Four Seasons Health Care (England) Limited

East Riding Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on 14 October 2014 and was unannounced. We carried out a second announced visit to the home on 15 October 2014 to complete the inspection.

The home was last inspected on 14 January 2014 when the provider met all the regulations inspected.

East Riding is a purpose built care home located in Morpeth. It accommodates up to 67 older people, some of whom have dementia related conditions. Accommodation is over two floors. There were 56 people using the service at the time of our inspection. People with general nursing and personal care needs lived on the ground floor which was known as the Millview unit. People who lived with dementia resided on the first floor which was called the Wansbeck unit.

There was a manager in post. She was not yet registered with the Care Quality Commission (CQC). She had sent in her application form and was awaiting an interview with a CQC registration inspector. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were procedures in place to keep people safe. Staff knew what action to take if abuse was suspected. Safe recruitment procedures were followed.

We saw that the premises were well maintained. We found however, that improvements were required with infection control procedures. The sluice machines for the cleaning of continence equipment were not operational.

We had concerns with certain aspects of medicines management, in particular with certain recording and administration systems. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Staff told us that training courses were available in safe working practices and dementia care. This training would help to meet the needs of people who lived at the home. Some relatives felt that a longer induction period was needed for staff. This was confirmed by one member of staff with whom we spoke. Other staff informed us that they felt supported and said that the training was adequate. The manager told us that she had developed a "flexible" approach to induction training which met the needs of individual staff who worked there.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The manager was submitting DoLS applications to the local authority to authorise. This procedure was in line with legislation and the recent Supreme Court ruling which had redefined the definition of what constituted a deprivation of liberty. The provider however, had not informed us of the outcome of these applications of which they are legally obliged to notify us. In addition, we found that further improvements were required in this area to ensure that "decision specific" mental capacity assessments were carried out in line with legislation.

We observed that staff supported people with their dietary requirements. A new chef was in post and people told us that there had been improvements in the quality of the meals.

Staff were knowledgeable about people's needs. We observed positive interactions between people and staff especially on the second day of our inspection.

An activities coordinator was employed to help meet people's social needs. Some relatives felt that more activities would be appreciated. The manager explained that they shared a mini bus with other local homes owned by the provider. The home was located on a steep hill and the manager said they had to rely on transport to support people to access the local community because it would not be safe to manually push people in wheelchairs up and down the hill.

A complaints process was in place. There was one ongoing complaint. The regional manager told us that if relatives were unhappy with the manager's response; the complaint would be passed to them to investigate. The regional manager informed us that a face to face meeting was often arranged where concerns could be discussed further.

The manager carried out a number of checks on different aspects of the service. These included health and safety; dining experience; infection control; medicines and care plans. We found however, that these checks did not always highlight the concerns which we found for example, with medicines management. In addition, actions identified were not always carried out in a timely manner, such as the delay in plumbing in the sluice machines.

Summary of findings

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

Not all aspects of the service were safe.

We saw that the premises were well maintained. We found however, concerns with infection control. The sluice machines for the cleaning of continence equipment were not operational. We considered that improvements were needed in this area.

We had concerns with certain aspects of medicines management, in particular with certain recording and administration systems.

Staff with whom we spoke knew how to keep people safe. They could identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The manager was submitting DoLS applications to the local authority to authorise. This procedure was in line with legislation and the recent Supreme Court ruling which redefined the definition of what constituted a deprivation of liberty. However, we found that further improvements were required in this area to ensure that "decision specific" mental capacity assessments were carried out in line with legislation.

People received care from staff who were trained to meet their individual needs.

People received food and drink which met their nutritional needs and they could access appropriate health, social and medical support as soon as it was needed.

Is the service caring?

Good

The service was caring.

During our inspection, we observed staff were kind and treated people with dignity and respect.

People told us that they were involved in their care. Surveys were carried out and meetings were held for people, relatives and friends.

Is the service responsive?

Good

The service was responsive.

An activities coordinator was employed to help meet people's social needs. We saw that an activities programme was in place. Some relatives told us that more activities specific to people who lived with dementia would be appreciated.

