Roseberry Care Centres GB Limited

Cedar Grange

Inspection report

Main Street
Cherry Burton
Beverley
North Humberside
HU17 7RF

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12 July 2016

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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 12 July 2016 and was unannounced. We previously visited the service on 21 January 2014. Since that time the registered provider has changed the company name and their registration with the Care Quality Commission. This is the first inspection under the new registration.

The home is registered to provide accommodation and care for up to 31 older people, including people who are living with dementia. On the day of the inspection there were 29 people living at the home, including one person who was having respite care. The home is situated in the village of Cherry Burton, close to the town of Beverley, in the East Riding of Yorkshire. There are various communal areas where people can spend the day and a large garden. There is a passenger lift so people can access the first floor of the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at Cedar Grange.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Risk assessments identified any areas of concern in respect of people's care and support needs, and there were strategies in place to reduce these risks but still promote independence.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the induction and on-going training provided for them. This included training on the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We checked medication systems and saw that medicines were recorded, stored, administered and disposed of safely. Staff who had responsibility for the administration of medication had received appropriate training and no-one who we spoke with raised any concerns about how they received their medicines.

People who lived at the home, visitors and social care professionals told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people

who lived at the home, visitors and staff. Visitors told us they were made welcome at the home and were kept informed about their relative's well-being.

Care plans recorded people's individual needs and how these should be met by staff. It was clear that staff had a good understanding of people's specific needs and how they wished to be supported.

We saw that people's nutritional needs had been assessed and people told us that they were very happy with the food provided. We observed that people's individual food and drink requirements were met and that they were offered a choice at each meal time.

The complaints procedure was clearly displayed in the home and people told us that any complaints they made or concerns they expressed were listened to and acted on. There were also systems in place to seek feedback from people who lived at the home, visitors and staff.

People who lived at the home, visitors and staff told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote people's safety and well-being. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

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.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse to the relevant people.

The premises and equipment used by people who lived at the home had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual needs.

People had access to health care professionals when required and advice received from health care professionals was incorporated into care plans.

Improvements were being made to the premises to make them more suitable for people who were living with dementia.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People who lived at the home told us that their privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests, their preferences and the people who were important to them.

People were encouraged to take part in activities and occupation, and to keep in touch with family and friends.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. People who lived at the home were also invited to comment on the care and support they received.

Is the service well-led?

Good

The service is well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for staff and visitors to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care. These were used as a learning opportunity for staff.

Cedar Grange

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.

The inspection took place on 12 July 2016 and was unannounced. The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses or has used this type of service.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received the PIR within the required timescale.

On the day of the inspection we spoke with six people who lived at the home, two visitors, two members of care staff, a cook, the registered manager and the area manager.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

We asked staff how they kept people safe and their comments included, "We make sure there are no obstacles or hazards" and "All staff have had moving and handling training and we use hoists for transferring some people. We cannot assist people with transfers unless we have had the right training." People told us that they felt safe living at Cedar Grange. One person said, "I feel as safe as I would in my own home." We saw that there were key pads at entrances and exits of the home and gates on the stairs. People who lived at the home and visitors used the passenger lift to move between floors; the stairs were only used by staff.

People said that there were usually enough staff on duty to support them. One person told us, "There are usually plenty of staff around" and another said, "Sometimes they seem to have problems getting staff but is has not affected me." Relatives said that there were usually enough staff visible in the home but one relative added, "They could do with more staff in the evening."

The registered manager told us that the standard staffing levels were five care staff during the day and three care staff overnight; this always included a senior care worker. We checked the staff rotas for a two week period and saw that these staffing levels had been maintained. In addition to care staff there was a laundry assistant, a housekeeper, a domestic assistant and a cook on duty each day. This meant that care staff were able to concentrate on providing personal care and support to people who lived at the home.

Staff told us that there were usually enough staff on duty but that, because of the dependency levels of people who lived at the home, they felt four staff were needed overnight. We discussed this with the registered manager and they told us that staffing levels during the night would be re-assessed as a result of our feedback.

