and everyone we spoke with said they did. People told us, "I feel I am kept safe always," "I feel safe here" and "The girls move me safely; they know what I can and can't do." A visitor told us, "[My relative] is safe here and looked after really well."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults from abuse as part of their induction training, then regular refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Safeguarding records showed us that no safeguarding concerns had been raised in the 12 months prior to our inspection, but concerns raised prior to this had been reported and investigated appropriately.

The registered provider had a whistleblowing policy, which enabled staff to report issues in confidence and without recrimination. Staff were aware of the policy and told us they would be comfortable using it if they had any concerns. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

People had appropriate risk assessments in relation to their individual needs. These included assessments in relation to skin integrity, continence needs, choking, oral health, bed rails and falls. The Malnutrition Universal Screening Tool (MUST) was also used to assess people's risk in relation to malnutrition. Risk assessments were reviewed monthly. We saw evidence that people had been involved in decisions about risk, such as consent forms for the use of bed rails.

There were also a range of general risk assessments for the home, such as first aid, use of chemicals, kitchen risks, cash handling, lone working and the laundry. These were up to date and had been reviewed by the registered manager. However, the paper copies on file did not all have the date of the last review on, so the registered manager agreed to add this. Health and safety meetings were held each month, involving all heads of department.

We saw that records of any accidents or incidents were completed by staff. The registered manager then completed an electronic record of the accident or incident on the registered provider's electronic 'datix' governance system, in order to record that appropriate action had been taken in response to any incidents. Records were also maintained in relation to falls, and the registered manager completed a monthly falls analysis, which showed in a simple visual format where, and how many, falls had occurred each month. Monthly falls meetings were held, involving all heads of departments, to review if any action was required each month.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that equipment was regularly checked and serviced at appropriate

intervals. This included the nurse call system, electrical wiring, gas installation and fire safety systems. Checks also included legionella testing, servicing of the passenger lift, hoisting equipment and weighing scales, and portable appliance tests on portable equipment. Servicing of the kitchen extraction system and laundry duct were booked at the time of our inspection. These environmental checks helped to ensure the safety of people who used the service.

The home had achieved a rating of five following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Personal emergency evacuation plans (PEEPs) were in place for people who would require assistance leaving the premises in the event of an emergency. These recorded the assistance and equipment people would need in an evacuation. The registered provider had an up to date fire risk assessment, fire evacuation procedure and evacuation guidance available for staff.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references, identification checks and registration checks for nursing staff. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. Once nurses were in post, the registered manager checked their nursing registration status with the Nursing and Midwifery Council (NMC) on a monthly basis, to ensure the registration was still valid. The registered manager and nursing staff were also aware of the requirements of the nursing revalidation process. Revalidation is the new process that all nurses in the UK will need to follow to retain their registration with the NMC. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We spoke with staff, people who used the service and visitors about whether there were sufficient staff to meet people's needs safely. Staff told us, "There are enough staff to support people with their needs and we are a good team" and "There are plenty of staff to meet people's needs." People who used the service told us, "When I press the call bell the staff do come quickly" and "Staff respond quickly if I ring my call bell." Comments from visitors included, "There are generally enough staff; I can always find someone, and there are enough staff to meet [my relative's] needs."

On the day of our inspection there was a nurse and six carers, plus the registered manager who was also a qualified nurse. The atmosphere in the home was calm and staff did not appear hurried. We observed staff responding promptly to call bells. We saw from staff rotas that shifts were staggered so that there was additional availability of staffing at busy times, such as between 7:00am and 8:00am. Staffing levels reduced in the afternoon and evening, when things were quieter. There were usually two nurses on the rota in the morning, but on the day of our inspection the registered manager was available to provide nursing support if required. Rotas showed that there was usually one nurse and at least two carers working on a night time. We saw that two regular agency nurses were used, to ensure there was consistency in covering the rota.

The registered provider employed a range of ancillary staff, such as housekeepers, laundry, maintenance, kitchen and activities staff, which meant that nurses and care staff could concentrate on the delivery of care to people.

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers

of staff to keep people safe and meet their needs.

The registered provider had an infection prevention and control policy and cleaning schedules were in place to ensure the home was clean and hygienic. One visitor told us that sometimes their relative's room was not always as clean as they felt it could be. We also discussed with the registered manager about a minor infection control issue in relation to hand washing facilities and a sluice room which was cluttered. However, overall we found that the home was clean and well maintained. The registered manager completed a daily walk-around of the home which included looking out for, and addressing, any cleaning issues identified or areas which were unsafe or untidy.

