

Premier Nursing Homes Limited

# Briarwood Care Home

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This inspection took place on 13 and 25 October 2016. The first day of the inspection was unannounced which meant the registered provider and staff did not know we would be visiting. The second day of inspection was announced.

At the last unannounced, comprehensive inspection on 15 December 2015, we identified short falls in staff training and medicine management. There was a lack of recruitment checks for agency staff and best interest decisions were not being made when people lacked capacity. The premises were not clear and there was a malodour throughout and some furniture was in need of replacement. We asked the provider to take action to make improvements to ensure they were meeting regulations. At this inspection we found that the registered provider had taken appropriate action and the service was no longer in breach of any regulation.

Briarwood provides nursing and residential care for up to 49 people and is a purpose built home with a residential unit downstairs and a nursing unit upstairs. The service predominantly supports older people with dementia care needs. The service provides lounge areas, dining areas and bathing facilities. All rooms at the service are en-suite. The service is located close to local amenities and bus routes.

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

People and their relatives told us they felt safe. Risk assessments were in place for people who needed these and they had been regularly reviewed and updated when required.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks. Falls were also monitored to identify if any trends were occurring.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place and the provider had a policy in place to minimise the risk of abuse occurring. Safeguarding alerts had been made and recorded when needed.

Emergency procedures were in place for staff to follow and personal emergency evacuation plans (PEEPS) were in place for everyone. PEEPs provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. A robust procedure for recording fire drills had been implemented.

Medicines were stored and managed appropriately. The provider had policies and procedures in place to

ensure that medicines were handled safely. Medication administration records were completed fully to show when medicines had been administered and disposed of. People we spoke with confirmed they received their medicines when they needed them.

Certificates were in place to ensure the safety of the service in areas such as electrical testing, controlled waste, legionella and fire fighting equipment. Regular checks were made by the maintenance staff in areas such as water temperature, emergency lighting and fire alarms.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed. All new staff completed a thorough induction process with the registered provider.

There was sufficient staff on duty to meet the needs of people who used the service and people and relative we spoke with confirmed this. Call bells were answered in a timely manner and staff were visible throughout the service.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal. Staff had received training to support them to carry out their roles safely.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service. Staff understood the procedures they needed to follow if people became at risk of malnutrition or dehydration.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take if they suspected a person lacked capacity. Documentation was available in care plans to show best interest decisions that had been made.

Each person was involved with a range of health professionals and this had been documented within each person care records. From speaking with staff we could see that they had a good relationship with health professionals involved in people's care. People's care records contained evidence of appropriate referrals to professionals such as falls team, tissue viability nurses and speech and language therapists (SALT).

The service was clean and neutrally decorated throughout but was not always adapted to support people living with a dementia, however plans were in place for improvements to be made. People were able to bring their own furniture and personalise their bedrooms if they wished.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

People, and where appropriate their relatives, were actively involved in care planning and decision making. This was evident in signed care plans and consent forms. Information on advocacy was available for anyone who required it.

Care plans detailed people's needs, wishes and preferences, and were person centred. Care plans had been regularly reviewed and we saw evidence that people and relatives had been invited to these reviews.

The service employed an activities coordinator. We saw a range of activities that were on offer; and on the day of inspection we saw activities taking place. People were able to tell us about the activities on offer and told us they enjoyed the activities provided.

The service had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint.

Staff told us they enjoyed working at the service and felt supported by the manager and that standards had been improved. Staff told us they were confident any concerns would be dealt with appropriately. We could see from our observations and speaking with people that the manager had a visible presence at the service.

Quality audits were completed by the manager in areas such as care plans, medication, nutrition, accidents and incidents, falls and infection control. Where issues had been identified, action plans had been developed.

Feedback questionnaires had been sent to people and relatives to ask their views of the service. Action plans had not been developed, but we saw minutes of resident meetings which showed that any issues that had been identified had been discussed and appropriate action had been taken as a result.

The service worked with various healthcare and social care agencies and sought professional advice to ensure the individual needs of people were being met.

The manager understood their role and responsibilities and was able to describe when they would be required to submit notifications to CQC.

## 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 and their relatives told us they felt safe. Risk assessments were in place for people who needed these and they had been regularly reviewed and updated when required.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place. The registered provider had a policy in place to minimise the risk of abuse occurring.