Summary of findings

A complaints process was in place. There was one ongoing complaint. The regional manager told us that if relatives were unhappy with the manager's response, the complaint would be passed to them to investigate. The regional manager informed us that a face to face meeting was often arranged where concerns could be discussed further.

Is the service well-led?

Not all aspects of the service were well led.

There was a new manager in post. She had applied to register with CQC to become a registered manager. The manager carried out a number of checks on different aspects of the service. These included health and safety; dining experience; infection control; medicines and care plans. We found however, that these checks did not always highlight the concerns which we found for example with medicines management. In addition, actions identified were not always carried out in a timely manner such as the delay in plumbing in the sluice machines.

The provider had not notified us of the outcome of DoLS applications which they were legally obliged to inform us.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Requires Improvement

East Riding 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 team consisted of two inspectors; a specialist advisor in dementia care and an expert by experience, who had experience of older people and care homes. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The inspection took place on 14 October 2014 and was unannounced. We carried out a second visit to the home announced on 15 October 2014 to complete the inspection.

We spoke with two regional managers; manager; deputy manager; three registered nurses; 10 care workers; an activities coordinator and the chef. We read eight people's care records and five staff files to check details of their training. We looked at a variety of records which related to the management of the service such as audits, minutes of meetings and surveys. We also read the local authority's quality monitoring visit report which was carried out in August 2014.

Most of the people were unable to communicate with us verbally because of the nature of their condition. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

We spoke with seven relatives during our inspection. We emailed a GP and psychiatrist to obtain their views and contacted by phone a reviewing officer and a social worker from the local NHS trust. We also consulted a member of staff from the local authority safeguarding team; a local authority contracts officer; an infection control practitioner from the local NHS trust; a member of staff from the local clinical commissioning group and a member of staff from the local Healthwatch organisation. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We also asked the provider to complete a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make. We did not receive a copy of the PIR prior to the inspection because there had been a technical problem with our website. The manager provided us with a manual copy of the PIR on the first day of our inspection.

Requires Improvement

Is the service safe?

Our findings

People with whom we spoke said they felt safe. One person said, "I don't feel unsafe at all." Another said, "Oh yes its safe." Other comments included, "Yes it's very safe" and "I absolutely feel safe."

There were safeguarding policies and procedures in place. Staff were knowledgeable about the actions they would take if abuse was suspected.

We checked medicines management at the home. We found some concerns with how medicines were managed. People and relatives however, did not raise any concerns about medicines. One person said, "I know what medication I am given and I understand why."

We looked at medicines administration records (MARs). We noted that these were generally completed accurately. We saw however, that one person took a medicine which required staff to take her pulse prior to administration to ensure that it was not too slow. We noted that staff had not recorded this. The omission meant that it was not always clear that the medicine had been safely administered.

We observed one of the nurses administer medicines. We saw that she gave three relatives medicines to give to their family members. She did not stay with the person to make sure that the medicines were administered. We checked these people's care plans and noted that there was no information or risk assessment in place regarding the delegation of this task to relatives to ensure that medicines were administered safely and correctly. One care plan stated, "[Name of person] requires a qualified nurse to administer all medication with which he is fully compliant." We spoke with the manager following our inspection. She told us that she had instructed the nursing staff to administer all medicines personally.

We checked the management of controlled medicines at the home. Controlled medicines are medicines that can be misused. Stricter legal controls apply to these medicines to prevent them being obtained illegally or causing harm. Staff used a register to record the receipt, administration and return of any controlled medicines. We checked this register and saw that staff had not noticed there had been an extra tablet in stock of one medicine that was required to be managed as a controlled medicine by the service's own policy. The count of tablets had been incorrect for three months before the deputy manager noticed that there was an extra tablet in stock and amended the register. Following the inspection, the manager informed us that a nurse now carried out a, "Full count of all controlled drugs" every Sunday night.

