St. Martin's Care Limited

Guisborough Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We inspected Guisborough Manor Care Home on 7 and 10 June 2016. The first day of the inspection was unannounced which meant the staff and registered provider did not know we would be visiting. We informed the registered provider of the date of our second visit.

Guisborough Manor Care Home is purpose built and can accommodate up to 63 people. The service provides care and support to people who require personal care and care for people living with a dementia. There are two separate units. The ground floor accommodates people who require assistance with personal care. The first floor of the service provides accommodation for people living with a dementia. At the time of our inspection there was 60 people using the service.

A new manager had been recruited and had been in post since 11 April 2016. The new manager had submitted an application to become the registered manager on 9 June 2016. A registered manager is a person who is 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.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about the different types of abuse and what actions they would take if they suspected abuse was taking place. Safeguarding alerts had been made when needed.

Risk assessments were in place for people who needed them and where specific to people's needs. However, some risk assessments required updating as they did not correspond with peoples current needs.

Emergency procedures were in place for staff to follow and personal emergency plans were in place for everyone. However, some of these were not up to date and did not identify peoples current needs in the event of an emergency.

Robust recruitment procedures were in place and appropriate checks had been made

There was sufficient staff on duty. People and relatives told us there was enough staff day and night to meet the needs of people who used the service. A dependency tool was used to determine safe staffing levels.

Medicines were managed appropriately. The service had policies and procedures in place to ensure that medicines were handled safely. Medication administration records were completed to show when medicines had been administered and disposed of.

Required certificates in areas such as gas safety, electrical testing and hoist and wheelchair maintenance were in place.

Staff performance was monitored and recorded through a regular system of supervisions and appraisals. Staff had received up to date training to support them to carry out their roles safely and had completed an induction process with the provider.

People were supported to maintain their health through access to food and drink. Appropriate tools were used to monitor people's weight and nutritional health. We could see that staff made referrals to health professionals when they became at risk of malnutrition or dehydration.

Staff demonstrated good knowledge and understanding of the requirement of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards. The manager had a system in place for recognising when DoLS applications needed to be made or reviewed. Best interest decisions were recorded in the care plans and included details of who was involved in the best interest decisions.

People were supported to maintain good health and had access to healthcare professionals and services when needed. People had regular visits from their own GP's.

From our observations, staff demonstrated that they knew people's needs very well and could provide the support that was needed.

People, and where appropriate their relatives, were actively involved in care planning and decision making; this was evident in signed care plans. Information on advocacy was available and staff told us they had been used in the past.

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

Care plans detailed people's needs, wishes and preferences and were person centred. Some care plans required updating as they did not correspond with people current needs in areas including mobility.

The service employed an activities coordinator to plan activities and outings for people who used the service. People told us they were extremely happy with the activities that took place.

The registered provider had a clear process for handling complaints which we could see had been followed.

Staff described a positive culture that focused on the people using the service. They felt supported by the management. Staff told us the new manager was approachable and they felt confident they would deal with any issues raised.

Staff were kept informed about the operation of the service through regular staff meetings.

Quality assurance processes were in place. The registered provider visited regularly to monitor the quality of the service.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks.

Feedback from staff and people who used the service was regularly sought through meetings and surveys and action plans were developed to improve the service.

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

The manager understood her role and responsibilities. Notifications had been submitted to CQC in a timely manner. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Risk assessments were in place but some were not up to date and did not correspond to people's current needs.

There were systems and processes in place to protect people from the risk of harm. Safeguarding alerts had been made when needed.

Personal emergency evacuation plans were not up to date for all people using the service.

People were administered medication safely and robust procedures were in place.

Is the service effective?

Good

The service was effective

Training, supervisions and appraisals were up to date.

Staff understood and applied the principles of Mental Capacity Act and Deprivation of Liberties Safeguard.

People were supported to maintain their health through access to food and drink and referrals were made to health professionals when they became at risk of malnutrition or dehydration.

