HICA

Albemarle - Care Home

Inspection report

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Date of inspection visit: 3 and 4 November 2015
Date of publication: 06/04/2016

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?	Requires improvement

Overall summary

We carried out this inspection on 3 and 4 November 2015. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was unannounced; which meant that the staff and registered provider did not know we would be visiting.

The home is required to have a registered manager in post and on the day of the inspection there was a registered manager in post who had been registered with the Care Quality Commission (CQC) since July 2013. A registered manager is a person who has registered with CQC 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.

At the last inspection on 4 November 2014 we asked the provider to take action to make improvements to infection control, the safeguarding of people from unlawful care and treatment and how the service was assessed and monitored. We found this action had been completed.

Summary of findings

Albemarle provides accommodation for up to 42 people who need support with their personal care. The service mainly provides support for older people and people who are living with dementia.

Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The service has all single bedrooms and nine bedrooms have en-suite facilities. There were 42 people living in the service at the time of our inspection.

The service submitted statutory notifications in line with requirements. However, they had failed to notify the CQC when people had a DoLS application authorised. We made a recommendation regarding this in the report.

We found the provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support. However we found that the audits had failed to identify that food and fluid charts were not always accurately recorded and also that some elements of care planning had not been updated. We made a recommendation regarding this in the report.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were appropriately actioned.

People's nutritional needs were met. People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day. People told us they enjoyed the food and that they had enough to eat and drink. People were supported to maintain good health and had access to healthcare professionals and services. However, we found the recording of people's food and fluids charts to be inconsistent.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes and we found that the recording and administration of medicines was being managed appropriately in the service.

We found assessments of risk had been completed for each person and plans to manage these risks had been put in place. Incidents and accidents in the home were accurately recorded and monitored monthly.

The home was clean, tidy and free from odour and effective cleaning schedules were in place.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the home deemed essential, such as safeguarding, moving and handling and infection control and also home specific training such as dementia awareness.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act (MCA) (2005) guidelines were being fully followed.

People told us they were well cared for. We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the home. People were able to make choices and staff supported them with this.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported. The home employed activity coordinators and offered a variety of different activities for people to be involved in. People were also supported to go out of the home to access facilities in the local community.

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?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people living in the home.

The home had a system in place for ordering, administering and disposing of medicines. However, we found that topical medicines were not always labelled to indicate when they were opened.

Is the service effective?

Good

The service was effective.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day. People told us they enjoyed the food and that they had enough to eat and drink. However, the recording of people's food and fluid intake was inconsistent.

When required, people who used the service received additional treatment from healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

Summary of findings

We saw people were encouraged and supported to take part in a range of activities.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires improvement 

The service was not always well led.

The service submitted most statutory notifications in line with requirements. However they had failed to notify the CQC when people had a DoLS application authorised.

The service had effective systems in place to monitor and improve the quality of the service, although they did not always ensure that high quality recording was maintained.

Staff and people who visited the service told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Albemarle - 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.

This inspection was carried out on 3 and 4 November and was unannounced. The inspection team consisted of one Adult Social Care (ACS) inspector. Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived in the home, four visiting relatives, three members of staff, and the registered manager. We spent time observing the interaction between people who lived at the home, relatives and staff.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, handover records, the incident / accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

At our last visit we found that some areas of the service were not cleaned to a hygienic standard. At this visit we found the home to be clean, tidy and free from odour although we noted an isolated odour on one corridor. We discussed the odour with the registered manager and they informed us that the area was continually deep cleaned but due to one person's incontinence they could not completely eliminate the odour. They told us they were in the process of replacing carpets with a non-slip, easy to clean flooring as and when rooms became empty to minimise any disruption to people living in the home. One person who was visiting the home told us "The odour in the home has got much better since they have done the floors. The Lino is much better than the carpets."

The home employed domestic staff who told us they were well supported and were always provided with suitable products and equipment to effectively carry out their role. They also showed us that daily, monthly and deep cleaning schedules were in place and that they carried out a 'top and bottom' of each room every month. This involved cleaning behind the furniture, cleaning the skirting boards and windows and washing the curtains. We saw that hand-washing facilities were present in all of the toilets and bathrooms and that appropriate personal protective equipment (PPE) was readily available.