The registered manager told us in the PIR that all staff at the home completed training on safeguarding adults from abuse, and that the principles of whistle blowing were included in this training. We also saw that information about safeguarding adults from abuse and whistle blowing was displayed on the home's notice board, along with a newsletter from the safeguarding adult's board. This showed us that this information was available to people who lived at the home, visitors and staff.

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. The training records evidenced that all staff, including ancillary staff, the home's maintenance person and the administrator, had completed this training. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or a potential incident. Staff told us that they would report any concerns to the registered manager and that they were confident they would be listened to and that appropriate action would be taken. We found that when safeguarding concerns had been identified, the safeguarding 'threshold' tool provided by the local authority had been used by the registered manager to identify whether the issue needed to be managed 'in house' or whether an alert needed to be submitted to the local authority safeguarding adult's team.

A member of staff explained to us that they did not use restraint at the home. We saw that one person's care plan included a record of their behaviours that could be challenging to other people. This included details of the incident, whether there were any triggers to this behaviour and how the situation was dealt with by staff. We saw that, in each instance, staff used reassurance and talked calmly to reduce the person's anxiety levels. Over lunchtime we observed that one person who became anxious was effectively calmed by staff, which showed us they understood the person's specific support needs.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained, the person's identity had been confirmed and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that only people who were considered safe to work with vulnerable people had been employed at Cedar Grange. We saw that a copy of questions asked at employment interviews and the candidates responses had been retained for future reference. One member of staff told us that they had not been able to start work until their DBS check had been received, even though it took ten weeks.

On the day of the inspection we saw that there were four care workers on duty plus a senior care worker. Four care staff were working in the main building and one member of staff was working in The Lodge. The registered manager told us that staff used a mobile phone to contact each other, for instance, should the staff member in The Lodge require assistance. In addition to this, the call bell sounded in both units and that would alert staff in the main house that assistance was needed in The Lodge.

Risk assessments had been completed for any areas that were considered to be of concern. We saw that everyone who lived at the home had risk assessments for medication, pressure area care, falls, nutrition and tissue viability. Some people had risk assessments in place for their more specific needs, such as the use of bed rails, swallowing, use of a wheelchair and showering in a wet room. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date, and that they had been scored to identify the level of risk. We noted that mobility assessments recorded any equipment and the number of staff needed to help people to mobilise safely, and that care plans recorded the equipment people had in place to promote good pressure area care.

We saw that any accidents or incidents involving people who lived at the home were recorded. The accident / incident report included a body map where any injuries could be recorded, and some people had observation charts in place following falls. This helped staff to monitor the person's recovery. At the end of each month the individual accident reports were collated into one report. The overall report recorded the action taken by staff at the home, such as seeking medical attention, submitting an alert to the safeguarding adult's team and notifying the person's relatives. The report also included a summary of all falls during the month, such as details of the area of the home where the fall occurred, the time of day and any changes to medication that might have caused the fall. There was a record of whether the person had been referred for specialist support from the 'falls' team. This meant that accidents and incidents were being analysed to check whether any patterns were emerging or there were areas that required improvement.

The registered manager told us in the PIR document that they had a contingency plan that was kept in the emergency evacuation folder in the reception area of the home so that it was easily accessible. We saw the plan advised staff on the action to take in the event of emergency situations such as fire, flood or utility failures and was reviewed each month. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the premises in an emergency.

There was a copy of each person's PEEP in the emergency evacuation folder and in each person's care plan. There had been a small fire at the home caused by a mirror on a windowsill and the sun's reflection. The person concerned told us that this had made them feel nervous but we saw that appropriate action had been taken to reduce the risk of such an incident reoccurring.

There was a fire risk assessment in place and we saw service certificates in respect of the fire safety system and fire extinguishers. In addition to this, weekly checks were carried out by the home's maintenance person on the fire alarm system and fire doors, and monthly checks were carried out on emergency lighting. Regular fire drills were taking place to test people's reactions in the event of a real fire being detected.

