Mr Jagath Nanda Kumar Adikaram and Mrs Antonia Adikaram

Rosewood Lodge Residential Home

Inspection report

4 Southfield
Hessle
Humberside
HU13 0EX

Tel: 01482641106

Date of inspection visit:
11 February 2016

Date of publication:
20 April 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?	Good

Summary of findings

Overall summary

Rosewood Lodge Residential Home is a care service that provides accommodation and personal care for older people, including people who may be living with dementia. It is registered to accommodate up to 20 people. The home is situated in a residential area of Hessle, close to the boundary of Hull, in the East Riding of Yorkshire.

This inspection was carried out on 11 February 2016 and was unannounced. The service was last inspected in January 2014 and the service was found to be compliant in all of the standards apart from requirements relating to workers. This was followed up in March 2014 and the service was found to be compliant.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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 assessed 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 had been put in place to minimise risk. 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, dignity and end of life.

The registered manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the Mental Capacity Act 2005 (MCA) guidelines had been followed. The home did not use restraint, but the registered manager understood the process to ensure that any restraint was lawful.

People's nutritional needs were met. People told us they enjoyed the food and that they had enough to eat and drink. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day.

People told us they were well cared for and we saw people were supported to maintain good health and had access to services from healthcare professionals.

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 decisions regarding their care. Staff were aware of the end of life process for people living in the home, recorded their views and wishes and held reflective debriefings following a person's death.

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.

People were 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.

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.

We found the registered provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support.

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 on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

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

The home had a robust system in place for ordering, administering and disposing of medicines.

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 we found the Mental Capacity Act 2005 (MCA) guidelines were being fully followed.

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 who used the service received, where required, 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.

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?

Good

The service was well led.

The service had effective systems in place to monitor and improve the quality of the service.

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.

Rosewood Lodge Residential 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 11 February 2016 and was unannounced. The inspection team consisted of one Adult Social Care (ASC) 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 commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR in the agreed timescale.

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

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 for three members of staff,

staff rotas and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

The registered provider had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authority's safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local authority's safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents. We saw the last concern was submitted in February 2016.

We spoke with staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to either the senior member of staff on shift, or the registered manager. One member of staff told us "If I saw anything that concerned me, I would report it straight to the senior or take it to the manager if I needed to." Another told us "I would speak with the manager or go to the safeguarding team." We viewed the service's training records and saw that all staff had received safeguarding training. This showed that staff had the appropriate knowledge and training to help keep people safe.

The registered provider had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs, including an assessment of risk for falls, nutritional status, continence, moving and handling and pressure care. We saw these were reviewed monthly and amended accordingly. We saw additional risk assessments had been carried out by the registered manager to ensure that people using the service, staff and visitors to the home were safe. These included environmental risk assessments for each area of the home including the garden and external environment, kitchen, bathrooms, bedrooms, and staircases. We saw Personal Emergency Evacuation Plans (PEEPs) were in place 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 us that the registered manager had taken steps to reduce the level of risk people were exposed to.

We saw that accidents and incidents were accurately recorded and audited monthly. The registered manager told us they looked for any reoccurring incidents and examined which staff were on shift, the location of any accident / incident, whether the person was ill or suffering from an infection and what action had already been taken to minimise risk.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas services, water temperatures, electrical items and all lifting equipment including hoists and the passenger lift. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm system, fire extinguishers and emergency lighting 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 that monthly audits of equipment were also carried out to ensure that any damaged, broken or dangerous equipment was repaired or replaced at the earliest

opportunity. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

On the day of this inspection we found there was the registered manager, two senior care staff, two members of care staff, a member of domestic staff and a cook on duty. We looked at staff rota's and saw that during the night, the service had two members of staff rostered on and the registered manager or a senior carer was on call. A member of staff told us "We are all pretty good at covering the rota if people are off sick or on annual leave" and "The manager adjusts staffing levels as she needs to; she will also work herself if we are ever short." One person who used the service told us "They only have two staff on a night and I worry that if they had two incidents at the same time would they be able to cope." We discussed this with the registered manager and they told us that either themselves or a senior carer were always on call and could be at the home within a matter of minutes. Our observations confirmed there were sufficient levels of staff to effectively meet the needs of the people using the service.

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 ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults.

We saw that interviews were carried out and these included additional questions to ensure that the applicant was suitable to work with vulnerable people. The questions included a discussion around any gaps in employment history, whether they had been involved in any disciplinary action in their previous employment and the reason they wanted to leave their current post. Staff were provided with job descriptions, terms and conditions of employment and information on staff rules and regulations, which outlined the registered provider's expectations of their staff. This helped to ensure staff knew what was expected of them.

Training records showed us that the registered manager and senior care staff had completed training in medication handling in the last 12 months. We saw that several care staff had also completed the training including three of the services night staff. This meant that medication could be administered at any time during the day or night without people having to wait for a senior carer or the registered manager to be available to administer 'as required' medication such as pain relief.