The service had policies and procedures in place to guide staff in safeguarding people from abuse. The registered manager explained how they used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We found that the local authority safeguarding team had recently been in contact with the registered manger in relation to the management of one person's behaviours that challenged the service. We saw that the home had responded fully to their recommendations, increased staffing levels and arranged additional training for the staff team This showed that the registered manager followed guidance to ensure people remained safe.

The staff we spoke with told us they had received safeguarding training and they could offer insight into the types of abuse that could occur in a care setting. All of the staff told us they would initially speak with the senior carer on duty regarding any concerns and would escalate this appropriately if they were dissatisfied with the response they received from within the provider organisation. One member of staff said "I would record what I had seen as soon as possible and I would then speak with the manager. If they didn't address the issue then I would speak to [Name of regional director]. If it was still not sorted I would speak to the safeguarding team."

Staff told us they were also aware of the whistle blowing policy and that they could contact either the local authority or the Care Quality Commission (CQC) with any concerns. One member of staff told us they had reported a concern in the past and this was fully investigated by the registered manager and they were satisfied with the outcome. This showed the registered manager took their responsibility to investigate allegations of abuse seriously.

We saw there were systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included assessed risk for falls, pressure care, mobility, nutritional status, sensory impairment, mobility, breathing and anxious or distressed behaviour. All accidents and incidents were accurately recorded and included detailed information of the time of day they occurred, what action had been taken and which external agencies had been notified. We saw that 72 hour action plans were put in place following any accidents and these required the staff to increase the frequency of observations and record any unusual or different behaviour.

We saw the registered manager monitored and analysed all accidents and incidents and reported these on a monthly basis to the registered provider for further analysis. This was a measure to help ensure that any learning was identified and appropriate adjustments were made to minimise the risk of the accidents or incidents occurring again.

We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. Records confirmed that regular checks of the fire

Good

Is the service safe?

alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, portable appliance testing (PAT), gas boiler, fire extinguishers, emergency lighting and also all lifting equipment including hoists. This showed that the provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks 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 ensures that people who use the service are not exposed to staff that are barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This helped to ensure staff knew what was expected of them.

We found there were sufficient numbers of staff on duty to meet the needs of the people living in the home. The registered manager told us that people's needs were continually changing and therefore they needed to reassess staff numbers on a weekly basis and respond accordingly. We saw that some people had one-to-one staff support provided due to an increase in their level of need. All of the people we spoke with felt there were normally enough staff on duty. One person said "I just push the button and they come." The staff we spoke with told us that, although they were busy, they felt the number of staff was suitable.

We were told that management and senior care staff had received training in the safe handling of medication from the pharmacy that provided their medication and also in-house by the registered provider. We saw that the last training session took place in October 2015. This was confirmed by our checks of the staff training plan and staff training files. Staff also told us that regular medication competency checks were carried out as part of ongoing supervision.

People told us they received their medication on time. One person said "I always get my medication on time." Another said "They always come and give me my medication, they are a god send." We observed a medication round at lunchtime and saw that the member of staff completed this task in a polite and patient manner. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We looked at how medicines were managed within the home and checked a selection of medication administration records (MARs). We saw that medicines were stored safely in a secure cabinet, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. We did however note that some topical medications including creams were not dated to confirm when they were opened. This is needed to ensure that topical medication is not used past the expiry date or for longer than recommended. We discussed this with the registered manager who told us they would address this with the staff responsible.

We saw that medication was audited on a weekly basis by staff and we also found the pharmacist that provided the medication completed regular audits with the home and that they achieved 92% in the last audit completed.

Good

Is the service effective?

Our findings

At our last visit we found the provider was not meeting the requirements of the Deprivation of Liberty Safeguards. At this visit we saw that the registered provider had taken action to address the concerns raised.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The 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 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 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 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. We found that four people were subject to a DoLS authorisation at the time of the inspection. We saw that all documentation had been completed correctly including the appropriate assessments and the registered manager had reminders in place to ensure they were aware of the expiration date of each DoLS authorisation.

Staff told us they had received training in MCA and DoLS and were able to show awareness of the key principles of the act. We saw that when decisions were made on behalf of people that the staff team had consulted with the relevant people.