We looked at systems in place to ensure people received their medication safely. The registered provider had a medication policy. We saw that staff responsible for the administration of medication had received training in medication management and were assessed for their medication competency.

People's care files contained a care plan with details of any support required with medication. We saw these were reviewed each month, to ensure they were reflective of people's current needs. We looked at a selection of medication administration records (MARs). We found these were appropriately completed, to show that people had received their medication as prescribed. We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs. There were protocols in place for people who were prescribed medication for use 'when required'. These protocols gave clear instruction to staff when and why the person may require this medication and records were completed when people received them.

Medication was appropriately and secured stored. Medication was retained in its original packaging and was tidy and well organised for each person. We saw that fridge temperature checks were recorded every night to ensure that medicines stored in the fridge were safe to use. Daily room temperature checks were also recorded, to ensure that medicines were stored at the appropriate temperature. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored correctly within a suitable cabinet in the medication room, and that controlled drugs records were accurately completed.

We also observed medication being administered and spoke to staff about various aspects of medication management, including medication audits and the safe disposal of medication. Staff demonstrated a good level of understanding.

This showed us that there were systems in place to ensure people received their medication safely.

Good

Is the service effective?

Our findings

We asked people who used the service if staff had the right skills and experience to do the job. People's comments included, "The staff are wonderful…Staff are very good and patient with people" and "The nurses are very good and really helpful." We noted that in a relatives satisfaction survey conducted in June 2016, two out of 13 respondents indicated they did not feel staff were well trained in their roles. However, one visitor we spoke with told us, "They [staff] are amazing here and we are really happy with the attention [relative] receives." Another told us, "The nurses are particularly good. [Name] and [Name] are excellent; very clued up and very caring. If there's a problem they'll try and sort it."

We saw records that showed us that all staff completed an induction when they started in post. The registered provider had introduced a new 'working together as one' induction workbook for all new carers, based on the requirements of the Care Certificate. The three carers that had started most recently had completed, or were part way through, this workbook. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers. Staff also completed induction on-line training alongside the workbook, and practical training on topics such as moving and handling. Staff confirmed to us that they shadowed experienced senior care staff for at least three days before providing any care to people independently.

Staff completed refresher training annually for certain key topics, such as safeguarding, safer people handling and infection control. Other training topics were refreshed at different frequencies in line with the registered provider's training expectations. The registered manager was able to monitor when staff were due to complete refresher training, as records were held electronically. The training included emergency procedures, dementia care, food safety, nutrition and hydration, person centred care, medication, dignity and falls awareness. The registered manager told us they also organised any other additional training that they, or staff, identified would be useful in order to meet people's individual needs. For instance, nurses had recently received suprapubic catheter training to refresh their skills in this area, and some additional falls awareness training was booked to take place the month following our inspection.

We saw evidence of staff supervision and staff briefings, both covering a range of appropriate topics. The registered manager told us that instead of team meetings they now held daily staff briefings, which enabled them to update staff on any key information, medical alerts and reminders. They told us that they found this a much more effective method for ensuring that they were able to communicate with staff directly and regularly. They told us that they also held group supervisions where more time was needed to discuss and address topics in detail. Staff confirmed that in addition to group supervisions, they also had formal supervision meetings on an individual basis and an annual appraisal. One staff member told us, "I have just had my yearly appraisal. The registered manager does my supervisions and appraisal and I can talk openly to them at any time. I can talk about any concerns, my development, issues and goals for myself in supervision." This showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Nobody who used the service was subject to a DoLS authorisation at the time of our inspection, but we saw that the registered manager had submitted a DoLS application to the local authority for one person, and was awaiting the outcome of this.

Care files contained mental capacity assessments in relation to specific decisions, such as the capacity to consent to photography and bed rail use. We saw evidence in care files that people had been involved in decisions about their care, where they had the capacity to do so. For instance, in one care file we viewed the person had signed their consent to the use of bed rails. The views of people and their relatives had also been recorded in care reviews. Care files also contained information about whether the person had a Lasting Power of Attorney (LPA), and if so, whether this was for finance and affairs, for health and welfare or for both. Full details in relation to LPA's were held with financial and administrative records in the office.

Staff had completed MCA training. They were able to demonstrate an understanding of the principles of the MCA, the importance of gaining consent before providing care to someone and when best interests decisions may be required.

This showed us that staff sought consent to provide care in line with legislation and guidance.

We looked at the support people received with their nutritional needs. Care files contained a nutritional risk assessment and an eating and drinking care plan. Care plans included information about the type of diet required, food preferences and any adapted cutlery needed. We were told that food intake was recorded for people assessed at particularly high risk due to their nutritional needs or weight loss, but at the time of our inspection nobody required their food intake monitoring.