We noted that some people required their medicines to be administered covertly. This procedure involved disguising medicines in food or drink to help ensure that people refusing medicines as a result of their illness had access to effective medical treatment. We checked one person's care plan but did not see any evidence that advice had been sought from the pharmacist to ensure that it was safe to administer medicines in this way.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Prior to our inspection we received information of concern that the home's sluice machine for the cleaning of continence equipment was broken. The sluice machine had been broken since June 2014. During our inspection we saw that although two new sluice machines had been purchased; these had not been plumbed in and staff were still manually cleaning continence equipment. We spoke with an infection control practitioner from the local NHS trust about this issue. She told us, "Best practice for infection control would be to use a washer disinfector because of the risk to staff when they are manually cleaning commodes because of aerosol contamination." The manager informed us that she was in "daily contact" with the estates department to ensure that this issue was dealt with as soon as possible.

We considered that further improvements in infection control procedures were required.

People said that they were happy with the condition of the premises. One person said, "Yes the room and the home are lovely." Other comments included, "I am happy with my room. My son asked if I wanted a bigger room but I am happy" and "Yes it's all right…I like my room."

We noticed that the Wansbeck unit had been decorated to meet the needs of people who were living with dementia. There was a variety of tactile objects attached to the walls in the corridors that people seemed to respond to well.

We checked the condition of equipment at the service. We noticed that several armchairs in one of the lounge areas in

Requires Improvement

Is the service safe?

the Wansbeck unit did not have a base cushion; instead, thinner pressure relieving cushions were placed on the base of these chairs. We spoke with staff about this issue. They told us that placing pressure relieving cushions on top of the armchair cushions made the seating too high for some people and there was a risk that they could fall over the arm of the chair. We considered that it would be better for these people to have their needs assessed to ensure that their seating arrangements met their needs. Following our inspection, the manager told us that they were liaising with the occupational therapist about chairs and one person had already received a bespoke armchair.

We checked staffing levels at the home. Some people told us that more staff would be appreciated. One person said, "The number of staff varies. Don't get me wrong, there's nowt wrong, but sometimes it appears that they are short of staff. It's not their fault. Just odd times they are a bit later reacting. They have a favourite saying 'five minutes' it's open ended." A relative said, "No there is not enough staff up here. These carers work their socks off. They don't have time." Other comments from relatives included, "Sometimes there's not always enough staff, but there is often only one nurse to cover two floors. There is not enough when people don't turn in" and "I don't think there's enough of them."

Day staff informed us that there were enough staff to meet people's needs, although more staff would be appreciated to enable them to spend more time with people. We contacted six members of night staff by phone. They also told us that they could meet the needs of people who lived there with the numbers of staff on duty. One member of staff said, "Staffing levels are alright. It can be busy though." Another said, "Sometimes we are one member of staff down, but we manage." A third said, "There is an issue with staffing, but we just get on with it. We manage to do everything."

The manager told us that there were often two nurses on duty through the day. We looked at the previous week's staff rota. We noted there had been one nurse on duty for three of the seven days. In addition, we saw that the number of care workers on duty sometimes fell below the number which the manager stated should be on duty. The manager told us that she was a registered nurse and would assist with care and nursing duties if required which was confirmed by staff.

We spoke with the manager about staffing levels. She told us that she was still trying to recruit one full time nurse for days and night shift and explained that the provider had employed a "nurse recruitment officer" who was responsible for recruiting nurses. The manager explained, "She has said that it is her priority to recruit nurses for East Riding." She also informed us that she was recruiting more bank staff to cover those shifts which permanent staff were unable to cover due to holidays or sickness.

Although staff informed us that people's needs were met with the numbers of staff on duty, we considered that further improvements were needed at this present time to ensure that there were enough qualified, skilled and experienced staff employed to meet the needs of people who lived there.

Staff told us that relevant checks were carried out before they started work. These included Disclosure and Barring Service checks which were previously known as Criminal Record Bureau checks. In addition, two written references were obtained. These checks were carried out to help make sure that prospective staff were suitable to work with vulnerable people. We spoke with a member of staff who had recently been employed. She told us, "[Name of manager] interview skills were excellent. She put you totally at ease."

Requires Improvement

Is the service effective?

Our findings

People told us that they thought that staff were knowledgeable and could meet their needs. One person said, "Oh yes the staff are very good; but there again you've got to know which ones to ask, its nee [no] good asking the new starter."