We discussed the use of restraint in the home and were told that restraint would only be used as a last resort. We were told that one person who was subject to a DoLS authorisation had a plan in place to advise staff how to use low level hand holds to prevent them from hurting themselves during periods of distress. We saw the registered manager had arranged training to provide all staff with the skills to intervene if needed. However, we were told that the person had not displayed this type of behaviour since the plan was put in place.

Staff told us they had completed an induction before they started working in the home. One member of staff said "I completed my induction at the head office and then I shadowed the deputy manager before I was included on the rota." The registered manager told us that all new employees had to complete a five day corporate induction which provided staff with the key skills to effectively carry out their duties. This included moving and handling, safeguarding, understanding privacy and dignity, MCA and DoLS, infection control, nutrition and hydration, health and safety and fire awareness. Staff were then required to complete the care certificate over a 12 week period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives.

We viewed training records and saw that staff had completed training in a variety of topics that would enable them to effectively carry out their role. Staff told us they were also required to achieve NVQ level 2 with some staff then choosing to complete level 3. This meant that staff had the necessary skills to enable them to safely and effectively carry out their roles.

People's nutritional needs were met. People told us they were offered a good choice of food and that they enjoyed it. One person said "The food is lovely. I have problems swallowing so have to have pureed food. You would be surprised at how much choice I still get." Another person said "I know today we are having lamb and mint sauce or chicken chasseur; it's hard to make your mind up." However, another person told us "I miss the cooked breakfast, we only get cereals and toast in the morning now." We saw that refreshments were offered between meals with hot and cold drinks, biscuits and fruit on offer.

Lunchtime was a relaxed and enjoyable experience for people. We saw that tables were laid with tablecloths, flowers, napkins and cutlery. We saw that some places were laid with plastic cutlery and crockery. We discussed this with a member of staff and they told us that the person who had the plastic crockery had previously smashed their plate on the table, therefore a risk assessment had been completed and the decision to use plastic crockery was made.

Good

Is the service effective?

We found that that there were two separate sittings at lunchtime. The early sitting was for people that required assistance with eating. This enabled staff to support people without any distractions ensuring that people received enough to eat in a relaxed and pleasant environment. We observed staff supporting people and saw this was done in a dignified manner. Staff sat at the same level as the person they were supporting and we heard one member of staff providing continual prompts to remind one person not to eat too quickly to minimise the risk of choking.

Staff were kind, caring, encouraging and persuasive throughout mealtimes and wore smart black tabards which created a sense of occasion. People were offered a choice of hot meal and two choices of pudding. We saw that when people were unable to decide what to have, staff took a plated up meal of each choice to the person and allowed them to select the meal they wanted. We saw people were served their food in good time and that people were offered a second portion of food. This helped ensure they had enough to eat.

We saw staff were concerned when people had lost their appetite. We heard a member of staff mention that the person they had been supporting to eat in their room had not eaten very much. The cook stated “I wonder if [Name] will try a bit of ice-cream, [Name] normally loves it.” They then provided the member of staff with some ice-cream to take to the person. This showed that the kitchen staff knew people’s likes and dislikes and also knew the importance of ensuring that people got enough to eat.

We saw the home used the Malnutrition Universal Screening Tool (MUST) to help assess people’s nutritional needs and determine what ‘plan’ a person should be on in relation to their current weight and body mass index (BMI). The MUST was also used to inform staff when a referral to the GP or dietician was necessary to fully assess a person’s nutritional status. The registered manager told us that people were weighed on a monthly basis, unless the person had lost their appetite or had experienced a significant weight loss, then they would be weighed weekly. We saw that people’s weights were recorded in their care plans so they could be monitored.

Some people had food and fluid recording charts in place to record the quantities of food and drink they were consuming to ensure their nutritional needs were being met. However, we saw that these were not always accurately recorded. For example, the type of food consumed was not stated, nor was there an accurate description of the quantities of food consumed at each mealtime. We discussed this with the registered manager who told us they would address this with the staff team and remind them of the importance of accurate recording.

Peoples health needs were supported and were kept under review. We saw evidence that individuals had input from their GP’s, district nurses, chiropodist, optician and dentist. Where necessary people had also been referred to the relevant healthcare professional. All visits or meetings were recorded in the person’s care plan with the outcome for the person and any action taken (as required).