Medicines were stored and managed appropriately. Medication administration records were completed fully to show when medicines had been administered and disposed of.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed.

### Is the service effective?

Good 

The service was effective.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal. Staff had received training to support them to carry out their roles safely.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take if they suspected a person lacked capacity.

Each person was involved with a range of health professionals and this had been documented within each person care records.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service.

### Is the service caring?

Good 

The service was caring.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

People, and where appropriate their relatives, were actively involved in care planning and decision making. This was evident in signed care plans and consent forms.

Staff were able to explain how they treated people with dignity and respect.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Care plans detailed people's needs, wishes and preferences, and were person centred.

There was a range of planned activities. People were able to tell us about the activities on offer and told us they enjoyed what was provided.

The service had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint.

### **Is the service well-led?**

**Good** ●

The service was well-led.

Staff told us they enjoyed working at the service and felt supported by the management.

Quality audits were completed by the manager. Action plans had been developed when required.

Regular meeting took place for people who used the service, relatives and staff.

Feedback was sought from people and relatives through questionnaires. Any issues identified as a result had been discussed in resident meetings and appropriate action had been taken.

# Briarwood Care Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 17 October 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting the service. A second day of inspection took place on 25 October 2016 and this was announced. 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.

Before the inspection we reviewed all the information we held about the service which included recent notifications submitted to the Care Quality Commission (CQC). We spoke with the local authority contracts and commissioning teams and the local safeguarding team. The registered provider had completed and submitted 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 what improvements they plan to make. We used this information to plan our inspection.

During the inspection we reviewed a range of records. This included four people's care records and eight people's medication administration records. We also looked at four staff files including recruitment, four staff files relating to training records and four staff files relating to supervision and appraisal. We also looked at records relating to the management of the service and a variety of policies and procedures.

We spoke with six staff members including the manager, the administrator and four care staff. We spoke with five people who used the service and three relatives. We spent time observing staff interaction with people and looked at all the facilities provided including communal lounges and dining areas, bathrooms and peoples bedrooms, with their permission.

# Is the service safe?

## Our findings

We asked people if they felt safe living at the service. Everyone we spoke with confirmed they felt safe. One person said, "There's no one I'm frightened of." A relative we spoke with told us, "I think people are very safe here, I have no issues." Another relative told us that carers accompanied their relative to go outside and smoke and she felt reassured that their relative was safe because of this.

Individual risk assessment plans were included in care plans for people where appropriate. These included falls risk assessments. For example staff had noted that one person was having an increasing number of falls recently which had led to staff reviewing the care plan, updating it and contacting the falls team for advice. Another person had been assessed as at risk of choking. A risk assessment had been produced which detailed the person required a liquid diet and supervision with eating due to 'rushing food'.

Care plans also included risk assessments to assess if someone could be at risk of developing pressure sores; experienced respiratory disorders, diabetes, mobility problems; and problems associated with incontinence. People who were identified to be at risk had appropriate plans of care in place such as plans requiring that they used airflow mattresses and positional changes were made every two hours. Charts used to document change of position were clearly and accurately maintained and reflected the care that we observed being given.

We looked at arrangements in place for managing accidents and incidents and what actions were taken to prevent the risk of reoccurrence. Records were in place to show that accidents and incidents were reviewed on a monthly basis by management who checked to see if there were any repeated patterns. Appropriate forms were completed for each accident or incident that had occurred. We spoke with staff who were knowledgeable about what action they would take if a person was suffering regular accidents, for example making referrals to other professionals such as the falls team. From records we looked at we could see that there had been an increase in the total number of accidents and incidents throughout September and October. The manager told us this was due to one person who had suffered a number of falls and action had been taken to address the issues such as referrals to the falls team and increased observations.

Personal emergency evacuation plans (PEEPs) were in place for each person who used the service. PEEPs provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. The PEEPs contained information about what assistance would be required and other considerations, such as medical conditions, that would need to be considered to evacuate someone safely. We could see that PEEPs were reviewed and updated when needed.

Risk assessments were in place associated with the day to day running of the service. Regular checks were made by the maintenance staff in areas such as water temperature, emergency lighting and fire alarms. Required test certificates in areas such as electrical testing, controlled waste, legionella and firefighting equipment were in place.