One relative said, "The premises have sometimes looked a bit tatty, but they have had new carpets, flooring and painting done recently and they are keeping up the standard." On the day of the inspection we saw that the premises looked in a good state of repair and decoration. The home's maintenance person carried out checks on the emergency call system, wheelchairs, window opening restrictors, bed rails, water temperatures and the external environment. We checked a sample of maintenance certificates such as those for the electrical installation, gas safety, portable electric appliances, hoists / slings, bath hoists and the passenger lift; these showed that regular servicing had taken place to ensure they remained in good working order.

Only eight senior staff had responsibility for the administration of medication and training records evidenced that these members of staff had completed appropriate training. One member of staff told us they were 'acting up' as a senior care worker. They described their recent medication training and told us that it had included checks on their competency.

We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, recorded, administered and returned when not used. We observed that medicines were stored safely and securely; the medication trolley was fastened to the wall in the medication room and was locked when not in use. Prior to the inspection we received information stating that the medication trolley was sometimes left open in communal areas of the home. On the day of the inspection we saw that the person administering medication wore a tabard stating they should not be disturbed. However, they were interrupted by staff and visitors to the home on a couple of occasions, although they locked the trolley when it was unattended. We discussed this with the registered manager and they told us they would ensure all staff understood the senior member of staff administering medication must not be disturbed, so other staff on duty would have to respond to the telephone and callers to the premises.

We saw that controlled drugs (CDs) were stored securely. CDs are medicines that require specific storage and recording arrangements. In the main house there was a suitable cabinet in place for the storage of CDs and a CD record book; CDs for people living in The Lodge were stored in the same CD cabinet. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cabinet balanced. We also saw that CDs were audited (usually weekly) to ensure no recording or administration errors had been made.

The temperature of both medication rooms was checked and recorded each day. There was a medication fridge in the main house and the temperature of the fridge was checked and recorded each day. This ensured medication that needed to be kept cool was stored at the correct temperature. The date was recorded on the packaging of medication that was stored in boxes or bottles when it started to be used, to ensure it was not used for longer than the recommended period of time.

We looked at medication administration record (MAR) charts. We saw that MAR charts were accompanied by

a photograph of the person concerned to aid staff with identification. We found that medication records were clear, although we noted there were a small number of gaps in recording. We checked these recording omissions and found that the medication had actually been given, but the MAR chart had not been signed. Any hand written entries on MAR charts were signed by two people to reduce the risk of errors occurring. There were protocols in place to advise staff on how 'as and when required' (PRN) medication should be administered and recorded. There was a separate chart to record the administration of pain relief patches and we saw that this had been completed accurately by staff.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to help staff identify the time of day they needed to be administered.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The care plans we reviewed included a DoLS screening checklist that assessed whether an application needed to be submitted to the local authority because the person was being deprived of their liberty. The registered manager contacted us prior to the inspection to check on the requirement to notify CQC of any DoLS authorisations, and these were subsequently submitted as required. We noted that, when a person had a DoLS authorisation in place, this was clearly recorded in their care plan. There was also a record of when the authorisation expired and an application for renewal needed to be submitted.

The training record evidenced that all staff, including ancillary staff, had completed training on mental capacity, and some staff had attended training on DoLS. This meant that staff had been provided with information to help them to understand the principles of the MCA and DoLS.

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that people had signed to confirm their consent to staff administering their medication, to a care plan being developed, to photographs being taken and in respect of going on outings. In some instances a relative had signed these consent forms. It was not always clear whether they had the authority to consent on behalf of their family member because they acted as Power of Attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. The registered manager told us they would make sure it was made clear in care records when relatives had POA as well as the scope of their authority.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "Some people can still read so we give them time to read information", "We have picture menus to help people choose meals" and "We ask one person questions and then show them picture cards to help them respond." We saw examples of how staff supported people to make day to day decisions on the day of our inspection.

We observed the serving of lunch in the main dining room and the small dining room in The Lodge. We noted that staff created a pleasant atmosphere to encourage people to enjoy their meal and to chat to each other. Tables were set with cutlery, napkins and a glass and although condiments were not on the tables,

they were clearly visible for people to see. People were given a choice of main course. When one person was served with their main course they said they were not hungry. They were offered a sandwich as an alternative and they accepted. Another person said they were tired and did not want their meal. Staff supported them to go to their room to rest and told us they would prepare them a meal later. We saw that people were able to eat at their own pace and when they had finished their meal, staff asked them if they had enjoyed their meal and if they had had sufficient to eat. Staff encouraged people who were reluctant to eat, but were not 'overbearing'.