Most relatives said that they thought that staff were skilled at looking after people. One relative said, "Yes they do look after him effectively at the minute." However, two relatives whose family members lived in the Wansbeck unit felt that the training and induction could be improved. One relative said, "I think the training is inadequate." Other comments included, "The training is poor. They are given two days induction…this is not adequate" and "They don't know enough about dementia - I think they are getting some training. It's about perception and awareness they need something"

Staff told us that there was training available. One member of staff told us, "I'm doing my NVQ 2. I've asked [name of manager] about doing a palliative care course. I'm up for any training available." The manager provided us with information on training which showed us that staff had completed training in safe working practices and training to meet the specific needs of people such as dementia care. Staff told us that most of the training was e-learning but face to face training was also available. We spoke with a new member of staff who told us that she had undertaken induction training and felt supported. Another told us that she thought that the induction period could have been longer.

We spoke with the manager about the length of induction training. She told us, "We've extended the induction to be flexible." She told us and records confirmed that one member of staff had required a longer period of time to ensure that they felt confident in their role. She stated, "We've done it [induction] at a slower pace which meets the needs of the staff member. I don't tend to work to the two days; it's what fits with the member of staff."

People were complimentary about the food. One person said, "Oh the food is good; anybody that complains should have their head examined. There is a choice; I'm not a fish eater or fond of fish stuff so they get me something else. Oh aye there is plenty, sometimes you have a job getting it all down." Other comments included, "Most of the time the food is very nice," "The food is good; you have a choice. The meals are just right" and "The food is good and I can get extra. I always get what I like and I get a choice."

We noticed that menu boards with pictures were displayed around the home to help inform people about the menu choices which were available. We saw however, that these boards did not correspond with the meals which were actually served. We spoke with the manager about this issue. She told us that a new cook had been employed and some of the meals on the menus had been changed.

We spoke with the chef who was knowledgeable about people's dietary needs. He told us, "There's a monthly weight loss sheet and I get a copy of this…When the resident first comes in, I get a copy of their likes and dislikes and any specific dietary needs." He said that he was trying new dishes to see what people liked. He said, "It's always poached fish and last week I made it with a tomato and basil sauce which was popular." He informed us that he observed the serving of the meals. He said, "I always go out and oversee the serving of the meals. It's important to get some feedback about the meals."

We observed people over their lunch time. We saw that staff supported them on a one to one basis. Some people required their food to be pureed or a soft consistency. We noticed that pureed meat and vegetables were served in distinct portions on the plate, rather than being pureed together. The chef told us, "We always separate the meat and vegetables rather than presenting everything in one lump. It looks so much better."

We checked how the provider was meeting the principles outlined in the Mental Capacity Act 2005 (MCA)

The MCA is designed to empower and protect people who may not be able to make some decisions for themselves which could be due to dementia, a learning disability or a mental health condition. The Alzheimer's Society state, "People should be assessed on whether they have the ability to make a particular decision at a particular time."

We noticed and the manager confirmed that mental capacity assessments had not always been carried out for "decision specific" decisions. We noted that in most cases, one mental capacity assessment had been completed to cover a number of different decisions. The manager told us that she was aware of this issue and staff were now carrying out "decision specific" mental capacity assessments for

Requires Improvement

Is the service effective?

decisions such as the use of bedrails; covert medicines; Do Not Attempt Cardiopulmonary Resuscitation and lap belts on wheelchairs. She told us that this process would take time since there were more than 30 people who required mental capacity assessments.

We spoke with staff about the MCA. Some staff were not fully aware of the principles of the Act or how this affected people who lived at the home. We spoke with the manager about this issue. She told us that staff had carried out MCA e-learning; but face to face training had now been organised and some staff had already received this. She hoped that this face to face training would enable staff to have a better understanding of the complexities of this Act.

We noted that a "DoLS screening tool" was in place in each person's care plans. However, this tool had not been updated following the Supreme Court judgement in March 2014 which redefined the definition of what constituted a deprivation of liberty. Staff had therefore completed this tool and indicated that people were not deprived of their liberty when there was actually a deprivation of liberty authorisation in place.