When people needed to attend the hospital we saw they had patient passports in place. Patient passports explained how to care for people should they be admitted to hospital. These included key information regarding whether the person had any allergies or any particular needs that would enable the hospital staff to provide more personalised care.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that the staff were kind and caring. Comments included "The staff are all good and seem happy in their work. They are always polite and very kind" and "The staff are very friendly." We spoke with people's relatives and they agreed. One said "The home has a nice feel to it and the staff are very good." Other people said "The staff are very caring, they are lovely" and "The staff are wonderful, they are very kind to [Name]."

Throughout the two days of our inspection there was a calm and comfortable atmosphere within the service. On arrival music was playing and we found some people who lived in the home were already dressed and enjoying their breakfast, whilst others chose to remain in their night clothes if they wished. We saw one staff member offering encouragement to one person to have a wash and get ready for the day; however the person declined the offer stating "I'm fine thank you." One relative told us "There's no set routine, I know that [Name] can get up in the middle of the night and she will have a cup of tea with the staff."

People told us they were able to make choices. One person said "I choose where I have my lunch. Sometimes I go in the dining room and sometimes I like to have it in my room" and "They give you a choice of whether you want a big or a small cup of tea. I always have a big cup." Another told us "I decide what time I get up and go to bed. Sometimes you just want to have a lie in and they leave me to it."

Staff were knowledgeable about people's needs. They told us they could read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships, their likes and dislikes and their usual daily routine. One staff member said "I don't look at the residents collectively - they are all individuals. I know who I share a joke with whereas there are others I wouldn't dream of it." A visiting healthcare professional told us "The staff seem knowledgeable about the people living in the home."

We saw staff supporting people living in the home in a friendly, caring and confident manner. Staff were seen to manage different scenarios and approach each individual in a manner that was responsive to their individual needs. We observed one member of staff patiently assisting one person back to their room providing clear instructions on how to best use their walking aid. They ensured they went at pace the person was comfortable with and provided them with constant reassurance throughout the manoeuvre.

We observed staff interacted positively with the people who used the service. They showed a genuine interest in what they had to say and responded to their queries and questions patiently, providing them with the appropriate information or explanation. We saw people who used the service approach staff with confidence; they indicated when they wanted their company and when they wanted to be on their own and staff respected these choices. People told us that staff respected their privacy. One person said "The staff are polite and they always make sure they knock on the door before they come in my room."

We saw that the registered manager provided flexibility in how people chose to live within the home. We saw that a husband and wife who lived in the home had received support from staff to convert one of their bedrooms into a living room so they had a place to relax together during the day. This offered them privacy from other people in the home and enabled them to continue living together in an environment that more closely resembled how they had lived prior to moving into the home.

Discussion with the staff revealed there were no people living at the service with any 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 some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this

Good

Is the service responsive?

Our findings

People were encouraged to offer feedback, share their experiences or raise any concerns. The service had policies and procedures in place to effectively manage any complaints that they received. A copy of the complaints procedure was available in the reception area of the home and people living in the home and their families were also provided with a copy in the homes service user guide. We saw that complaints were always fully investigated and that the complainant always received a prompt and thorough response. There was evidence that appropriate action had been taken in response to complaints received, and that complaints were discussed during staff meetings and used as an opportunity for learning.

People told us they knew how to make a complaint but had not needed to. One person said "I know I can speak to either [Name of registered manager] or [Name of deputy manager], but I've got no complaints." One relative told us "If I had any problems I would speak with [Name of manager]."

There were other opportunities for people living in their home and their families or friends to raise concerns or provide feedback to the registered manager. These included 'residents' meetings, relative meetings, and quality assurance surveys.

We viewed records of meetings for people living in the home and saw that nine people had attended the last meeting held in August 2015. They had discussed whether people were aware of their key worker, if they were happy with the frequency of their baths and showers, if they had any suggestions for food and drink and if there were any places they wanted to visit the next time the minibus was available. People commented they had enjoyed the trip to the market. Although most people found the meetings useful one person told us "I used to go to the meetings but nothing gets done about the suggestions." We noted that the minutes of the meeting did not state what action had been taken to address any issues raised or whether trips that had been requested were subsequently arranged. The registered manager told us they would ensure that actions were recorded in the minutes in future.