We saw that there was a menu in the dining room that contained both words and pictures; this helped people with cognitive difficulties make a choice at mealtimes. During the morning, we heard care staff describing these choices to people. One person who lived at the home told us, "The food is quite good. We have a good cook. Occasionally we get a choice and they know what I like."

The cook told us that there was a list in the kitchen that recorded people's likes and dislikes and any special dietary requirements. Nutritional assessments were included in care plans and we saw that details of any special dietary requirements were included, such as thickeners for liquids to reduce the risk of choking and any adaptations that were required, such as plate guards. One person's care plan recorded the signs that staff needed to look out for that would indicate they were having difficulty swallowing and the action to take, such as contacting the Speech and Language Therapy (SALT) team or the GP.

There was a 'Nite Snack' menu displayed on notice boards around the home. This informed people and their visitors that snacks were available in the evenings or overnight if people wanted something to eat. The day we carried out this inspection was very warm and we noted that everyone was offered an ice-cream to help them keep cool.

People told us that staff had the skills needed to carry out their role. A person who lived at the home told us, "They get the odd young one that is inexperienced but otherwise they are all good." We checked the training records for two new members of staff and these evidenced that care workers completed a thorough induction programme prior to commencing work unsupervised. Topics covered in induction training included safeguarding adults from abuse, care plans, personal care, handover meetings, choice, the use of bed rails and moving and handling. The registered manager told us that the newest member of care staff had commenced the Care Certificate. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. She said that all new staff would be expected to complete the Care Certificate, unless they had already achieved a National Vocational Qualification (NVQ) in Health and Social Care. New staff told us that they spent time shadowing. Shadowing is when new care staff are partnered with an experienced member of care staff as they perform their job. This allowed new care staff to see what was expected of them.

We checked the home's training record and this showed that the organisation considered essential training to be fire safety, food hygiene, moving and handling, health and safety, safeguarding vulnerable adults from abuse and nutrition / hydration. Some none essential training was also available to staff, such as pressure ulcer prevention, dementia awareness, end of life care, challenging behaviour and mental capacity. Records showed that most staff had completed this training. The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively.

Staff had been issued with a job description and a handbook that contained information about their employment and the standards that they were expected to adhere to. This meant that staff were clear about the role for which they had been employed.

We saw the staff supervision matrix in the registered manager's office. This showed that all staff had attended two or three supervision meetings with a manager during 2016, apart from staff who were on maternity leave. The registered manager told us that the aim was for staff to attend six supervision sessions throughout the year and we saw that they were on target to achieve this. Staff told us that they felt well supported; they said that they attended supervision meetings with a manager and that they got the opportunity to raise any concerns and discuss their practice. One member of care staff told us, "These are two way meetings when we can raise concerns and talk about anything."

Relatives told us they felt involved in decisions about the health and welfare of their family members. People who lived at the home told us they could access their own GP when necessary and also had input from other professionals such as the district nurse and chiropodist. We saw that there was a list of forthcoming visits from a chiropodist listed on the home's notice board. Any contact with health care professionals was recorded in people's care plans, including the reason for the visit and the outcome. We saw that any advice received from health care professionals had been incorporated into people's care plans. Any communication from NHS departments was retained with people's care records so that it was available for staff.

The registered manager told us that they completed food and fluid charts when requested to do so by a GP or other health care professional, or when care staff had identified concerns. Charts were used to record food and fluid intake, bed rest and positional changes when this had been identified as a need. The same charts were also used for a period of 72 hours when people were newly admitted to the home as part of the assessment process.

We saw that some people had a patient passport in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. The patient passports we saw included sufficient detail to help hospital staff understand the person's specific needs, such as special dietary requirements and their preferences for personal care. If the person had a Do Not Attempt Resuscitation (DNAR) or DoLS authorisation in place, this was recorded in their patient passport.

