Keldgate Manor Estates Limited

Keldgate Manor

Inspection report

Keldgate
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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

Overall summary

This inspection took place on 3 December 2015 and was unannounced. We previously visited the service on 10 July 2014 and made a recommendation about how staff shared information with people who lived at the home and how specific care needs were met. We visited the service again on 10 March 2015 and made recommendations about managing safeguarding issues and how staff training was recorded.

The home is registered to provide accommodation for up to 35 people who require assistance with personal care, some of whom may be living with dementia. On the day of the inspection there were 19 people living at the home. The home is situated in Beverley in the East Riding of Yorkshire. It is close to the centre of the town and town centre facilities. There is a car park for visitors and staff.

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); the registered manager had been in post for many years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe whilst they were living at Keldgate Manor. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records evidenced that staff had completed training that equipped them to carry out their roles effectively. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

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

People told us that they received the support they required from staff and that their care plans were reviewed and updated as required. People told us that staff were caring and that their privacy and dignity was respected.

People's nutritional needs had been assessed and people told us they were happy with the meals and refreshments provided. We saw that people were encouraged to drink throughout the day to promote hydration.

There was a complaints policy and procedure in place and people told us they were confident that any complaints or concerns they raised would be listened to. There were systems in place to seek feedback from people who received a service, and this feedback was used to identify improvements that needed to be made.

The quality audits undertaken by the registered manager were designed to identify any areas that needed to improve in respect of people's care and welfare.

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?
The service was safe.

Staff had received training on safeguarding adults from abuse and moving and handling. This helped to protect people from the risk of harm.

There were sufficient numbers of staff employed to meet the needs of people who lived at the home. Staff had been recruited following robust policies and procedures.

People were protected against the risks associated with the use and management of medicines.

Good

Is the service effective?
The service was effective.

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS), and that best interest meetings were used to assist people to make decisions.

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

People told us they had access to health care professionals when required.

Good

Is the service caring?
The service was caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

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

We saw that people's privacy and dignity was respected by staff.

Good

Is the service responsive?
The service was responsive to people's needs.

Visitors were made welcome at the home and people were encouraged to take part in activities.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for their care were recorded.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager if they had any concerns.

Good

Is the service well-led?
The service was well-led.

There was a registered manager in post and there was evidence that the home was well managed.

Good

Summary of findings

There were sufficient opportunities for people who lived at the home, staff and relatives to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Keldgate Manor

Detailed findings

Background to this inspection

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

The inspection took place on 3 December 2015 and was unannounced. The inspection was carried out by one 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 has used this type of service. The Expert by Experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

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 authority who commissioned a service from 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.

On the day of the inspection we spoke with three people who lived at the home in depth and chatted to others. We also spoke with four visitors and three members of staff. Following the day of the inspection we spoke with a three health care professionals and a social care professional.

On the day of the inspection we 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 service, including staff training, health and safety and quality monitoring records.

Good

Is the service safe?

Our findings

At the last inspection of the service on 10 March 2015 we identified some concerns in respect of the management of a safeguarding issue.

At the inspection on 3 December 2015 records showed that staff had completed training on safeguarding adults from abuse. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns to the registered manager or care manager. They said that they were confident that they would take appropriate action and ensure issues were dealt with in line with the home's policies and procedures. We saw that any safeguarding alerts were stored in a folder along with Care Quality Commission [CQC] notifications. This included a record of when the safeguarding team had been contacted to discuss issues and this had not resulted in an alert being submitted.

In addition to staff, some people who lived at the home and relatives had completed training on safeguarding adults from abuse in April 2015. This meant that the registered manager had ensured people were aware of safeguarding issues and how they needed to be managed.

Staff told us that they would not hesitate to use the home's whistle blowing policy if needed, and that they were certain their confidentiality would be protected. One person told us, "Yes, I would feel comfortable and confident that I would be listened to and not be judged."