We considered that improvements were needed to ensure that staff followed the principles of the Mental Capacity Act 2005.

We read people's care records and noted that people had access to a range of health and social care professionals including GP's, dietitians, speech and language therapists, social workers, opticians and podiatrists. This was confirmed by those health and social care professionals with whom we spoke.

Good

Is the service caring?

Our findings

People were complimentary about the staff. One commented, "Oh they are excellent they really are. They are very kind and quite frankly I don't know how they keep their temper, I could not do it." Other comments included, "I was poorly last week just for the day but they were very concerned" and "Yes they are lovely; they always give me a cuddle." Comments from relatives included, "They are lovely and patient with him," "You can tell they are caring" and "He's well looked after."

On our first visit we noticed that interactions between staff and people were more functional and task related especially on the Wansbeck unit. During our second visit, we observed more caring interactions between staff and people. We spent time talking with staff and concluded that they genuinely cared for the people they looked after. One member of staff told us, "I love working here. We know the residents well." This was reflected in our observations of staff practices. One person became upset in the lounge where she was sitting. A care worker sat down beside her and put her arm around her shoulder to comfort and reassure her.

People told us that staff respected their privacy and dignity. One person said, "They are very caring and respectful." Another said, "Yes I suppose they do respect my privacy and dignity. They are very nice." Other comments included, "Some of the staff here are ace. The two staff from the Philippines are polite and courteous," "Oh aye the staff are good…The staff are respectful." One relative told us, "They are greeted nice."

Staff were able to give us examples of how they respected people's privacy and dignity. One staff member said, "I always make sure the door is closed and the resident is covered if I'm helping them to have a wash." We noticed however, that some people were not wearing slippers and shoes and several did not look as if they had brushed their hair. We spoke with the manager about our observations. She explained that sometimes people refused personal care such as having their hair brushed but staff always returned later to see if the person wanted assistance with tasks such as having their hair brushed or nails manicured.

The manager told us that no one was currently accessing any form of advocacy and that she would look into advocacy services on an individual basis when the need for an advocate arose. Advocates can represent the views and wishes for people who are not able express their wishes.

People told us that they were involved in their care and staff asked for their views. One person told us, "Oh yes they listen." Meetings were held for people and relatives to discuss what was happening at the home and also to obtain feedback from people themselves and their relatives.

Good

Is the service responsive?

Our findings

People told us that staff met their needs responsively. One person said, "They are very attentive and are good." A social worker with whom we spoke said, "One person has transferred from another care home. The move has been good."

We spoke with health and social care professionals about communication between staff and themselves. The reviewing officer informed us that sometimes she was not kept informed of all changes or incidents relating to the people with whom she was involved. The social worker with whom we spoke however, told us that she was notified of all changes and said, "[Name of manager] is particularly good at letting me know of any changes. She's one of the few care home managers who emails me."

Some relatives whose family members lived in the Wansbeck unit felt that improvements could be made in this area. One relative said, "Yes it's responsive, but you have to keep nudging them and asking them what's going to be done." We spoke with the manager about this comment. She informed us that staff always contacted health and social care professionals if there were any concerns about people's health and wellbeing.

An activities coordinator was employed to help meet the needs of people who lived at the home. She spoke enthusiastically about her role and explained how she organised activities to meet people's individual needs. She told us that she had organised a recent visit to an open air museum and explained that one person used to be a shepherd and raised prize winning sheep. She said that a member of the museum staff had brought over a sheep dog and the person, who sometimes became agitated, sat with the sheep dog for most of the visit. She had also organised a visit to the colliery museum since many of the people who lived at the home had worked or had a connection with the local colliery. She told us, "Some of them worked down the pit and I wanted to help bring back some of their memories…I'm open to anything - you have to look outside of the box."

Some relatives informed us that that the activities provision within the home could be improved. One relative stated, "They have everything downstairs, and singers, nothing up here, no stimulation. Only ever one or two taken out." We spoke with the manager about this issue. She told us, "[Name of activities coordinator] offers activities for everyone. We offer activities regardless of residents' abilities and [name of activities coordinator] tailors activities to each resident."