The service worked with other professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring

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

Staff were knowledgeable of the likes, dislikes and preferences of people who used the service.

Care and support was individualised to meet people's needs.

Is the service responsive?

Good

The service was responsive

People who used the service and relatives were involved in decisions about their care.

People's preferences and needs were reflected in the support they received.

A range of activities took place which were well participated.

A robust procedure was in place for managing complaints. People we spoke with knew how to make a complaint if needed.

Is the service well-led?

Good

The service is well-led

Quality assurance processes were in place and regularly carried out to monitor the quality of the service.

The registered provider sought feedback from staff and people who used the service on a regular basis.

Staff told us they felt supported and included in the service by the registered provider.

Guisborough Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 10 May 2016 and the first day was unannounced which meant the staff and registered provider did not know that we would be visiting. We informed the registered provider of the date of our second day visit. The inspection team consisted of two inspectors.

Before the inspection we reviewed all the information we held about the service. The registered provider had been asked to complete and return a Provider Information Return (PIR) prior to the inspection. 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.

At the time of the inspection there were 60 people who used the service. We spent time with people on both floors, in communal areas and observed how staff interacted with people. We spoke with five people who used the service and two relatives. We looked at all communal areas of the service and some bedrooms and en-suites with people's permission.

We spoke with seven staff members. This included the manager, the deputy manager, the cook, the activities coordinator and three care staff. We also contacted commissioners of the service and the local safeguarding authority who did not report any concerns at that time.

We look at five care records and the medication administration records of five people. We also looked at seven staff records, which included recruitment, training, supervision and appraisals. We also examined records which related to the day to day running of the service.

Requires Improvement

Is the service safe?

Our findings

We asked the people who used the service and their relatives if they felt safe. People told us they felt safe. One person said, "I definitely feel safe here, safer than I did at home." A relative told us, "I know [my relative] is safe here, I would recommend this place to anyone."

We looked at arrangements in place for managing accident and incidents and what actions were taken to prevent the risk of re-occurrence. Records were in place to show that accidents and incidents were reviewed on a monthly basis. From records we could see that one person had suffered several falls each month over a three month period. We spoke to the manager about this who informed us that the person had been referred to the Local Authority for an assessment for nursing care because their needs had increased. Records did not identify timescales of when the referral had been made or any further actions that had been taken to reduce the risk of falls for this person. We could also see that the monthly reviews had identified a higher number of falls during the hours of 1am and 6am on the first floor dementia unit. As a result safety checks had been increased and were now taking place every hour, rather than every two hours. We could see that there had been a reduction in falls at those times as a result of the action taken by the manager.

We looked at arrangements in place for managing risk to ensure people were protected from harm. Risks to people were assessed and care plans put in place to reduce the risk of them occurring. Where a risk was identified further assessments took place to assist in taking remedial action. For example, a risk assessment for one person showed they were at risk of falls. This led to a moving and handling care plan being produced. However, one care plan that we looked at was not up to date and did not correspond with the person's needs. This person required assistance with mobility form two staff members but the risk assessment detailed this person was able to mobilise independently with the use of a walking aid. The persons change in needs had been identified in the monthly risk assessment review but changes had not been made to the risk assessment. We spoke to the manager about this who told us they would review the care plan immediately. The service used recognised tools such as Malnutrition Universal Screening Tool (MUST) and the Braden scale for pressure damage to assess risks to people. Malnutrition Universal Screening Tool (MUST) is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Risk assessments were regularly reviewed to ensure they met people's current support needs.

Risks to people arising from the premises and environment were also assessed. Regular checks were made of areas including water temperatures, bed rails, window restrictors, hoists and wheelchairs and fire fighting equipment. Required maintenance certificates were in place for areas such as fire alarms, slings and hoists, electrical testing and call alarms.