We talked to people about the variety and quality of food available at the home. People told us, "The food is good; I like it. We have choices around food and drinks when I want them" and "The choice of food is very good and the food is healthy for me and I like it." Another person told us, "The food is good and I know the chef knows what I can and can't eat and looks after me." Feedback from visitors about the food was also positive.

We observed a mealtime at the home and saw that people could eat in the dining room or in their own bedroom if they preferred. There was a relaxed atmosphere in the dining room and tables were laid with glasses, condiments and napkins. People were shown the menu and offered a choice from the two main options available. The food looked hot and appetising. We observed people eating independently in their own rooms, and staff were available to assist where required.

When we spoke to the chef about people's special dietary requirements, they were knowledgeable about people's needs and preferences. They had a copy of each person's dietary requirements in a diet notification

forms folder, and a display board in the kitchen with people's allergies, type of diet and any dislikes. The board also showed any birthdays that week, so that the chef could make a cake or something special for them.

This showed us that people were supported with their nutritional needs.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had received support from other healthcare professionals where required, such as GPs, podiatrists, community physiotherapists and a consultant neurologist. There were also instructions in care files where people needed specific assistance to maintain good health, such as support with pressure care. A GP routinely visited the home fortnightly and a conducted a telephone consultation with the home on the week in between visits. District nurses also visited people living at the home on a regular basis. People we spoke with told us, "If I felt unwell, the nurses are very good and would look after me" and "If I'm not well I tell the carers and they would get the nurse or my doctor." A visitor told us that the home had worked well with visiting healthcare professionals in order to support their relative with their health needs; "The district nurse has given my [relative] really good care regarding their legs and the resident nurses here have kept the requirements of the district nurse going, so now my [relative] has no need for bandages on their legs for the first time in approximately five years."

Good

Is the service caring?

Our findings

We asked people who used the service if staff were caring and the feedback we received was consistently positive. People told us, "Staff are really caring towards me and they listen to me," "They are very kind," and "Staff are caring and kind to me." Another told us, "Carers treat me well; everybody has been nice to me." They continued, "Staff treat me with respect and we laugh together."

Visitors we spoke with told us, "Staff are helpful, really patient and caring. When [my relative] was in hospital two staff went to visit them, which meant a lot to me." Other visitors told us, "Staff are generally caring" and "The staff are really nice."

Support was delivered in a kind and caring way. Staff knew the people they were supporting well, and were able to talk with them about things they found important. For example, we saw staff reassuring one person who was hesitant and unsure where they wanted to go. The member of staff offered positive encouragement and talked to the person about their recent birthday. This led to the person calming and enabled the staff member to establish that the person wanted to go to their bedroom. Staff stopped and talked with people as they moved around the building, which helped to create a homely atmosphere.

Staff we spoke with demonstrated a caring approach towards the people they supported. One told us, "I really do care about the people I work with; I've been doing this job for [some time] now." We saw that relatives of staff had attended events at the home and one had become a friend and regular visitor to one person. We saw from photographs that when the registered manager had got married they had held a pre-wedding celebration event at the home, so that people who used the service could be part of the celebration, and we were told that people had really enjoyed this.

People were treated with dignity and respect. Throughout the inspection we saw staff delivering support in an unhurried way and at people's own pace. We saw that staff always knocked on people's bedroom doors before entering and were respectful when addressing, or discussing people who used the service. People told us that staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing and washing. One person told us, "When I'm having personal care, they [staff] are all very considerate and gentle with me…My dignity is important to staff. I have my own sit down shower in my room and the staff are very good and know how I like my care to be done." Another told us, "I have privacy in my room when I want it."

Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as, "Always ask for consent before giving care, make sure people are covered up as they want to be to protect their dignity, make sure doors are shut to keep their privacy." We also saw in one care file that the emotional impact of having a catheter, and how this had affected the person's confidence about going out, had been recognised and sensitively considered.

We observed staff offering choices and responding to requests from people. It was evident from people's care files that people had been involved in decisions about their care, where they were able to do so. One

person told us, "[Staff] respect my wishes" and another said, "I get up when I want to and go to bed when I want to."

Care files also gave instructions to staff on how to promote people's independence wherever possible. For example, one person's care file included specific instruction to staff about what the person could do for themselves; such as washing their own hands and face, and what they needed help from staff with; such as washing their body. Another care file emphasised how important it was to the person to be as independent as possible, including brushing their own teeth. Comments from people using the service included, "I am free to make my own choices and am as independent as I can be. I can ask for support if I want it."