During our visit we observed that staff had organised a game of skittles. The previous day an animal assisted therapy experience had taken place. Rather than bringing traditional pets for people to stroke and observe; the therapist had brought exotic and unusual animals for people to experience. One person said, "An entertainer comes in and those who can dance get up. We have had animals in, it was very good, there was a great big hairy spider. The schools came in but this was stopped as they were short of teachers but it started up again. I can go out with a member of staff." Another stated, "They are very good with me. We have the chair exercises and a quiz."

The home was located on a steep hill. The manager told us that the location of the home meant that they had to rely on transport to take people out into the local community since it was too dangerous to manually push people up and down the hill in their wheelchairs into the local town. The manager explained that they did share a mini bus with other local homes which the provider owned but commented, "We would massively benefit from having our own mini bus. We're in a beautiful area and we would really benefit from having our own bus. At the minute the spontaneity is missing."

There were a number of systems and procedures in place at the home which helped ensure that staff provided a responsive service. Handovers were held at the beginning of each shift. This handover procedure helped staff provide continuous and safe care. We spoke with one bank nurse who told us, "I always get a good handover."

The nurse informed us and records confirmed that staff faxed a record called a, "Situation, Background, Assessment and Recommendation" (SBAR) to the GP surgery when requesting advice or a visit. The nurse told us, "If we have any concerns about anyone, I will fill in the SBAR and send to the GP. "The SBAR technique provides a framework for communication between members of the health care team about an individual's condition. This process meant that GPs were fully aware of all the relevant information before visiting or providing advice.

We saw that emergency health care plans (EHCP) were in place in some of the care plans we looked at. One of the

Good

Is the service responsive?

nurses told us, “Emergency health care plans contain information to help communication in an emergency to ensure timely access to the right treatment and specialists.” The nurse told us that not everyone had an EHCP, but explained that this was work in progress and the aim was for everyone to have one in place. We read an EHCP which related to the treatment of a person’s chronic obstructive pulmonary disease. The nurse explained that this procedure and detailed plan meant that action could be taken and medicines administered immediately to alleviate the person’s symptoms.

We spoke with a member of staff from the local clinical commissioning group. She told us that the manager was actively working with relevant members from the multi-disciplinary team with regards to falls prevention. We noted that the manager analysed accidents and incidents. This process helped identify any trends and ensured that actions were put in place to help reduce the likelihood of further incidents. We observed that some people who were at risk of falls had a sensor pad which was placed on their chair or bed and alerted staff if the person got up and was at risk of falling. We saw that another person had a “high - low bed” which could be lowered to the floor when the person was in bed to help prevent injuries. It could then be raised to assist staff with transferring the person to get up. Another individual wore a special helmet to protect his head if he fell.

Some relatives told us that they would prefer a member of staff to sit in the main lounge area in the Wansbeck unit to monitor people. One relative said, “It would be nice to feel that someone was sitting here if he did try and get up.” We spoke with the manager about this comment. She told us and our own observations confirmed that there was always a member of staff in the vicinity of the main lounge area to monitor people and interact with them.

There was a complaints procedure in place which informed people how their complaint would be dealt with and the timescales involved. Information about how to complain was also included in the service user guide. We spoke with people and relatives about the complaints procedure and whether they were happy with the service provided. Comments included, “I have no complaints, I am very happy,” “I think I would know how to make a complaint - yes, I was a teacher,” “If I had a complaint I would say to them I was unhappy,“ “I would write a letter or a note if I wanted to complain” and “They are very good and I cannot complain.” We spoke with one relative who had made a complaint. She told us that she had been unhappy with the outcome of her original complaint but a meeting with the regional manager had been arranged to discuss her concerns further. We spoke with the regional manager who told us that if relatives were unhappy with the manager’s response, the complaint would be passed to them to investigate. The regional manager informed us that a face to face meeting was often arranged where concerns could be discussed further.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who had commenced employment in May 2014. The previous registered manager had left shortly before the new manager arrived. The new manager had come from the NHS and was an experienced nurse. This was her first management role and first job in the private sector. She had applied to register with the Care Quality Commission (CQC) and was waiting to undertake an interview with a CQC registration inspector who would assess her ability to manage the home, according to the criteria outlined in the CQC registration regulations 2009.