An up to date safeguarding policy was in place and displayed at the service. Training in safeguarding was up to date for all staff. Staff we spoke with demonstrated a good level of knowledge and understanding of the different types of abuse and the procedures they would follow if they suspected abuse was taking place. All staff we spoke with told us they would not hesitate to whistle blow (tell someone). One staff member told us, "I am very confident any concerns I raise would be dealt with how they should be." Another member of staff

told us, "I have reported things like this before. I would always report no matter what. They have always been dealt with. This is their [people who use the service] home and we are here to keep them all safe."

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 including what assistance would be required and other considerations such as medical condition that would need to be considered to evacuate people safely. However, some of the information contained in the PEEPS was not up to date. For example, it was recorded that one person could mobilise independently with the use of a zimmer frame. When we checked the persons care plan we could see that their needs had changed recently and they now required two staff members to assist with mobility. We spoke to the manager about this who told us they would update the information immediately.

We also asked the provider if they had a 'grab bag'. A grab bag is a bag of essential items that would be useful in an emergency. This is usual located in an easy accessible area, such as the reception area, so that it can be located quickly in an emergency. The manager told us that they currently did not have a grab bag but this was something they were in the process of implementing.

We looked at records that showed fire drills had taken place for staff in February 2016 and October 2015 and included a night time fire drill. A list of staff who had participated was also visible.

We saw records that showed water temperatures were checked regularly by the maintenance man and were within safe limits.

During the inspection we looked at four staff files. We found the registered provider operated a safe recruitment process. We could see that an application form had been completed and any gaps in employment history had been investigated. We also saw evidence of a formal interview, two checked references from previous employers and a Disclosure and Barring Service check had been completed before employment commenced. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with children and vulnerable adults. This helps the employer make safer recruitment decisions and also reduce the risk of unsuitable people working with children and vulnerable adults. However, we did see that one staff member did not have two checked references before employment commenced. We spoke to the manager about this who told us that an audit had been completed on this file and it was identified that the staff member had two checked references but they were from the same employer so a further reference had been requested. This reference had been returned after employment commenced.

We looked at the arrangements for ensuring safe staffing levels. During the day there were between three and four carers and one senior on the ground floor and at night there were two carers and one senior. On the first floor during the day there was four carers and one senior and at night there were two carers and one senior. The manager and deputy manager provided on call support to all staff when they were not on duty on a rota system.

The registered provider also had a dependency tool that was completed each month to ensure there were enough staff on duty to meet the needs of the people who used the service. The dependency tool looked at areas such as mobility, communication, dietary needs, personal care and social motivation for each person using the service. However, it was not clear how these dependency levels determined safe staffing levels. We spoke to the manager about this who told us that the tool is used but can sometimes be inaccurate and management would staff according to the needs of people who used the service. The manager said, "We use

the dependency tool loosely as we are trying to develop a tool that is more person centred." From the information provided we could see that calculations on the dependency tool indicated that four staff would be needed on the first floor. We could see that five staff were actually allocated so although the tool was used it was overridden when management felt there was a need to do so to ensure safe staffing levels.

Systems were in place for the safe management of medicines. People's use of medicines was recorded using medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person's MAR contained their photograph, any known allergies and details of the medicines they were using and how they should be administered. This helped to ensure people received the right medicines.

We reviewed five people's MARs and saw that there were no gaps in administration. Where medicines had not been administered the reasons for this had been recorded. A list of staff signatures from staff administering medicines was stored at the front of the MARs. This helped create a clear record of who was administering medicines.

Separate MARs were used to record the use of topical medicines such as creams. These included body maps with detailed guidance of where the medicine should be used and how much should be applied. People using 'As and when required' (PRN) medicines had individual records with guidance to staff on when and why people might need to use them. These records also contained evidence of the service working with external professionals to ensure people had access to the right medicines when they needed them. For example, there was a consultant's letter on one person's medicine records indicating they need more pain relief following an operation. This information had been used to update their MAR.