Discussion with staff indicated that there were currently no people using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. The registered provider's equality and diversity statement was prominently displayed on the wall in a corridor. Support was provided to enable people to practice their religious beliefs. The registered manager explained how they had supported a person who was of Greek Orthodox faith and another person who was Jewish, and the home had established links in these communities in order to meet these people's needs, particularly in relation to their end of life care. The registered manager also explained that they had someone who had recently started to use the service who was of Catholic faith and they were arranging for a Catholic Priest to visit the person at the home. There was a monthly multi-denominational service at the home, available to people who used the service, and this was also attended by some relatives. People were offered the opportunity to go out to church, but the registered manager told us that people were currently happy with attending the service at the home instead.

Nobody who used the service had an advocate at the time of our inspection, but the registered manager told us that social services were sourcing an advocate for one person. Advocates help to ensure that people's views and preferences are heard. Staff told us about how they communicated with people who did not use words, in order to ensure their views were heard. One staff member told us, "If someone can not communicate verbally, I know by their body language, facial expression and how they are."

Visitors we spoke with told us they were able to visit any time. One person told us, "Visitors can come and see me whenever they want to and they are made welcome by staff. Staff always ask my visitors if they would like a drink, so they look after them." Another told us, "My visitors are made to feel welcome and know the staff well."

Good

Is the service responsive?

Our findings

Care was based on people's assessed needs and preferences. Before people started using the service their support needs were assessed, to ensure the service could meet their needs. A profile was completed, which included person centred information, such as; 'what people like and admire about me', 'important things about my life', 'what things I enjoy during the day' and 'my personal care needs'. On admission to the home further assessment of people's needs, interests and risks was undertaken, including information about people's family history, cultural needs, physical ability, emotional well-being, hobbies and past times, likes and dislikes.

Where a support need was identified a care plan was put in place to provide care in the way the person wanted. We observed care plans in place covering a wide range of support areas, such as personal hygiene, continence, eating and drinking, daily activities, occupations and family/community links, mobility, sleeping and night time routines, physical health, psychological health, medicines, preventing pressure ulcers, ensuring comfort and alleviating pain.

Care plans were detailed and contained information on how people wanted to be supported. For example, one person's eating and drinking care plan reflected the fact that they were now choosing to eat in their room, and that they were wanting to lose a little weight, so were trying smaller portions and salads now that the warmer weather was here. Care plans were regularly reviewed to ensure they reflected people's current preferences. We saw that the registered provider used a 'resident of the day' system, which ensured that each person's care was reviewed monthly, involving the person, care and activity staff. Ancillary staff were also involved, such as the chef, administrator and maintenance staff, to ensure all the person's needs were considered.

This meant that staff had the information they needed to provide personalised care to people.

A visitor we spoke with told us, "I have seen my [relative's] care plan and feel involved in what is being done for them and can give my opinion too." Another visitor told us, "The nurse involves me in decisions. I know I could ask to see [my relative's] care file if I wanted to [with my relative's permission], but I don't tend to."

When we spoke with staff they were knowledgeable about people's needs. Staff told us how they got to know people; one said, "I have got to know people's individual needs by talking to them and reading their care plans. I read the life story and learn about someone's life." Another told us, "[Person-centred care] is about meeting individual's needs and choices. We ask people about themselves to get to know them. Personal histories are in the care plan." A visitor told us, "Staff know people as individuals and this is really good because they know their needs too."

The registered provider employed a dedicated activities co-ordinator, who held a QCF (Qualifications and Credit Framework) Level Two Award in Supporting Activity Provision in adult social care. The service was a member of the National Activity Provider's Association (NAPA) and activities were provided each week day. We saw that there was a calendar of activities for the month available on display in the home. Activities on

offer included creative writing, hand massage, sing-alongs, coffee mornings, scrabble, craft, film club, armchair exercises, a karaoke machine and one to one activity sessions with people. On the day of our inspection we observed a 'knit and natter' group taking place, which five people attended and appeared to enjoy. We also observed people in the hair salon having their hair styled and nails painted.

Staff told us about a number of trips that people had been out on recently, including to the Harrogate Flower Show and to Skipton Canal. A staff member told us they took one person to the park in their wheelchair, where they enjoyed a cup of tea or ice cream. There were also weekly visits to a local garden centre, when three people were taken each time, on a rota basis. The service had a minibus and three minibus drivers.