We asked people if they felt safe living at the home and they confirmed that they did. One person said, "Absolutely, the carers are wonderful" and another told us "Yes, it is homely – I feel safe in my room." Another person told us they felt safe but that they would like a lock on their door. We discussed this with the registered manager and they told us this person had been offered a key to their door but they had declined. They said they would discuss this with them again. Comments from relatives included, "Yes, there is always someone around to look after her" and "I have no complaints about it [my relative's safety] – I would recommend this home to other people."

We asked staff how they kept people safe and comments included, "Making sure people get the right medication", "Using correct moving and handling techniques and checking equipment regularly", "Our training on safeguarding adults from abuse" and "Checking equipment as we go along – bed rails and footplates on wheelchairs."

Care plans recorded assessments and risk assessments in respect of moving and handling and the risk of falls. Risk assessments were scored to identify the level of risk involved and recorded the details of any equipment the person required to assist them to mobilise. We observed staff assisting people to mobilise on the day of the inspection and noted that this was done safely. A member of staff told us that the only restraints they ever used were lap belts on wheelchairs to prevent people from falling out.

There were other assessments in place to assess the risks associated with nutrition, pressure area care, infection control and medication. The risk assessments recorded details of the risk and how these could be managed. When people displayed behaviours that could put themselves or others at risk, plans had been developed to advise staff how to manage the person's behaviour to minimise any risk. This showed that any identified risks had been considered and that measures had been put in place to try to manage them.

We checked the accident book and noted that accidents and incidents had been recorded appropriately. These were collated each month and the report showed that each accident form had been checked by the registered manager to assess whether any further action needed to be taken. We saw one accident form that recorded, "Service user fell out of bed. To look at having mattress on the floor – to discuss with district nurse and to request a hospital bed." This showed that consideration had been given to any improvements that needed to be made to reduce the risks of accidents reoccurring. The care manager told us that an annual audit of accidents was also carried out to identify any emerging patterns or areas that required improvement.

All medicines were stored in the medication trolley and the trolley was stored in the medication cupboard and fastened to the wall when not in use. The temperature of the medication fridge and medication cupboard were monitored regularly and recorded; this evidenced that medicines were stored securely and at the correct temperature.

Good

Is the service safe?

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 indicate the time of day the medicines needed to be administered. The assistant manager told us that they colour coded the medication administration record (MAR) charts to correspond with the blister packs; this reduced the risks of errors occurring. Any medication that were not stored in the blister pack were stored in the medication trolley; we saw that packaging was dated when opened to ensure the medication was not used for longer than recommended. We noted that external and internal products were not stored separately, as recommended; the team leader told us that they would ensure this was how products were stored in future.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs) and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage and recording of CDs and noted they were stored safely. We checked a sample of medication held against CD records and saw that the stock of medication held matched the records in the CD book. Two staff had signed the CD book to record when medication had been administered and the team leader told us that the amount of stock held was checked every time a CD was administered.

There was an audit trail to evidence that medication that had been prescribed by the GP was the same as the medication delivered by the pharmacy. On one occasion staff identified that the pharmacist had supplied incorrect medication for a person and this was dealt with effectively by staff at the home. There were satisfactory arrangements in place for the disposal of unwanted or unused medication.

We checked a sample of medication administration record (MAR) charts and saw that they included a photograph of the person concerned (to aid recognition for new staff), any allergies and a list of medication prescribed. There were no gaps in recording. We noted that the reverse of the MAR chart included information about how the person liked to take their medication, and that codes were being used appropriately to record when people had refused their medication. Charts to record where creams should be applied were being used appropriately.

All staff who had responsibility for the administration of medication had completed training. The registered manager told us that they also carried out competency checks on staff to ensure they retained the skills they needed to administer medication safely, although they acknowledged that none had been carried out recently. They told us they would reinstate these checks and record them.