Medicines were securely stored in locked medicine trolleys. When they were not being used for medicine rounds these were stored in locked treatment rooms. The temperature of the treatment rooms was monitored and recorded on a daily basis. We noted that on the first day of our inspection the temperature of the treatment room on the first floor exceeded recommended levels, and that it had done on five occasions in May 2016. This had been noted by staff on their monitoring records, with 'to report' recorded. A member of staff told us that a fan was used to reduce the temperature of the medicine room and medicine trolleys could be moved to a cooler, secure room in the basement. We spoke to the manager about this who told us she had not been made aware of the previous five occasions when the medication room had exceeded recommended temperature levels and that they would address this with staff. The manager told us they would look into storing the medication in the basement permanently as the temperature is cooler and within safe limits for storing medication.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for disposal. Some people were prescribed controlled drugs. These come under 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 observed a medicines round. Staff supported people at their own pace and explained what medicines they were taking. People were given a choice over whether they wanted their medicines.

Communal areas and bathrooms were clean and tidy. Members of the housekeeping staff said they had all the equipment they needed to keep the service clean. One said, "We put our orders in with the office and it usually comes straightaway." Cleaning equipment was securely stored when not in use in a locked room.

Good

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 their induction had provided them with enough knowledge and skills to care for people and felt the quality of training was good. One staff member told us "We get training whenever we need it. I feel confident that I have the right training I need." Another staff member told us "I have been here years and I have always had training. It's good to refresh and keep up to date. I know if I felt I needed training in an area it would be sorted for me". We could see from the training matrix that 70% of staff had completed a Health & Social care qualification at a level two or above.

We looked at the training matrix for all staff. This showed that training was up to date in most areas and covered mandatory training such as fire safety, food hygiene, moving and handling, COSHH, health and safety and safeguarding. We could see that infection prevention and control training was outstanding for a small number of staff and at the time of inspection refresher training in this area was not planned. The manager told us refresher training courses were due in the next 2 months. Staff had also undertaken training specific to people who used the service such as dementia awareness, end of life care and behaviours which challenge. People we spoke to and their relatives thought staff were suitably trained to look after them. One person said "I can't say anything bad about the care, the staff all seem to know what they are doing." A relative we spoke to said "The staff are brilliant, they know everything. They certainly have the skills and knowledge that they need. [My relative] has deteriorated a lot over the past couple of months and I have had no cause for concern over the staffs ability. They have been brilliant."

Staff were supported with regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received four supervisions a year and an annual appraisal. Records of these meetings confirmed they were used to discuss any support needs the member of staff had, as well as confirming their knowledge of the service's policies and procedures. The registered manager used a chart to track which members of staff needed a supervision or appraisals. This showed that supervisions and appraisals were up to date.

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).

Mental capacity assessments were undertaken if there was a possibility people lacked capacity, which was in accordance with the principles of the Mental Capacity Act 2005. Where people lacked capacity, best interest decisions were recorded in their care records. These decisions contained evidence of the involvement of people's relatives. The registered manager used a chart to monitor when DoLS

authorisations had been granted, to keep people safe, and when renewal applications were needed.

Staff we spoke to had a good level of understanding with respect to people's choices and consent. We could see that training in MCA and DoLS was up to date and 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 in areas such as consent to treatment, sharing information and consent to photographs being taken.

Some people had made advanced decisions on receiving care and treatment and do not attempt cardio-pulmonary resuscitation (DNACPR) orders had been completed. The correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professional completing the form.

People were supported to maintain a balanced diet. Risk assessments were in place to monitor people who were at risk of malnutrition and dehydration. We could see that these were regularly reviewed and action had been taken where needed. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals. Staff had received food hygiene training and were able to tell us whether the people they supported had specific dietary needs and if so what they were. People's dietary needs and preferences were displayed in the kitchen and the cook was able to describe how these were met, for example through the preparation of pureed and diabetic sensitive diets. The registered provider supplied the service with a menu, but the cook said they were free to adapt this to meet people's preferences. They said, "We adapt it here. Our residents love fish and chips and egg and chips so I order stuff in." Menus were display in written format on the dining tables but we saw no evidence of pictorial menus being used.