Records showed that regular fire drills were taking place for both day staff and night staff. A detailed record



of the fire drills that had taken place were recorded and we could see different scenarios had been used on each fire drill that had taken place. Any issues that had been raised during the fire drill and what could be done to improve the process in the future were recorded by staff. We could see that it was identified staff needed further training in relation to zones. This had been actioned.

The staff we spoke with were all aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any concerns. Staff told us the manager would respond appropriately to any concerns. The manager said abuse and safeguarding was discussed with staff at supervision sessions and during staff meetings. Staff we spoke with confirmed this to be the case. We looked at training records in relation to safeguarding training and could see that staff had training in this area.

We looked at records relating to safeguarding. We could see that referrals had been made to the local authority and recorded appropriately. Details contained in the safeguarding record did not indicate whether further action had been taken or whether any strategy meetings had taken place as a result of the alert. We spoke with the manager about this who told us they would include this information to ensure there was a thorough record.

Staff told us they would not hesitate to whistle blow (tell someone) regarding any concerns they had. One staff member told us, "I would always report anything to my manager or senior. I know it would be dealt with in confidence". Another staff member told us, "I would always report and ensure it wasn't swept under the carpet. That wouldn't happen here, not with the new manager."

During our inspection in December we identified concerns regarding the safe storage and recordings of topical medicines and the accuracy of recordings of current medication in people's care plans. At this inspection we could see that systems were now in place for the safe management of medicines. People's use of medicines was recorded using a medicine administration record (MARs). A MAR is a document showing the medicines a person has been prescribed and the recording when they have been administered. All of the MARs we looked at contained an up to date photo of the person. A photo helps staff to ensure they are administering medicines to the right person. The people's MARs corresponded with information in the person's care plan. Topical creams were now being stored in people's room and accurate recordings of when topical medicines had been administered were completed.

The service had a medication policy in place which staff understood and followed.

We reviewed eight people's MAR's and saw there were no gaps in administration. Where medicines had not been administered the reason for this had been recorded. A list of staff signatures for those staff administering medicines was stored in the front of the MARs. This helped create a clear record of who was administering medicines. We observed a medicines round and found the correct procedures were followed when administering medicines, including accurate recordings.

Medicines were stored securely in a locked medicines trolley. When they were not being used for medicine rounds they were stored securely in a locked room. Room and fridge temperatures were recorded each day to ensure medicines were stored at the correct temperature.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines that they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for safe disposal. Some people were prescribed controlled drugs. These are governed by the Misuse of Drugs Legislation and have strict control over administration and storage. We could see that they were securely stored and were audited on a daily basis. We checked stock levels and could see these

corresponded with records.

We looked at staffing levels in the service. Rotas showed that, on the ground floor during the day one senior and four care assistants were on duty and at night one senior and one care assistant. On the second floor nursing unit, during the day there was one nurse and four care assistants, at night there was one nurse and two or three care assistants on duty. On the day of inspection we found that staff on duty corresponded with these rotas.

During our inspection in December 2015 we identified concerns that appropriate checks were not made when agency staff were used to provide cover at the service. The manager told us that they now request full completed profiles from the agency and will only allow agency staff to work at the service if these were received. A record had been created which contained all full completed profiles for any agency staff that had been used.

People we spoke with confirmed there was enough staff on duty day and night and that staff had enough time to be able to spend one to one time with them. One person we spoke with told us, "Staff are always jolly and there seems to be enough. I suppose there could always be more." Another person told us, "I am quite happy with the amount of staff." A relative told us that they thought there were always enough staff and had often "seen staff spending quality time with people."

During the inspection we looked at four staff recruitment files. We could see from the records we looked at that safe recruitment procedures had been followed and improvements on the recruitment process implemented since the last inspection. Applications and interviews had been completed. Two checked references and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with vulnerable adults.

During our last inspection in December 2015 we found that communal environment in the service was poor as it had a bad odour, plus flooring and seating was badly stained and in need of replacement. During this inspection we could see that improvements had been made. Communal areas and bathrooms were clean and tidy. Recent refurbishment had been completed and included new flooring throughout the home, some new furniture and redecoration. There were plans in place to develop the service further by creating an 'old style sweet shop' and a relative's kitchen. Throughout the day we saw housekeeping staff cleaning communal areas, bathrooms and people's rooms. Cleaning equipment was securely stored when not in use in a locked room.