There was a recruitment policy and procedure in place. We checked the recruitment records for one new member of staff and another member of staff who had not yet started their employment at the home. For the first staff member we saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service 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. We saw that this information had been received prior to the person commencing work at the home. For the second staff member we saw that an application form had been completed, one reference obtained and checks made with DBS. The registered manager told us that this person would not be given a start date until their second reference had been received, and a telephone call had been made to both referees to verify that the information in the references was correct. This meant that only people considered suitable to work with vulnerable people had been employed. Staff were provided with job descriptions and terms and conditions of employment. This ensured staff were aware of what was expected of them.

Employment interviews were carried out and we saw that people were asked about their motivation for working with vulnerable adults, their values and ethics, and information about safeguarding adults from abuse. We saw that people who lived at the home were involved in the recruitment of new staff as representatives of the home's committee. This meant that people were able to comment on an applicant's suitability for the post.

On the day of the inspection we saw there was the registered manager, the care manager, the assistant manager, two care workers, a cook and a domestic assistant on duty. We checked the staff rotas for a two week period and noted that these levels had been maintained.

Good

Is the service safe?

Permanent staff were supported by a small number of agency staff. However, these were 'regular' agency staff who knew people who lived at the home well. We spoke with two agency staff and they told us they worked at the home most days and would work for the home on a permanent basis if they were given the opportunity.

Visitors to the home told us there were enough members of staff on duty. One visitor said, "Yes, no complaints, they look after her very well" and another said, "Yes, always someone around." Another visitor told us that there was one day when a care worker went off sick and no cover could be found. They said, "But staff still coped very well." Health and social care professionals told us they could usually find a member of staff when they needed them; they said they understood that if they had to wait this was because staff were busy assisting other people.

We saw the registered provider's business continuity plan. The plan advised staff on the action to take in the event of flood, power failures, an outbreak of infection and other emergency situations. The plan also included staff telephone numbers and details of where emergency supplies were stored. On the day of the inspection we noted that there were no personal emergency evacuation plans (PEEPs) in place. This was discussed with the registered manager and following the inspection these were produced and forwarded to us. The PEEPs recorded the assistance each person would need to evacuate the premises in an emergency.

There was an environmental risk assessment in place that identified any risks in the premises and the grounds, and how these could be managed and minimised. We looked at the maintenance certificates to check that equipment was serviced on a regular basis. There were current maintenance certificates for the fire alarm system, emergency lighting, fire extinguishers, the electrical installation, mobility and bath hoists, the stair lift and the passenger lift. More regular maintenance checks had been carried out in-house by the home's handyman; these included window opening restrictors, portable appliances, water temperatures and a weekly fire alarm test. Staff wrote in a repairs book and the handyman recorded when the repairs had been completed. Beds with bed rails attached were serviced by the company that supplied the beds. The registered manager told us that the company carried out an annual inspection and that if staff noted any concerns, they telephoned the company and they visited the same day to check that the bed and bed rail were safe.

We saw that the gas safety certificate was out of date; the registered manager had arranged for the service to be carried out the following week. The registered manager informed us that the engineer had been delayed and actually carried out the work on 17 December 2015. A copy of a current service certificate was forwarded to us.

We noted that the premises were clean throughout and that there were no unpleasant odours in either communal or private areas of the home.

Good

Is the service effective?

Our findings

At the last inspection of the service on 10 March 2015 we identified some concerns in respect of how staff training was recorded.

At the inspection on 3 December 2015 people who lived at the home and visitors told us that staff seemed to have the skills they needed to carry out their roles. One person told us, "Yes, they are very well trained" and a visitor told us, "Yes, (staff) have always been nice and taken care of her."

The recruitment and training policy and procedure recorded that new staff would receive an induction pack on their first day at the home, and would start to complete the Care Certificate within three months of their start date and a National Vocational Qualification within one year of their start date. On the first day of their induction training staff were orientated to the home and received various documents and policies and procedures to read. Staff were expected to complete their full induction programme within six months; topics included dignity at work, dementia, infection control, the Mental Capacity Act 2005 (MCA), nutrition and hydration, moving and handling, fire safety and end of life support.