We looked at the menu plan. We could see that there was a four weekly rolling menu. Two meal options were available at each meal times and people were asked to select what they would like for lunch and evening meal after breakfast each day. People we spoke to told us that they were able to select a different option if they preferred.

We asked people about the food. One person said "Its ok, it could be better. We have just started having meetings with the cook so I am hoping things will start to improve." We saw minutes of this meeting that had taken place and action plans that had been developed as a result. Another person told us "The food is fine; it's not outstanding but its good enough. There is choice and I like most things on the menu anyway."

We observed the lunch time experience on the first floor. The dining room was pleasantly presented and staff were available to offer assistance when needed. We could see that no condiments were available on the tables. One person asked for salt and pepper to go with their meal and this was not available. A staff member had to go to the ground floor to source this leaving the person waiting with their meal in front of them. We spoke to the manager about this who told us that salt and pepper should be readily available and that she would address the issue. A variety of food and drink was offered and staff were knowledgeable about people and their preferences, for example one person choose to remain seated in the hallway and requested their meal to be served there. A staff member responded to the request and came into the hallway with a table and placed it in front of the person and then went and collected their plate, cutlery and napkin and placed it on the table. The staff member explained everything she was doing and chatted in a positive manner whilst making the person comfortable. We could see that a high level of support was needed at meal times and could see that there was enough staff on duty to respond to these needs.

Care records contained evidence of close working with other professionals to maintain and promote people's health. These included GPs, district nurses, the local mental health team, social workers and dieticians.

Good

Is the service caring?

Our findings

People who used the service told us they were very happy and staff were caring. One person said, "I can't say anything bad about the care staff, they do a very good job." Another person said, "I am very happy here. I have company and I have made friends. All the staff look after us, they are a good bunch." A relative told us, "Staff here are superb. The staff work with love and treat everyone as if there were their own family. It's marvellous. It has invigorated [relatives] life coming here."

During the inspection we spent time observing staff and people who used the service. It was hot and sunny on the first day of our inspection and we saw staff supporting people to move into the garden to enjoy the weather. Staff explained kindly and patiently why they were asking people to wear sun hats and eat lollies to keep them cool. People clearly enjoyed spending time in the garden.

We saw that staff were respectful and called people by their preferred names. Staff were patient with people when speaking to them and took time to make sure people understood what was being said. One person was asked if they would like a cup of tea with their lunch, and they responded that they would prefer a whisky. The member of staff discreetly asked a senior carer who was dispensing medicines if this was okay, and when they were told it was they prepared a whisky for the person. One person asked for support to go to the toilet. A staff member responded immediately, stopping what they were doing and assisted the person to the toilet.

Throughout the inspection we saw examples of kind and caring interactions between people with staff, often based on shared jokes. In one example, we saw a member of staff joking with a person about how much they liked their trainers and asking if they were going out running. The person using the service took this in good part by responded with laughter.

Care plans detailed peoples wishes and preferences around the care and treatment that was provided. We could see evidence, such as signatures in care plans, that people had been involved in care planning and in some situations relatives had also been involved. We saw letters in peoples care files inviting relatives to regular care reviews. One relative told us, "They always keep me up to date with everything. I am fully aware of all aspects of [relatives] care and support needs."

We observed staff seeking people's permission before any care and treatment was provided to people and people we spoke with confirmed that staff asked for permission before they assisted with people's needs. We saw staff knocking on people's doors and waiting for permission before entering. We observed one staff member speaking to a person at lunch time. They asked if they wanted help to cut their food up. Permission was given and the staff member provided the support needed.

People using the service had access to independent advocates. An advocate is someone who supports a person so that their views are heard and their rights are upheld. There was information available for people if needed and information was also displayed around the home. The manager told us that one person had used an advocate recently.