People told us, "I sometimes do the activities and get the leaflet about what is going on and join in if I want to" and "We get a list of what is going on in the home about activities and meetings, so I know what is happening. I socialise with other people, always get involved and go to meetings and interact with people." Others told us, "I go out every day and get the bus in to the shopping centre" and "I like spending time in my room; I do my reading and my crosswords and can watch TV when I want to. Staff pop in to see me in my room." Another said, "I go out with my [relatives] and with the staff on the days out; we have some lovely days out."

A visitor told us, "My [relative] is 100 years old and goes out on the activities and enjoys the days out. They have had their hair permed and nails varnished today."

This showed us that people received personalised care that was responsive to their needs and there were a range of activities available to people.

There was a complaints procedure in place and a system to record and respond to complaints. The complaints procedure was available to people who used the service. Records showed that one complaint had been received in the year prior to our inspection, and this had been appropriately investigated and action taken to address the issue raised.

People we spoke with told us they knew how to raise a complaint. Comments included, "If I had a concern or a complaint I would speak to a carer about it," "I have no complaints; I would speak to the manager if I did" and "If I had a complaint I would talk to the senior on duty and I know it would be passed on to the manager." Another told us, "I would talk to the manager if I needed to. Staff listen to me and I talk to them if I have a problem. If I had a complaint I would talk to staff and I know they would sort it out for me." Visitors also told us they would feel comfortable raising any concerns.

We saw that people had opportunity to share their views about their care and issues at the home. This was evident from minutes of residents meetings, resident and relative surveys, and the 'resident of the day' review process. Two people who used the service told us that they did not attend the resident meetings but another told us, "I go to the residents meetings and I talk freely; I can have my opinions heard and give input to the meetings." We saw from minutes of meetings that where relatives had made particular suggestions, for instance for changes to activities, the registered provider had surveyed others for wider opinion on the matter and taken a majority view before making a decision.

This showed us that people's views and opinions were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager in post and they had been registered with the Commission since April 2014. The registered manager understood their role and responsibilities. There was also a deputy manager for the service, who provided clinical leadership to the nursing team.

When we spoke with people about the management of the service the feedback was consistently positive. One person using the service told us, "The manager is always around and will have a chat with me" and "The manager is very good, I would talk to them if I was worried about anything." Visitors told us, "The manager is very approachable and I am always welcomed by staff" and "I believe the home is well run and organised; [Registered manager] is good." Other comments from visitors included, "I have no complaints or worries about the care of [my relative]" and "I'm really happy with [my relative's] care."

Comments from staff included, "The leadership is very good and the manager is very supportive of me" and "The manager is really supportive, and so are the team, if there is anything I am not sure of." Others told us, "The management is good. They are approachable and I would go to them with any concerns and can talk to them" and "The manager is great and I definitely feel supported." Comments from staff also demonstrated a positive culture, team approach and job satisfaction; such as, "I have a good team around me. They are always willing to help if I want something" and "I feel my voice is listened to by the team and by the manager, and I love my job and love working here. We all get on and we help each other." Another told us, "I love it here; the atmosphere is fantastic. We have a laugh and everyone is lovely."

The registered manager told us they kept up to date with best practice and legislation by completing regular training and updates from the registered provider, along with knowledge and best practice gained via their position within the ICG (Independent Care Group) and as a member of the local safeguarding board. They also volunteered to take part in local best practice initiatives where opportunities arose, such as one that had recently been proposed by dieticians at the local hospital regarding nutrition. Key information about best practice and any changes in legislation was shared with staff in briefings.

The registered provider conducted annual satisfaction surveys. Responses to surveys were collated and the registered manager told us that the results of the most recent survey would be sent out to each family. They told us it would also be discussed at the next resident and relatives meetings to let people know what action was taken as a result.

The service had systems in place to audit the quality of the care they provided to people. As well as the satisfaction surveys conducted, the registered manager completed a range of audits. The frequency of each audit was set out in an audit calendar from the registered provider. There were audits in relation to medication, catering, care files, infection control, falls and health and safety, and any required actions were identified in these. We found audits had led to improvements being made. For instance, the catering audit had resulted in the home getting a new kitchen floor and cooker. They also gave other examples of how quality assurance processes had helped to drive improvement, such as the new approach to staggering mealtimes, which had come about as a result of feedback in a residents meeting. The assistant operations

director also completed monthly audits. Audit findings were reported to the registered provider electronically and any actions remained on the service's action plan until they were marked as completed. The registered provider and registered manager were therefore able to keep track of any outstanding actions.

This showed us that systems were in place to monitor and review the delivery of care and the quality of service that people received.

Policies and procedures were in place, and based on up to date legislation and guidance. We asked for a variety of records and documents during our inspection. Overall we found these were well kept, easily accessible and stored securely.