The policy recorded that staff would be expected to undertake refresher training every three years, or more often if needed, on topics considered to be essential by the registered provider. The topics included medication, first aid, Deprivation of Liberty Safeguards (DoLS), health and safety, diet and nutrition, and moving and handling. We asked staff what training they had done in the last year and they mentioned training on medication and safeguarding adults from abuse. The assistant manager told us that all staff had requested further moving and handling training and they were currently accessing this training via a DVD. This showed that staff were receiving on-going training to support them in their roles.

However, one visiting health care professional told us that they thought staff required further training to help them to understand how to manage people with complex medical needs. This was fed back to the registered manager following the inspection. They told us they would arrange additional training for staff if they felt a person's specific needs were not being met, and seek advice from health care professionals about the type of training that would be helpful.

Staff told us that they felt supported and that they had one to one supervision meetings; these are meetings when staff can discuss their performance and any concerns with a manager. One member of staff told us, "Yes, I can talk to the registered manager and care manager" and another member of staff said that all staff had supervision with either the registered manager or the care manager.

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 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 authorisations to deprive a person of their liberty were in good order. We saw that documentation had been completed appropriately by the registered manager, who displayed a good understanding of their role and responsibility regarding MCA and DoLS. The DoLS applications and authorisations we saw in care plans were accompanied by best interest documents and capacity assessments.

Two people at the home had a diagnosis of dementia. Other people were living with dementia but did not have a formal diagnosis. We saw in care records the staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. One person's care plan recorded that a relative had Enduring Power of Attorney (EPOA) for them. This was in respect of property and their financial affairs, but not about health and welfare. A Power of Attorney 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.

People's preferred ways to communicate, and ways of helping people to make decisions, were recorded in care plans. We saw information such as, "Please take your time to understand me and my needs", "Speak clearly to me" and "Explain and give me time to think." Care plans also

recorded the types of decisions people were able to make, such as what to eat, when to get up and go to bed and whether to have a bath or a shower. One person's care plan recorded, "[Name] likes to sit with people she can talk to so she decides where she would like to sit." Staff told us that they helped people to make decisions by explaining the choice of food at mealtimes and showing them the choices on offer, and helping them to choose what to wear by showing them a choice of items from their wardrobe.

People told us that they were consulted about their care and that staff asked for consent before assisting them. We saw a letter that had been sent to all relatives, friends and advocates. This explained the use of patient passports, photographs and care plans and who information could be shared with. People who lived at the home [or a family member if appropriate] were asked to consent to this information being held and shared if needed.

We saw that people's personal preferences, dietary requirements and support needs were documented in their care plan. Staff told us that they talked to people when they first moved into the home about their dietary needs and their likes and dislikes. Entries in the care records we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. One person's care plan recorded, "Weigh weekly and monitor loss or gain. If losing too much get in touch with GP and ask for the dietician to become involved again." Staff also told us that they recorded food and drink intake for people when they were at risk of malnutrition so they could monitor their daily intake. They said that any food supplements were recorded on medication charts so there was a record of when people had taken any supplements. This showed us that there was a system in place to ensure that people using the service were supported to eat and drink safely and in sufficient quantities.

People who lived at Keldgate Manor told us they were happy with the meals provided. They told us that they did not have any special dietary needs and that their likes and dislikes were met. Comments included, "I am very fussy but they know what I don't like", "Food is very good, tastes nice, good choice" and "Good, it's like home from home, meat is always tender." A relative told us that their family member enjoyed the meals at the home and had put weight on since their admission.