Staff treated people with dignity and respect and were attentive to people who used the service. We saw that call bells were answered quickly and support needed was provided in a dignified way. We saw staff knock on peoples door's before entering and doors were closed when providing personal care. When we spoke to staff they were able to give details of how they respected a person's dignity when providing care. One staff member said, "It is their home. It is important to us all that they feel comfortable. No one wants to undress with a door open or curtains closed. I always make sure I maintain dignity but encourage them to be as independent as they can be." Another staff member told us, "I always talk them through what I am doing and make sure they are comfortable and happy with what I am doing."

In the main reception area the registered provider's dignity policy was displayed along with the dignity 'theme of the month'. The manager told us that it was a different theme each month and this was discussed in staff meeting and supervisions with all staff. The home also had a dignity champion in place.

At the time of the inspection there was no one receiving end of life care, however information on people's wishes and preferences was documented in their care files. Staff we spoke with were able to describe how they support someone on end of life care. Procedures were in place to arrange this where appropriate.

Good

Is the service responsive?

Our findings

Care plans were based on people's assessed needs and preferences. Before they started using the service people were involved in a care plan pre-assessment. This assessed their care and support needs in areas such as personal care, mobility, medication and social interaction and how they would like them to be delivered in a person-centred way. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

During our inspection we looked at five care plans. Care plans began with a 'Life Story'. This contained a photograph of the person and details of what was important to the person and how best to support them. Care plans were then produced to meet the person's individual support needs, in areas such as health and keeping safe, communication, eating and drinking, personal care, mobility, social interaction and mental health and wellbeing. Care plans were detailed and focused on the person's preferences. For example, one person's personal care plan detailed what they would prefer to do themselves and what they would like support with, including how they would like staff to help them comb their hair. The same person had a mental health and wellbeing care plan that described to staff how the person would communicate whether they were happy or sad, and how staff could help them to avoid situations that upset them. Another person's communication care plan reminded staff to speak loudly and clearly to the person as they sometimes had difficulty hearing. Care plans were reviewed on a monthly basis to ensure they met people's current support needs.

During the inspection we spoke with staff that were extremely knowledgeable about the care that people received. Records were in place to show that people and their relatives were invited to participate in the care planning process. Staff were responsive to the needs of people who used the service and the people and relatives that we spoke to confirmed this.

The service employed a full time activities co-ordinator who helped people to access a wide range of activities. We spoke to the activities coordinator who was able to give details of activities which took place at the service. The activities provided included verbal quizzes, bingo, afternoon tea, sing-alongs, garden activities, reminiscence sessions, coffee morning, miniature horse visits and entertainer days. The activities coordinator said, "We do activities in the evening also, but these are quieter activities such as movies and dominoes. We go out in a small group every week to different places to have lunch and a look around. When the weather is nice we make use of the outdoor space." The activities coordinator told us that she has good links with local schools, councils and churches and people are often invited to attend school concerns and plays.

The activities co-ordinator held activities meetings where people and their relatives could discuss the activities they would like. At a meeting on 10 April 2016, the requested included a film afternoon. We saw that this had been arranged. From the records we could see that people had enjoyed it. The activities co-ordinator reviewed each activity noting how many people participated and whether they had enjoyed it. They told us this was used to help plan future activities that people enjoyed.

Activities were widely promoted in communal areas around the service and in the monthly newsletter given to people using the service. A weekly planner was displayed in communal areas providing details of the coming weeks planned activities. A singer was present during the first day of our inspection and we saw people joining in with this and clearly enjoying themselves.

We spoke to people about the activities on offer. One person said, "[Staff] keep me busy with lots of different activities. I enjoy them all to be honest. [Activities coordinator] is brilliant. We get along really well." Another person told us, "There is plenty of stuff to do; [activities coordinator] keeps us well informed with what she has planned. She knows what we all enjoy and what we don't."