We saw that pre-admission assessments had been completed by the registered manager prior to people moving to live in the home. This ensured that the home was able to meet the needs of the person and also assessed any impact there could be on staffing levels. The registered manager explained that people initially moved to the home on a four week respite basis with a view to the move becoming permanent following a review. This provided an opportunity for all concerned to ensure that the home was the most appropriate place for the person to live in the long term.

A 'focus assessment' was undertaken which identified people's support needs, and care plans were then developed outlining how these needs were to be met. Risk assessments were also developed for those aspects of care where potential risk was identified. For example, we saw one person had experienced a period of weight loss. The staff had contacted the persons GP who had made a referral to the Dietician. An assessment had been completed and a plan to minimise the risk had been completed and recorded in the persons care plan.

We found that care plans also included information regarding peoples likes and dislikes, daily routine and life histories. We were told that this information was collected either from the person themselves or from a family member or friend. This provided staff with insight into what people used to do for a job, what hobbies they enjoyed and what things / people were most important to them.

We saw that care plans were reviewed monthly, however this did not always guaranteed they were fully reflective of people's current needs. For example, we saw that one person had recently been involved in an incident with another person living in the home. Their care plan stated that there were no 'compatibility issues' with other people living in the home. We discussed this with the registered manager and they were able to show us all of the steps the home had taken to ensure that there was no repeat of the incident and that people in the home were appropriately safeguarded. They also directed us to look at another part of the care plan that provided the relevant information. However, they acknowledged that this element of the care plan should have been updated to ensure it was truly reflective of the person's changing needs. They told us they would update this immediately.

We saw that people were involved in the development of their care plans and, where they were unable to be involved, the registered manager had spoken with friends

Good

Is the service responsive?

and family to ensure that the care provided was appropriate. One relative told us "My [Name] wouldn't understand what was in their care plan so I was asked to look at it and sign to say I was happy with it."

We found the home employed two activity coordinators and that daily activities were offered to people living in the home. One of the activity coordinators told us they worked from 10am – 8pm and this enabled them to provide both group and individual activities for people living in the home. We saw there was an activity board on display and this included pictures of the activities on offer so people were able to see what was happening in the home and when. A range of activities were listed including jigsaws, reminiscence, film afternoons, arts and crafts, Oomph exercise sessions and a Sunday church service.

People confirmed that activities were available. One person told us "They have trips out when the minibus is available." A relative told us "They went out last year for a Christmas meal and they have been on trips to Hornsea and down Hessle Road." On the day of the inspection we saw that the activity coordinator was engaging 15 residents in an 'Oomph' exercise session. These aim to improve physical mobility, social interaction and mental stimulation for people living in the home. We saw people laughing and joking with the activity coordinator and one person enjoyed a dance.

We saw that the registered manager had installed raised beds in the garden to enable people living in the home with an interest in gardening to continue enjoying this hobby. We were told that one person had a vegetable patch and they grew food that was then used in the homes kitchen.

During the two days of the inspection we saw that people's friends and families were free to visit the home as often as they wanted and at any time during the day or night. We saw that meal times were 'protected' times, however if people did choose to visit at this time they could spend time away from the dining room with the person they were visiting. We saw that people living in the home had developed friendships and we spent time talking with two people who had become friends through their passion for sport. People visiting the home told us they were made to feel welcome and one person told us "Although I live away I call twice a week and they always make sure I can speak to [Name]."

Requires improvement

Is the service well-led?

Our findings

At our last visit we found that the service was not always well led, as although there were systems in place to assess the quality of the service we found that these were not always effective.

At this visit we found that improvements had been made to the way the home assessed and monitored the quality of the service. We saw audits were carried out to ensure that the systems at the home were being followed and that people were receiving appropriate care and support. These included the environment, medicine systems, recruitment systems, care plans, maintenance of equipment, health and safety, infection control systems and accidents / incidents. We saw that when audits identified any areas for improvement, actions were taken to rectify the problem and where necessary, systems were altered to prevent any reoccurrence of the shortfalls. For example an infection control audit identified that some staff were found to be wearing nail varnish, watches and jewellery. This was raised as an agenda item at the next staff meeting and the risks associated with wearing these items and potential injury to people living in the home was discussed. Staff were told they must adhere to the homes dress policy.