We observed the serving of lunch and saw that there were sufficient numbers of staff in the dining room to assist people who required help with eating and drinking. There was a menu board with the choices for lunch recorded, although we noted there were no picture menus. The care manager told us that they had ordered some pictures so they could create a picture menu and they had just been delivered. Picture menus can help people with a cognitive impairment to choose a meal. People were not offered a choice of different meals at lunchtime and we were told that this was because they were asked earlier in the day; the cook showed us the list where people's choices had been recorded. Any special dietary requirements were recorded on the same list. We saw that people were offered both cold and hot drinks. One person asked for more soup and this was brought to them, another person asked for 'no vegetables' and this was complied with and another person had a cake for dessert that had been brought in for them by their spouse. This showed that individual choices were catered for. People were offered clothes protectors, and staff checked that people had finished their meal before they cleared away crockery and cutlery. Staff offered appropriate support to people and chatted to them; this made lunchtime a pleasant experience.

One person was reluctant to eat and we felt that if staff had spent more time with them they could have encouraged them to eat more. We later spoke to this person's relative who explained their family member had been in hospital recently and they had lost their bottom set of teeth. A replacement set were being made.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

People told us they could have access to their GP and other health care professionals when they asked. One person said, "Very easy, they always come the day I ask for them and the district nurse comes and does blood tests once a month" and another person told us, "Yes, they get one when I need one." Relatives told us they were kept informed of any events in respect of their relative's well-being. One relative told us, "They tell me when I come to visit and I come every other day" and another said, "Yes,

Good

Is the service effective?

they tell me whenever I visit what has gone on." Staff told us they would not hesitate to contact a GP if needed and the assistant manager said, "I would ring a doctor straight away."

A health care professional told us that there was good communication between themselves and staff. They said that staff asked for advice appropriately and, although they occasionally needed a reminder or additional support, they followed the advice they had been given. Another health care professional said, "The experienced staff at Keldgate Manor are very valuable resources when assessing a patient." A social care professional told us that they had advised the registered manager to contact a district nurse on behalf of a person they were assessing, and this had been actioned. We saw that any contact with health care professionals was recorded; this included the reason for the contact and the outcome.

Care plans also recorded information about any aids or equipment that people required to assist them in their day to day lives, such as mobility aids, continence aids, spectacles, hearing aids and pressure area care equipment.

People had patient passports 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. We saw that patient passports included up to date information. Some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' [DNACPR] form in their care plan folder. Those that we saw had been completed correctly.

We saw that, although signage within the premises was minimal, no-one had difficulty in finding their way around the home. Most people required assistance to mobilise around the premises so were helped by staff to locate bathrooms, toilets and bedrooms. Two of the people we spoke with told us they could find their way around the home. A third person told us they had difficulty finding their way around but said there were staff around to help them. A health care professional told us, "The fact that the building is not purpose built to be a residential home means that the facilities do not compare quite as well as a new purpose built one. However, this is usually manageable." We discussed with the registered manager that it might be useful for some additional signage to be provided to help people to find their way around the premises. The registered manager told us that they had fastened some signage to toilet and bathroom doors but, because it was fastened with Velcro, it was regularly removed by people who lived at the home. They told us they would take action to address this.

Good

Is the service caring?

Our findings

We asked people who lived at the home if they felt their care was centred around them, and they all responded positively. We also asked people if they felt staff cared about them. One person told us, "Yes definitely, and I have seen it in instances with others as well" and another said, "I don't know but they are pretty good." A visitor told us that they and other members of their family were happy with the care their relative received. They said, "Staff absolutely care about [Name] and [Name] cares about them. There are two or three people she is very fond of." Another relative said, "I am very, very happy with the care provided for my family member." Health and social care professionals told us that staff seemed to really care about people who lived at the home, and one health care professional mentioned one member of staff by name who they thought "Was an asset to the home." They added that people who lived at the home had told them they liked the staff and they received good care. One health care professional said, "Some staff are very caring and residents are made to feel at home."