People were complimentary about the manager. One person said, "If I had to complain then I would go to the manager. She's a lovely lass, she even comes up and asks if you want a cuppa. She's what you call a breath of fresh air." A relative told us, "She is a good manager; it's the third one in two years." Another stated, "I would say that the change in management has made a difference. There are new things in place. It's all positive. We are quite happy." The social worker with whom we spoke said, "[Name of manager] is very approachable and helpful and she responds quickly to any concerns."

Staff were positive about the manager. Comments included; "[Name of manager] is brilliant. Her man management skills are out of this world;" "[Name of manager] is at the end of the phone, it helps to know someone's there;" "[Name of manager] has mint management skills;" "Name of manager] has been absolutely brilliant. She phones up during the night to check we're alright;" "The new manager is just brilliant. She did a night shift the other night. It was good because she could see what we did;" "The manager is fab, everything you say she listens to" and "I cannot speak highly enough of the manageress. She's one of the best bosses I've ever worked for."

Staff told us that they felt that morale was generally good and they enjoyed working at the home. Comments included, "There's a good team on nights, we all pull together," "It's a mint [good] job and mint company to work for" and "I love it, I love it! I hope I'm able to do the job until I'm 80." We spoke with one member of staff who told us that she had worked at another care home. She explained that she had applied for a job at East Riding Care Home because of its reputation. She told us, "It's got a lovely atmosphere."

The home had achieved the silver standard of the PEARL accreditation scheme. PEARL stands for Positively Enriching and Enhancing Residents Lives. The PEARL programme is an accreditation programme specifically designed by the provider to ensure that services are providing the most up to date training, communication and interventions for people with dementia.

Prior to our inspection, we checked all the information we held about the service and saw that they had not sent us certain notifications. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We found that the manager had not notified us of the outcome of DoLS applications. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. This issue is being dealt with outside of this inspection process.

We spoke with the manager about the completion of notifications. She explained that since this was her first management role; she had been unaware of all changes, events and incidents which needed to be sent to CQC. She told us that she would submit the necessary DoLS notifications with immediate effect and reassured us that she was now aware of the CQC notifications process.

We considered that improvements were needed to ensure that CQC registration requirements, including the submission of notifications were met.

The manager carried out a number of audits on different aspects of the service. These included health and safety; dining experience; infection control; medicines and care plans. We found however, that these checks did not always highlight the concerns which we found for example with medicines management. In addition, actions identified were not always carried out in a timely manner such as the delay in plumbing in the sluice machines.

The manager told us that she listened to feedback from people, relatives and staff. Comments from people included, **"**It's outstanding, absolutely. No, I don't think I would change anything; they are completely approachable. We have meetings, we had one the other day and they asked for suggestions, I think it was useful." Another person said, **"**I'm quite happy. The service is good. I would not change anything. They have meetings but I don't go."

Surveys were carried out to obtain the views of people and relatives. A "You said we did" board was situated in the

Requires Improvement

Is the service well-led?

foyer of the home which detailed what actions had been taken in response to individual feedback. “Residents meetings” were also held. We looked at the minutes from a meeting which was held in July 2014. The activities coordinator wrote up the minutes which were very detailed and included actual quotes from people. One person had requested, “More quizzes please.” We saw that quizzes were carried out regularly. Meetings for relatives were also held. We read the minutes from a meeting which was held in May 2014. Laundry issues had been discussed.

The manager gave us examples of changes that she had made following feedback. She told us and records confirmed that people had wanted an allotment patch in the garden. She said that this garden area had now been finished. She said, “It’s all about acting on the things that are important to the residents. It’s something they asked for and we have acted on this.” She also explained how staff had told her that they felt that communication was sometimes not as good as it could have been. As a result, she had changed the handover system and instead of holding a separate handover meeting for staff who worked on the ground and the first floor, one handover meeting was held for both sets of staff. This helped ensure that staff were aware of what was happening on both floors. She told us, “This has helped to promote a team culture, instead of two teams - staff are working together.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. Regulation 13.**