We were given a copy of the 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 both herself and the deputy manager spoke to people on a daily basis and people were encouraged to voice any complaints. We spoke to people to see if they knew how to make a complaint. One person told us, "I just speak to the manager or the deputy. The manager is fairly new but I know it would be sorted." Another person told us, "I haven't ever really wanted to make a complaint to be honest but I suppose I would speak to the manager if I did have any problems." A relative we spoke to told us, "Everyone in here is approachable should I have any complaints, from the management to the cleaners. I have every confidence that any complaints would be dealt with immediately."

We looked at the record of complaints and could see that appropriate action had been taken and recorded. Timescales had been adhered to and any actions required had been appropriately managed.

Good

Is the service well-led?

Our findings

People who used the service spoke positively about the management team. We could see that the manager had a visible present at the service and regularly interacted with people. The manager's office was positioned on the ground floor and throughout our visit the manager's office door was open and we saw people who used the service, relatives and staff regularly going into the office to speak to the manager and the deputy manager. We could see there was an open door policy. One person told us, "The new manager hasn't been here long but I like her. She seems very nice and approachable." A relative we spoke to told us, "The manager is lovely, very caring and she listens. She hasn't been here all that long but can see she has had a positive impact on everyone."

The manager had started employment with Guisborough Manor on 11 April 2016 and submitted an application to CQC on 9 June 2016 to become the registered manager. At the time of our inspection this process was still ongoing.

Staff told us the manager was approachable and supportive of them. They told us if they had any concerns they had no problem approaching the manager or any other member of the management team and they were confident that any concerns would be dealt with appropriately. One member of staff said, "I get regular support and feel my views are listened to now. They never used to be but the new manager seems to listen to the staff more. She seems canny enough." Another staff member told us, "The manager seems really good and quick off the mark. I know the residents like [manager] as a lot of them have commented about the change."

Staff told us that the moral was good and that they all work well together as a team. They told us that they were kept informed about changes to the service and had the opportunity to raise any suggested areas for improvement and were included in the development of the service.

The manager investigated safeguarding alerts and accidents and incidents in a timely manner and informed the local authority and CQC when needed. Safeguarding and accident and incidents had been recorded thoroughly and any actions taken as a result had been accurately recorded by the manager.

The manager and registered provider 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 providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

Audits were carried out by the manager in areas including medicines, catering and care plans. Where issues were identified these were added to an action plan until remedial action had been taken. The manager and area manager monitored this, and the registered provider carried out their own general audit of the service to see if remedial action was being taken. We looked at the last registered provider's audit that had taken place in March 2016 and could see that where issues had been identified an action plan had been developed. We could see that some of the required actions had been implemented by the manager with any

remedial action taken documented. We saw that some of the actions required were ongoing and this was also documented.

Staff, senior staff and 'residents and relative' meetings took place to allow standards at the service to be discussed. Records showed that these meetings were held regularly. Where issues were raised an action plan was generated to plan remedial action. For example, at a meeting for people and their relatives on 26 May 2016 a request had been made for a meeting with kitchen staff to discuss menu choices. This had been arranged for 8 June 2016.

The area manager told us feedback was sought from people using the service and staff using written questionnaires every 6 months. Questionnaires were also sent to external professionals every 12 months to seek their views. The most recent questionnaires had been completed in October 2015. We could see that the information provided has been reviewed and was displayed in easy to read graph format. Twenty four people had completed and returned the questionnaires and people who used the service and relatives had provided positive feedback in areas such as social activities, menus, cleanliness of the home and attendance to personal care needs.

The manager told us feedback was constantly sought from people outside of formal questionnaires. They said, "We have such an open door approach. We have an open dialogue with everyone."

We asked the manager and staff what links they had with the local community. They told us, "We have good relationships with local schools, churches and the council. We often have children that come here to perform and we often get invited to the local school to watch concerns and shows. We are very much involved with the community." The manager told us, "The activities coordinator has great links with the wider community so we do what we can to get people involved."

From our discussions with the manager and staff we could see they followed the visions and values of the service closely and people who use the service were at the centre of this. We could see that staff had taken appropriate action to raise concerns and the manager ensured that CQC and the local authority were notified in a timely manner of incident which occurred at the service.