We observed positive interactions between people who lived at the home, visitors and staff which demonstrated staff were caring and compassionate. We noted that staff spoke with people in a respectful manner. A social care professional told us that the people they visited at the home were appropriately dressed and well-presented whenever they visited.

Although two people did not seem certain about this aspect of their care, one person told us they were happy with communication between themselves and staff. They said they were always kept informed about anything that concerned them, and about events at the home. This person also told us that staff communicated with them in a way they understood. They said, "I have a key worker and she is very sympathetic and understanding."

One person who lacked the capacity to consent or make important decisions had an Independent Mental Capacity Advocate [IMCA] to support them with decision making. There was also information about other advocacy services available to people who lived at the home. 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. There were other useful leaflets on display such as information about Alzheimer's and the Mental Capacity Act.

We saw that a member of staff knelt down next to someone to explain that the district nurse would be coming to see them that day; they explained things very clearly. We saw two staff explaining to someone [whilst they were assisting them to mobilise using a hoist] what was going to happen, and that they talked to them throughout the procedure.

Visitors told us they were welcome to visit the home at any time. One person who lived at the home told us, "A nurse at my doctor's practice visited [Keldgate Manor] and made a comment that the carers are the nicest of all the homes she has been to." Staff told us they helped people to keep in touch with relatives and friends. One member of staff said, "By telephone, by writing – we welcome visitors." They also told us that they had been concerned about one relative who had not visited as usual, and how they checked the relative was alright.

The people who lived at the home and relatives who we spoke with told us that staff always knocked on the door before entering and were respectful of people's privacy and dignity. One person told us, "Yes, they never come in without knocking on the door." Staff told us that they made sure doors and curtains were closed, that they covered people during personal care to protect their modesty and that the minimum number of staff were present. They also said that they spoke with people throughout personal care to explain what they were doing.

A visiting health care professional told us that there was a small treatment room where they could take people to provide health care support., and a social care professional told us that that their meeting had been held in a private room, and that the registered manager had asked if they would like them to stay for the meeting or go ahead without them. Another health care professional said, "When I arrive I am usually greeted by experienced care staff who speak to me in private regarding the patient I am visiting. We then proceed to see the patient, either in their room or in the allocated treatment room." This meant that people were able to see visiting health and social care professionals in private.

We saw that staff encouraged people to be as independent as they could be; staff supported people rather than 'doing

Good

Is the service caring?

things for them'. One person monitored their own fluid intake and output and recorded this on a chart kept in their room. Staff told us that they encouraged people to do as much as they could for themselves, such as "Simple things like washing their own face."

Good

Is the service responsive?

Our findings

At the last inspection of the service on 10 July 2014 we identified some concerns in respect of staff not explaining to people what was happening when they were assisting them, and that a nutritional plan was not being followed. .

At the inspection on 3 December 2015 we saw that assessments were undertaken to identify people's support needs and comprehensive care plans were developed outlining how these needs were to be met. Areas covered in care plans included mobility / physical well-being, medication, communication, continence, mental health / dementia, decision making / MCA / DoLS, personal risk and safety, social interests, pressure area care and pain. Where areas of concern had been identified, risk assessments had been completed that recorded the details of the risk, the level of risk and how the risk could be minimised. A relative told us that their family member had a thorough care needs assessment prior to being admitted to the home. A member of staff had carried out the assessment whilst their family member was in hospital and had spoken to their relative, who had provided some written information for staff at the home.

The care plans we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. They also included information about a person's particular care needs when they were feeling anxious or unhappy, under the headings "What relaxes me" and "Ways of reassuring me." Records evidenced that the information had been gathered from the person themselves, their family and from health care and social care professionals involved in the person's care where possible. The care manager showed us a copy of a 'This is My Life' file; people and their relatives had been invited to make one up with pictures and information about the person's life. This meant that there was information in place that helped staff understand the person's individual needs.