## Is the service effective?

### Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "We have done a lot more training recently and I know there is a lot of training planned. I feel I have the training I need to do my job correctly." Another staff member told us, "I did an induction when I first started. It covered lots of things. Training is good, I quite enjoy it. I have done some recently."

During our last inspection in December 2015 we identified that staff training was not up to date. During this inspection we looked at a training matrix which confirmed that training was now up to date for all staff. Mandatory training is training the registered provider thinks is necessary to support people safely. The manager told us that mandatory training was covered during the induction process and robust plans had been put in place following the last inspection to ensure all staff had completed this training. We looked at four staff files. Certificates were available to evidence training that had been completed in areas such as moving and handling, infection control, nutrition, medication and safeguarding, to name a few. Specialist training had also been provided to some staff in areas including dementia and pressure area care. Training consisted of e-learning (online training) as well as some practical, hands on training. Staff we spoke with told us they would prefer more 'hands on training but that the online training available was ok'.

People we spoke with told us they thought staff were suitably trained to look after them. One person told us, "Yes, staff are very well trained. [Staff member] looks after me very well."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. From the records we looked at we could see that these meetings were used to discuss any support needs the staff member had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and 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 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 Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During our last inspection in December 2015 we raised concerns that people who potentially lacked capacity to consent to care being provided had not been assessed or best interest decisions made using the mental capacity act had not been made. We could see that improvements had been made and the care

plans we looked at documented mental capacity assessments and best interest decisions that had been made. One care plan detailed that this person lacked capacity to consent to a lap belt being used on a wheelchair. A mental capacity assessment had been completed. Following the mental capacity assessment a best interest decision had also been completed. From the records we could see that a risk assessment had also been completed with regards to a lap belt being used and documented that it was the least restrict option to keep this person safe whilst in the wheelchair. Another care plan detailed that a person lacked capacity with regards to oral hygiene. Again, a capacity assessment had been completed and then a best interest decision was made and recorded stating the person should be assisted with oral hygiene twice per day.

Staff demonstrated an understanding of the Mental Capacity Act 2005 and were able to explain what action they would take if they suspected a person lacked capacity.

Staff had a good understanding with respect to people's choices and consent. We could see that consent to care had been given by people or, where appropriate, their relatives, and signed documentation was present in care plans to evidence this.

Some people who used the service had made advanced decisions on care and treatment and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) were in place. These DNACPR documents had been completed by relevant professionals and were in date. The manager told us they used a tracker so they could ensure DNACPR's were reviewed in a timely manner. A notice board displayed in the manager's office also identified people who had a DNACPR in place by using a colour dot against there name. Staff were aware what the colour dot indicated.

People were supported to maintain a balanced diet. People weights were monitored and recorded on a monthly basis. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). People's weights were monitored in accordance with the frequency determined by the MUST score, to check if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals if needed. Staff were able to tell us whether the people they supported had specific dietary needs and if so what they were. The cook adapted dishes to people's requirements (such as soft diets or diabetic diets) and ensuring alternatives were available if people did not want what was on the daily menu.

We looked at a menu plan. We could see there was a four weekly rolling menu. There were two meal options available at lunch and two options available at tea time. A selection of snacks were also available throughout the day which included fruit, biscuits, smoothies and scones. One person was observed to have a fridge in her room where they kept snacks.

We saw people were able to eat at flexible times. There was an allocated time for lunch and tea, but these could be changed to accommodate people's wishes. We saw that refreshments and snacks were provided throughout the day. People told us they enjoyed the food at the service. One person told us, "The food is good and always nicely presented." A relative we spoke with told us, "Meals are beautiful; staff have invited me to stay for a meal. There is always choice and [relative] has put weight on because staff encourage them to eat." However, one person told us they did not like the food and that quite a lot of the meals can be "dry" and "staff often forget the gravy and I like my gravy." Staff also thought that the menu could be improved telling us, "Older people prefer more traditional meals and I don't think some of the menu is suitable." We discussed this with the manager who told us that although people were 'dubious' initially the new menu had gone down well and people's comments had generally been positive.

During the inspection we observed a lunch time routine. Choices for lunch on the day of the inspection were soup or pasta with tinned fruit for dessert. This did not correspond with the pictures displayed on the pictorial menu in the dining room. We noted that the date and weather displayed in the dining room was incorrect, displaying 'Sunday' rather than Monday. We pointed this out to the manager who addressed the issue immediately. From our observations we could see that staff were attentive to people's needs and provided assistance when it was needed.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses, social workers and dieticians. We could see that referrals to these professionals had been made in a timely manner and these visits were recorded in people's care records.