The registered manager told us in the PIR that the home was previously decorated with 'busy' wallpaper. This had been replaced with plain walls as these were considered to be more suitable for people who were living with dementia. In addition to this, bedroom doors had been painted in different colours to assist people with recognition, and signage had been used to help people identify areas of the home such as toilets and the dining room.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. Comments included, "Staff are helpful", "I am quite happy and enjoy living here", "It's such a happy-go-lucky place" and "I was unsettled at first but have soon got used to things." One relative told us that their family member was "Loved by a lot of the staff."

We saw positive interactions between people who lived at the home and staff on the day of the inspection. We noted that people were comfortable in the presence of staff, and that staff were polite and sensitive to people's needs. Staff told us that they believed care workers and other staff genuinely cared about people who lived at the home. One member of staff said, "We are like one big family" and another said, "If a member of staff is not right for the job, this would soon be picked up and dealt with."

The registered manager told us in the PIR document that they had a dignity champion at the home. A dignity champion's role is to take a special interest in the topic of dignity and to promote this within the staff group. The registered manager said that staff were courteous towards people who lived at the home, knocked on door prior to entry, and dealt with personal issues sensitively and in a way that respected the person's privacy and dignity. We saw that staff respected privacy by knocking on doors and asking if they could enter the room, and then by asking people if they wanted their door open or closed. There was information about dignity champions and their role on the home's notice board.

The registered manager also told us in the PIR that there was an area of the home where people could see their visitors in private. However, one person who lived at the home expressed concern about there being only one toilet on the ground floor. This was close to the dining room and they told us there was sometimes a queue close to mealtimes. They also said that they thought it would be preferable to have separate male and female facilities. We discussed this with the registered manager who told us they were aware this was an issue and the organisation was currently considering how to improve toilet facilities.

The home's main notice board included information about advocacy services. 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. In addition to this, there was information about Independent Mental Capacity Advocates (IMCAs) who offer an advocacy service for people who lack capacity to make decisions for themselves. The contact details for CQC, the local authority ombudsman and Healthwatch were displayed on the relative's notice board.

The home's notice board included a named photograph of each member of staff who worked at the home. Photographs of the home's GP and the hairdresser were also displayed. This helped people who lived at the home and visitors to the home to identify members of staff and communicate with them.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff

who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included maintaining a safe environment, eating / drinking, personal cleaning and dressing, mobilising, socialisation, infection control, end of life care and sleeping. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

Each person's care records included information about their GP, their medical conditions and any known allergies. Care records also included a document called 'This is Me' which contained the headings 'The person who knows me best', 'I would like you to know', 'My home and family and things that are important to me' and 'My life so far'. There was information about the person's hobbies and interests; this gave staff useful information that they could use to get to know the person better and therefore provide more person-centred care. Although two of the documents we saw were fully completed, one contained only brief information.

Some of the people who we spoke with were aware that they had a care plan, but they told us they had not seen it. However, they all said that staff understood their care and support needs. One relative told us that they had input into their family member's care plan. They said, "They have told me all that is in it and talked to me about it, more than once."

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information, and more formal reviews had been organised by care managers to review the person's care package.

We asked staff how they got to know about people's individual needs. They told us that they would read care plans, speak to the person concerned, and to their relatives and friends. One member of staff said, "We spend time with people and get to know them." A relative told us, "Once they got to know (name of family member) everything was fine."

We saw that care plans included a 'relative's communication record' that listed any discussions, either face to face or by telephone, held with people's relatives, and the topic of the conversation. The relatives who we spoke with confirmed they felt there was good communication between themselves and staff at the home.

Relatives told us that they could visit the home at any time and were made to feel welcome. They added that they were encouraged not to visit over mealtimes. This was because the home had 'protected' mealtimes. This meant that people had uninterrupted mealtimes in the hope that they would concentrate on eating and enjoying their meals.

People told us they had access to a hairdresser and we saw that the hairdresser was at the home on the day of the inspection. Music was playing at certain times of the day, there were pleasant gardens for people to use and some people sat outside for part of the day.