We also saw that the registered provider utilised an Early Warning Audit Tool (EWAT). This meant that every two months a regional manager from another area visited the home and carried out an audit to check how the home was performing. This provided useful information and feedback regarding areas the home needed to improve in and also recognition of what they were currently doing well.

However, although we had found that improvements had been made, the audits had failed to identify that food and fluid charts were not always accurately completed, or that some elements of the care plans had not been updated. Although this had not negatively impacted on the quality of care delivered improvements were still required.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found the registered manager of the service had informed the CQC of significant events including statutory notifications for serious injuries, allegations of abuse and the death of a service user; these were received in line with requirements and in a timely way. This meant we could check that appropriate action had been taken. However, we had not been notified of recent Deprivation of Liberty Safeguards (DoLS) that had been authorised by East Riding of Yorkshire safeguarding team, although, we saw from our records our records that these had been submitted in the past. We discussed this with the registered manager who told us they had completed the notifications but had delegated the task of submitting them to another member of staff whilst they were on leave. The registered manager acknowledged they were responsible for ensuring that CQC received all required notifications and provided reassurance that they would be submitted in line with requirements in the future. The registered manager promptly submitted the appropriate DoLS applications to ensure that our records were kept up to date.

We spoke with the registered manager about the culture of the organisation and how they ensured people who used the service and staff were able to discuss issues openly. The registered manager told us they had an open door policy and tried to ensure that they were accessible to people. This enabled people to approach them directly with any ideas, issues or concerns.

People living in the home, the staff team and friends and relatives all told us the registered manager was approachable. One member of staff said "[Name of manager] is supportive, helpful, and I can go to them with any problem, big or small and they will sort it out." A visiting relative told us "I have a good relationship with the manager; they seem open and honest and are very approachable. They have been very helpful with all the financial processes." One person living in the home told us "[Name] is a good manager. She knows how to manage her staff."

The registered manager said that good communication was important and they were able to communicate with the staff team in a number of ways. This included staff meetings, the handover book and supervisions. This meant that staff were kept informed of any issues that may affect them and also provided opportunity to discuss any concerns.

People told us that communication with the home was mostly good. One relative told us "The manager or a member of staff always call me to let me know if anything is wrong or if they want some information from me." However, another relative told us "I wasn't contacted when [Name] went into hospital." A member of staff told us that the staff

Requires improvement

Is the service well-led?

team “All got along” and that the communication between the day and night staff was good which ensured that any important information was always passed on to the next team.

We were told regular staff and ‘residents’ meeting took place and we viewed records of both. We found staff meetings were held monthly and were used as an opportunity to share information with staff and update them on any changes or improvements that might be taking place in the home. They were also used to address any issues that had been raised during quality audits that had taken place. We noted that the meetings appeared to be an information sharing event rather than an opportunity for open discussion. However, the staff we spoke with confirmed they were given opportunity to speak up and discuss any issues they may have.

The registered manager explained that consultation events were arranged for relatives and friends to enable them to keep up to date and also provide any feedback about the home. We saw that a regular newsletter was available and that ‘one off’ events such as a cheese and wine night and a mince pie and sherry night at Christmas had taken place or had been planned to gather feedback in an informal way. We were also told that prior to the homes menu changing friends and family had been invited for a taster session. One relative told us “I was invited to the tasting session and they wanted my feedback.” In the reception area there was an information board on display and there was also a television that was used to advertise both up and coming events and display past events.

The registered manager had distributed quality assurance surveys to the staff, people living in the home and people’s relatives. We viewed the quality assurance questionnaires that were sent to people who visited the home in March 2015 and noted these included questions relating to the homes cleanliness, whether there were any odours, the welcome they received and whether they feel improvements had been made. The responses were largely positive.

We found the records kept on people that lived in the home, staff and the running of the business were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people‘s personal and private information remained confidential.

We recommend that the registered manager seeks advice in regards to their quality management systems so that appropriate and accurate records are held.

We recommend that the registered manager follows the latest guidance on notifications that are required to be submitted to the Care Quality Commission.