The service was clean and neutrally decorated throughout. However, the building could be adapted further to support people living with a dementia. For example, doors were not colour-coded or marked in a way that would help people living with a dementia recognise them. Communal areas lacked décor which would help a person living with a dementia navigate to their room. Dementia friendly door sign for facilities such as toilets and bathrooms were in place. We spoke to the manager about this who told us that they had recently requested relatives provide memorabilia such as pictures and small objects, so the service could begin to make memory boxes which would be displayed outside people's rooms. We could see that some progress had been made and some people had old pictures on the doors to their bedrooms. The manager also told us of plans to create an 'old style sweet shop' where people could buy sweets, toiletries and newspapers. This was in the early stages of planning and the manager was unsure when work would be started to produce this.

## Is the service caring?

### Our findings

People who used the service told us they were very happy and staff were caring. One person said, "They are all very friendly, feel like one of the family" and "I am so well looked after here. The staff are marvellous, spot on" Another person told us, "Staff are nice and friendly, always chatting to me." A relative we spoke with told us, "Staff have done everything I have asked and more, they have just sorted out a hospital appointment at short notice."

During the inspection, we spent time observing staff and people who used the service. On the first day of inspection, we saw one person assisted the manager with some filing and paperwork. The person clearly enjoyed helping with this tasks and this was encouraged by the manager who gave clear instruction on tasks that needed to be completed and asked if they were happy to do such tasks. The manager later explained that the person suffered with a dementia and used to be a receptionist. As a result of their condition they thought that they worked at the service and asked for 'jobs' to do. We also saw staff spending time with people, chatting about general topics and sharing jokes as they moved around the building. This helped to create a relaxed and homely atmosphere throughout the service.

We saw staff were respectful and called people by their preferred names. Staff were patient with people when speaking to them and took time to ensure people understood what was being said. Staff members often approached people who used the service to check they were ok and had general conversations about the person's day and what their plans were for the coming week.

Staff explained to us how they respected a person's privacy and dignity, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choices and decisions. We saw staff seeking permission before any care and treatment was provided and people we spoke with confirmed this. One person said, "I can go to my room when I wish and staff always knock before entering." A relative we spoke with told us, "I usually visit [relative] and we go to their room. Staff always knock before entering."

We observed a staff member responding sensitively and caring to a person who wandered around the service and often attempted to go into other people's rooms. The staff member used distraction techniques to divert the person and helped them navigate to their own room.

Care plans detailed people's wishes and preferences around the care and treatment that was provided. We could see evidence, such as signatures in care plans, that people were being involved in care planning and, in some situations, relatives had also been involved. People we spoke with told us they were unsure if they had a care plan but did tell us that staff often write in records. Relatives we spoke with confirmed they were involved in their relatives care needs, and although they could not recall being involved in the initial care planning, they felt their views were taken into account. One relative told us, "I had a meeting recently with the social worker and care staff to discuss the care, I have attended review meetings."

People spent their recreational times as they wanted to and had access to communal areas as well as private space if they wished. We saw people were able to go to their rooms, as they wished, throughout the

day. People chose when they wished to rise on a morning and retire on an evening. This helped ensure people received care and support in the way that they wanted.

It was evident from discussions with staff and the manager that all staff knew people well, including their personal history, preferences and like and dislikes. One staff member said, "These people are like family to me, I like to think I know them all inside out." The manager told us, "I love working here. I know them all very well and I like to interact. When I joined the service my office was located on the top floor which was away from all the people and staff – I moved my office to the ground floor straight away. I like people to see me and be able to have general chats and catch up's."

People who used the service had access to independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The manager told us that people had used advocates in the past and information was available. Staff were aware of the process and action to take should an advocate be needed.

At the time of this inspection, there was one person who was receiving end of life care. The manager was able to provide, in great detail, the person's wishes with regards to end of life care and how support had been provided to the person's relatives. The manager told us they wanted to adapt the services current facilities available to relatives, which would include a relative's kitchen and seating area. The manager told us, "End of life care is so important, it's important to the person but as equally important to the relatives of the person and it needs to be right. I think having an area where relatives can go to freshen up and have some alone time would benefit them." During the inspection we could see that compassionate care was provided to the person receiving end of life care and their relatives. We saw relatives being comforted by care staff and management.