One person told us that the activities coordinator had left the home and the availability of activities had reduced since they left. We noted that activities ceased to be recorded in care plans in May 2016 when the activities coordinator left the home. One person said that they had taken part in activities such as bingo and dominoes, and that they were sometimes taken out. One person told us they would like to go out more. They said, "The day is so long" and "I cannot go out, for example, to get an ice-cream from the village rather than just watch TV." We discussed this with the registered manager who explained why this person was not safe to go out unaccompanied. However, they assured us they would look at different ways to occupy them with meaningful activities. The registered manager told us that they were in the process of recruiting a new activities coordinator and, in the meantime, staff was carrying out activities whenever they could. We saw there was a bingo session on the afternoon of our inspection and people were encouraged to take part.

We saw that the home's notice board displayed old newspaper articles about nearby Beverley and about the recent filming of Dad's Army in the local area. This provided a topic of conversation for people who lived at the home, visitors and staff.

The complaints procedure was displayed around the home and there was also a comments / suggestions book available for use. We checked the complaints register and saw that there had been five complaints made to the home since November 2015. Records included details of the initial complaint, the findings, any corrective action that needed to be taken and 'considerations for future preventative action'. This showed that complaints had been analysed to check if there was any learning that would lead to improvements in the service.

People who lived at the home and relatives told us that they felt able to express their opinions and if necessary, raise a complaint. Two relatives told us that they had raised issues in the past and that their concerns were dealt with effectively. One relative said, "I talked to the manager. I had an issue about medication. It was soon put right." Staff told us that, if someone complained to them, they would try to put it right. However, if the complaint was more serious they would pass it to the registered manager. They were confident people's complaints were listened to and dealt with.

We saw that meetings were held for people who lived at the home and relatives; the most recent meeting had been held in March 2016. This gave people another opportunity to express their views, make suggestions and ask questions about their care.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

People who lived at the home and relatives knew who the registered manager was and told us they could approach her to talk about any problems they might have. We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that they all responded well. One relative said, "The manager comes round regularly and asks if everything is OK."

Staff told us that there was good management and leadership at the home. One member of staff said, "[Name of registered manager] is fantastic, even on a personal basis. I can't fault her. She is respected by us all" and another said, "[Name of registered manager] is a good leader. If you have a private conversation with her, it stays private". Staff told us they would use the whistle blowing procedure if they needed to, and were confident the registered manager would protect their confidentiality.

The registered manager told us in the PIR, "Regular audits are carried out on care plans, medication, catering and infection control. I monitor care staff by ensuring I am seen on the floor. I talk to residents and ask them how they are and do they feel comfortable with the care they receive."

We saw that there was an effective quality assurance system in place that included surveys, audits and meetings. Audits were carried out each month on care plans, catering, infection control and medication. We saw that audits highlighted any shortfalls in a corrective action plan and that the next month's audit checked that corrective action had been taken. The registered manager told us that, if any urgent shortfalls were identified, these were dealt with immediately. The audits were scored to measure the effectiveness of the area being monitored. The information gathered in the audits was fed into a quality key performance indicator (KPI) report that was submitted to the organisation's head office for analysis and monitoring purposes.

A satisfaction survey had been distributed to relatives in October 2015. The information in the surveys that had been returned to the home had been collated and analysed, and the outcome was displayed on the relative's notice board. This showed that the organisation was open about the feedback they had received.

Staff meetings were held on a regular basis. There were meetings for the full staff group and meetings for specific groups of staff such as night staff, cooks and domestic assistants. The minutes of these meetings showed that the topics of infection control, health and safety, key working and the dress code had been discussed. Staff were required to sign the minutes of meetings to evidence they had read them. This ensured that all staff were aware of the topics discussed and the decisions made. Staff told us that these were 'two-way' meetings where they could express their views. One member of staff said, "We can ask questions and make suggestions."

Staff described the culture of the home as "Old fashioned home from home", "One big family", "It's a lovely home to work in and I love my job" and "Open, any concerns are talked about openly." They told us that staff would learn from any accidents, complaints or incidents as they would talk about the issues and how they could make sure they did not occur again. One member of staff described how a person had fallen and how this had upset staff at the home. Strategies had been put in place to ensure the person was closely supervised to reduce the risk of this occurring again.