Staff we spoke with displayed an in-depth knowledge about each person's care needs. They told us they got to know people's individual needs by talking to them and their families as well as looking in their care plans. One member of staff said, "I have time to talk to them. If they can't answer I ask their family." Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift and by reading the care plans. They said that they also used a 'catch up' book that was written in daily. This information was discussed at each handover meeting, i.e. at 08:00 and 20:00 each day. A health care professional told us that staff were knowledgeable about people's needs. They mentioned one member of staff who they said, "Does not even need to think – they know service users so well."

One person told us they were not certain that they had been involved in developing their care plan, but two people told us they had been involved and one person told us their care plan was reviewed each year. We saw that care plans were reviewed on a monthly basis and any changes to care were recorded. We noted that care plan additions were not always dated and we discussed with the registered manager how it was important to date any amendments so there was a record of when changes had been made to the person's care plan. However, we had no reason to believe that care plans were not up to date. We noted that more formal reviews were arranged by Social Services when they had commissioned the placement at the home. The person concerned, along with staff from the home, were invited to attend the review meeting. This meant people had an opportunity to comment on whether their care plan was meeting their current needs.

In addition to a care plan, people had a 'chronology of events' folder in place. Each person had a weekly sheet that recorded any activities they had taken part in, quality time spent with staff, any professional visits and body maps in respect of any injuries or bruises. This meant that staff had a 'quick' checklist where they could see the person's care provision for that week.

Staff told us that there was no activities coordinator employed at the home, but they had the time to assist people to take part in activities and to sit with them to have a chat. On the day of the inspection we saw a member of staff encouraged people to take part in a ball game in the morning, and there was a church service in the afternoon. Staff made sure that anyone who wished to participate had the chance to do so. One person told us, "There are church services here – I like these." Another person told us that they knew there were activities available but they did not wish to take part. One person told us they would like to go

Good

Is the service responsive?

out more and this was fed back to the registered manager. Visitors told us that their relatives took part in activities. One visitor said, "She does some activities here – she likes the soft ball throwing."

The registered manager told us that they no longer had a planned activity programme; they talked to people on the day and activities varied depending on peoples' choices. Staff told us that they played boules and took part in boules competitions, that they did quizzes, there was a regular church service and a hairdresser visited the home every Wednesday. We saw that activities undertaken by people were recorded in their daily records.

We asked people if they were consulted about their care and about how the home was operated. One person told us, "I am on the residents committee and we have residents meetings once a month. I once raised a concern about food and it hadn't happened again" and another person said, "I have filled in a survey." One person also told us that they would be happy to talk to the registered manager. They said, "Yes, she comes to my room if needed and pops in every so often." We saw that there was a suggestion box that invited people to share their comments and suggestions. These arrangements showed that people were consulted and asked to express their views, and that their views were listened to.

We asked people if they felt they had choice and control over their care. They all said that they did; one person told us, "Yes, I am a bossy lady!" Staff told us, "You have to weigh up the risks. We do try and give them as much independence as we can."

We checked the home's complaints log and saw that there had been no formal complaints since the last inspection. There was information displayed within the home about the complaints procedure; this explained what people should do if they were unhappy with any aspect of their care. People told us they knew who to speak to if they had a concern or complaint. One person said, "I would tell my keyworker or I would see [Name] who is very understanding. [Name] is a very good manager and she tries to fix things" and another person said, "Not sure – I am sure I could tell my key worker." Visitors told us that they would not hesitate to complain. Their comments included, "I would tell [Name] and would feel okay – I know nearly all the staff" and "I'd see whoever is in charge but I have never needed to". One relative told us that they had raised concerns with the registered manager; these had been looked into and there had been a satisfactory outcome. Another relative said that the registered manager and care manager were open and that this meant they felt they could be open with them. They felt sure that any concerns they raised would be put right by members of staff or the management team.