## Is the service responsive?

### Our findings

During our inspection we looked at four care plans. Care plans began with a pre-admissions assessment, which had been completed before the person moved to the service. This meant the service was ensuring they could meet people's care needs before they moved to the service and looked at areas including medical history, mobility, skin condition and communication needs. A spiritual and cultural care plan had also been developed which included details of the person's history, relatives, likes, dislikes and preferences.

Care plans were produced to meet individual's supports needs in areas such as communication, mobility, nutrition, personal hygiene and sociability. Care plans were detailed and focused on the person's preferences and were reviewed on a monthly basis. The care plans that we looked at were all up to date and were person centred. For example, one care plan detailed a person's preferred night time routine stating that they liked to have the bathroom light left on, a cup of tea with one sugar, bedroom door closed and used two pillows and a quilt. Another care plan detailed that a person was able to brush their own teeth but required staff to 'place a small amount of toothpaste on the toothbrush and hand it to the person'.

During our last inspection in December we identified that care plans were not always reviewed and updated in a timely manner. We could see, on this inspection, that improvements had been made and all the care plans we looked at were up to date and had been regularly reviewed.

When people had a specific care need plans were in place to help ensure they received person-centred support. For example, one person was assessed as high risk of choking. A nutrition care plan had been developed to help manage this which detailed why the person was at risk, the type of diet that was to be provided and any aids needed to support the person to be able to eat independently, such as plate guards and feeder beakers.

We spoke with staff who were extremely knowledgeable about the care that people received. Staff were responsive to the needs of people who used the service and people and relatives that we spoke with confirmed this. One person told us, "They [staff] are all fantastic. I don't know what I would do without them. They know me inside out." A relative we spoke with said, "They know [person] as well as I do. They always respond to requests."

People were supported to access activities which they enjoyed. The service employed an activities coordinator who planned these according to the preferences of people who used the service. Board games, reading material and movies were available throughout the service and we saw people enjoying watching television in the communal lounges and people helping with tasks around the service. We could not see any details of activities that were arranged displayed around the service. We spoke with the manager about this who told us, "We have one resident who removes any items from the notice board. The weekly activities are usually displayed on the notice board but [person] has removed them. We have requested a covered notice board to try and prevent this from happening."



During the inspection, we saw evidence of planned activities taking place. On the first day of inspection a quiz was taking place, led by the activities coordinator. On the second day of inspection a hairdresser was present and we saw staff interacting with people asking them 'what style they were having this week'. We saw staff spending one to one time with people, chatting or playing board games and staff had a visible presence in the service.

We spoke with the activities coordinator and they stated there was a planned programme of activities, however this was flexible and largely depended on what activities people wished to do on the day. They told us about a recent trip to Kirkleatham with three people supported by three staff. They told us they have regular walks in the local community and had singers and entertainers attending approximately twice a month. We asked how people who were less mobile were facilitated. A PAL activities checklist (Pool Activity Level) which can give a guide as to a person's ability in a number of activities is completed for each person. An example was given of a person who was "bed bound" and that if, for example, they had previously enjoyed knitting they could offer wool winding and other similar activities. During the inspection we observed some people utilising 'twiddle muffs'. Twiddle muffs are knitted bands with added items inside and out. They are designed as a stimulation for restless hands specifically for people with a dementia.

We were provided with a weekly timetable of arranged activities which including cinema evenings, colouring in, coffee mornings, reborn dolls, inflatable snakes and ladders, singing and dancing, fidget toys and musical memories to name a few. Entertainers also visited the service to provide activities. These included singers, zoo lab, guitarist and weekly visits from the hairdresser. Reminiscence boxes were in the process of being developed and relatives had recently been asked to provide items for these boxes. The manager described this as 'a work in progress' and we saw evidence of some reminiscence boxes being produced.

We looked at the records relating to activities. We could see that the activities were well recorded and documented if the person had enjoyed the activities on offer. Group activities and one to one times spent with people were also recorded. Records documented if the person was involved in the activity, if they remained focused or if they became unfocused. It was clear to see from the information recorded if people had enjoyed the activities.