Staff told us that they would record any concerns or complaints that they became aware of, and would inform the registered manager or care manager. Staff said, "I would deal with the complaint myself if I could" but that the registered manager would be informed of any serious concerns. They told us that people's concerns and complaints were taken seriously and were listened to, and if there was any learning to be had, they would be discussed in handover and staff meetings.

A health care professional told us that they had discussed one issue with the home that appeared to be a misunderstanding between staff at the home and a health care professional. They had decided to set up a communication book so that information that needed to be shared was recorded, to reduce the risk of further misunderstandings.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) for a number of years; this meant the registered provider was meeting the conditions of their registration. This also led to the home providing a consistent service.

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

We asked for a variety of records and documents during our inspection. We found that these were easily accessible and stored securely.

We saw that there were clear lines of communication between the registered manager, the care manager and staff. The registered manager knew what going on within the service and about the specific needs of people living there. We asked staff how well the home was managed. They were very positive and comments included, "Lovely family" and "Well managed."

One visiting health care professional told us that there was a good management team at the home. They included the team leader in this comment – they said she was "Great" and was respected by other staff. However, another visiting health care professional told us that, although some staff were excellent, others were less professional. They said, "There may be a culture of not respecting the client enough and cultural change is hard to initiate." We noted that a meeting had been held with staff to address these issues. The agenda recorded that "Professionalism and working together as a good team" was the topic for discussion, and we saw that gossip, dignity, respect, professional boundaries and confidentiality were debated. There was also a policy and procedure in place on social skills. This advised staff about good communication, respect, building relationships and duty of care. This showed that the registered manager had taken these issues seriously and had made efforts to improve professionalism and the staff culture.

The registered manager said the culture of the home was "Family run and a homely environment" and "Approachable, open-door policy and to lead by example". We asked visitors if there was a positive culture at the home. One visitor said, "Yes, they are very good. [Name] has settled very well." Another relative described the atmosphere of the home as, "Friendly, welcoming, comfortable and relaxed." They added that relatives were made to feel part of the "Keldgate Manor family." A member of staff said, "There is a good culture at the home – open. The management and leadership is very good" and other staff told us that people were listened to and "Loved" and that the home was "Warm, friendly and happy." Staff also said that there was good communication and co-operation within the staff group.

Audits were carried out on various topics such as medication, infection control, care plans and nutrition; we noted that these were recorded in a report format rather than a checklist. The registered manager told us that they, the care manager and the assistant manager met every two or three weeks; they checked all care plans at these meetings and made any amendments they felt were needed. This ensured care plan entries were being monitored and care plans were kept up to date.

We saw that satisfaction surveys had been distributed to people who lived at the home in October 2015, and that ten had been returned. People had the option to complete the form anonymously if they wished to do so. People were asked if the staff were kind and caring and if they were kept waiting for long periods of time. Responses were positive although two people said they occasionally had to wait for assistance. Comments included, "Very happy with care" and "Never want for anything."

Health and social care professionals were also given satisfaction surveys, and a survey had been sent out to family and friends. Again, we saw that responses were positive and comments included, "All the staff have been lovely towards myself, my family and [Name]", "Staff are always keen to discuss up to date daily issues as needed" and "Maybe a bit more to do for those that can." One person had commented that the home would benefit from having more wipeable chairs, and the registered manager told us that these had been purchased. This showed that people's comments had been listened to and acted on.

Staff said that they attended monthly staff meetings and that these meetings were a 'two way process'. Information

Good

Is the service well-led?

was shared with them but they also got the opportunity to raise concerns, ask questions and make suggestions. They said that any complaints, safeguarding incidents or accidents would be discussed at staff meetings so that all staff were aware of any learning that was needed. We asked staff if there were any examples of how things had improved at the home following surveys, meetings, complaints etc. One member of staff explained about an issue that had been raised at a residents meeting and how action had been taken the next day to make the necessary improvements.

We asked the registered manager if there were any incentives for staff. We were told that they had introduced "Employee of the month" and that the employee was chosen by the home's committee.