We asked people who used the service about activities on offer. People told us, "There is usually something to do" and that staff "Keep them busy." One person proudly showed us their recently awarded certificate for 'Gold Award Winner, Target Throwing' and told us they really enjoyed the activities on offer. Another person told us how they had "Particularly enjoyed the miniature horse visit and painting their hooves."

We were given a copy of the registered provider's complaints procedure. The procedure gave people details about who to contact should they wish to make a complaint and timescales for actions. The manager told us that they speak with people on a daily basis so people who used the service would generally express any concerns they had to them and this was encouraged by management. We saw evidence of people approaching the manager throughout the inspection. One person told us, "I would speak to [manager] if I had any problems. To be honest I could speak to any of the staff. I can't say I have any complaints at the moment." Another person told us, "I don't need to complain, I am happy here."

We looked at the record of complaints. We could see complaints had been investigated in line with the complaints policy and outcomes sent to all parties involved. General complaints were also recorded and actions taken were documented.

## Is the service well-led?

### Our findings

The manager joined the service in June 2016 and had recently begun the process of applying to be the registered manager. The manager had a clear vision of the culture of the service and told us, "We have worked really hard to improve standards since the last inspection. I have seen a big improvement in the last four months. We are making steady progress and I have lots of ideas on how further improvements can be made. The changes have been difficult for staff but they all understand that the changes are for the better and we are all working together as a team."

People who used the service spoke positively about the manager. There was a management office located on the ground floor of the service and throughout the day of inspection we saw people coming into the office to speak to management. We could see the manager had a visible presence at the service and regularly interacted with people. The manager spent a lot of time with people who used the service and staff, having conversations with them about their health, any plans they had for the coming week and observing practice around the service. One person told us, "Oh [manager's name] is lovely. Things have got better since they came." It was clear that the manager was familiar with people who used the service and relatives that came to visit.

We asked staff about the management of the service. All staff we spoke with confirmed they were supported by management. The service had undergone several managerial changes in the past 12 months and some staff told us this had been a difficult time. One staff member told us, "It been difficult because when someone new comes in they make changes, then suddenly they have gone and someone else is here. The new manager seems to be making all the right changes though. We just hope they stay here." Another staff member told us, "[Manager's name] is just what this place needed. I have seen a big change in the short time they have been here. I feel more supported now."

Regular staff meetings had taken place with the most recent meeting in September 2016. The minutes of the meeting showed that staff had the opportunity to raise concerns and be involved in decisions about the service. Areas that were discussed included health and safety, safeguarding, rotas, roles and responsibilities, maintaining dignity, training and annual leave. Regular resident meetings had also taken place with the most recent in September 2016. People were given the opportunity to discuss areas such as menu planning, décor and activities.

During the inspection, we looked at feedback that was sought from staff and people who used the service. Questionnaires had been distributed in April 2016 and returned to the service. The information had been analysed by the manager and easy to read graphs had been produced to show how the service had performed. From the questionnaires we could see that people had commented on the furniture around the service stating 'it is very shabby'. Other suggestions included more small tables around the service for drinks, lack of seating for visitors and the outside space not being used. No action plans had been produced as a result of the feedback provided, however we could see that some of these areas had been addressed in 'resident and relatives meetings' and plans were in place to replace all bedroom furniture.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services, ensuring they provide people with good services and meet the appropriate quality standards and legal obligations. Monthly audits were carried out in areas such as health and safety, infection control, nutrition including weights, medication, care plans, falls, complaints, training and pressure area care. From the records we looked at, we could see where issues had been identified; action plans had been developed to ensure remedial action was taken. For example, a care plan audit identified that there was no photograph in the person's record and a section of the care plan was not signed. An action plan had been developed and this had been 'signed off' when the action had been completed. Another audit identified that some staff required moving and handling refresher training. As a result training had been arranged. The information from these audits was then submitted monthly. The registered providers head office who analysed all of the information provided.

The manager also undertook 'daily walk rounds' of the service. A recent 'daily walk round' had identified not all staff were wearing name badges, a personal item had been left in one of the bathrooms and one person's breakfast pots had been left in their bedroom. An action plan had been developed and the issues had been addressed immediately. Discussions with staff had taken place as a result.

From discussions with the manager, we could see that continuous improvements were being made and people who used the service were at the centre of this.

The manager understood their roles and responsibilities and was able to describe the notification they were required to make to CQC.