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 saw that a photograph of the person was featured on both the medication file and the person's medication administration records (MARs) to ensure the right person was given the right medication. We saw that a picture of each tablet was printed on the MARs to help staff identify the medicine; if a tablet was dropped or destroyed this would enable them to record this appropriately.

We looked at how medicines were managed within the home and checked nine MARs. We saw that medicines were obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. We saw that medication was stored securely in a locked cabinet and that there were also facilities available to store controlled drugs (CDs), although, at the time of this inspection, there were none held on the premises. We saw that as there were only a small number of

medicines that required refrigeration in use within the home, the registered manager had requested advice form the pharmacy, who informed them they were able to store these in a separate container in the homes kitchen. We saw that medication was audited monthly and additional random audits took place weekly to ensure that the all medication was accurately recorded and accounted for. We did note that on some occasions the temperature of the medication room had reached 23°C and this may need to be monitored in the warmer months to ensure that the medication is not stored above recommended temperatures.

During the inspection we found the home to be clean, tidy and free from odour. Infection control audits were completed on a monthly basis and we saw that there was detailed information available for staff on hand washing, mattress care and what to do in the event of an outbreak or suspected outbreak of an infectious disease within the home. Cleaning schedules included daily, weekly and deep cleaning tasks to be completed by the domestic and night staff. This showed us that the registered manager had considered the impact of infection for people in the home and had put interventions in place to minimise this risk.

Good

Is the service effective?

Our findings

The people we spoke with told us that they thought the staff had the skills to effectively carry out their role. One person who used the service said "They all know what they are doing" and "I've seen them all come in to do training which is reassuring."

We saw that as part of the induction staff were required to shadow more experienced staff for two weeks before they were included on the rota. The registered manager told us that for the first week, the new starters were required to watch what the role entailed and ask questions and then during the second week they started to carry out the different elements of the job. When the new starter felt ready and the registered manager deemed them competent then they were added to the rota and included as part of the staffing numbers. We also saw that regular reviews were held during the initial period of employment at weeks one, two, four, eight and 12 and that feedback was provided. This showed us that the registered manager recognised the need for a thorough induction. "

We saw that all new staff completed an organisational induction and were then expected to complete the Care Certificate within a twelve week period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives. It covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Following the completion of the Care Certificate, staff were enrolled on the National Vocational Qualification (NVQ) level 2 in care. NVQs are nationally recognised work based training courses. The registered manager told us staff were also encouraged to complete NVQ level 3. Training records we viewed confirmed this.

The registered manager explained that training was delivered through distance learning packages and also through face to face training for those topics that required 'hands on' knowledge, such as moving and handling. A member of staff told us "The moving and handling trainer came into the home and demonstrated how to safely move people using our own equipment." We spoke with staff and they told us that they received regular training in topics including, safeguarding, moving and handling, medication, infection control, health and safety, emergency first aid, equality and diversity and dementia. The service's training records confirmed this. We also saw that more specific training was also offered in topics such as challenging behaviour, dignity and end of life care amongst others. This meant that staff had the required skills to effectively meet the needs of the people they cared for.

Staff told us they felt supported by the registered manager and that they received regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. One member of staff told us "The manager is a great boss and they are always available if you need them" and "I have supervision about every 3 months." We looked at supervision records for three staff and saw that the last supervision recorded for two of them was in September 2015. We discussed this with the registered manager and they told us that annual appraisals had also been completed since this date. Records we reviewed confirmed this.

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 nobody was subject to a DoLS authorisation and the service had made no applications to the local authority at the time of the inspection. During this inspection we did not identify any practice that would constitute the need for a DoLS authorisation and from our conversations with the registered manager we were confident that if someone was deprived of the liberty the appropriate authorisation would be requested.

We saw that care plans recorded the decisions people were able to make and the types of areas that might require a best interest decision. We saw that consent was request for carrying out tasks described in the care plan, photography, consulting with other professionals and also the support people required to answer any questions or provide information. We saw that where people lacked capacity to make their own decisions, the decision maker was identified in the file.

Staff told us they had completed MCA training both during and after their induction and records confirmed this. During our discussions with staff, we found that they had the appropriate levels of knowledge regarding MCA for their roles. The registered manager told us that restraint was not used in the home and this view was supported by the staff we spoke with.

We saw that most people ate meals in the dining room, but some people chose to eat their meals in their bedroom or in one of the lounge areas. We observed the lunchtime experience in the main dining room and in one of the lounges. We saw that the tables were set with tablecloths and placemats and there were condiments available on each table. We saw that the lunchtime meal consisted of three courses and these were all prepared and cooked in the home's kitchen. This consisted of a soup starter, a choice of two hot meals and also a choice of one hot and one cold dessert. When people did not want either of the meals offered, we were told that the cook would always prepare them something different depending on their personal preference. We saw that staff were quick to offer support and provide assistance for those people who needed it and that this was carried out in a respectful and non-demeaning manner. We saw hot and cold drinks were provided throughout the day and that people were offered biscuits, fruit or a snack, in-between meals.

We spoke with the cook and found they were knowledgeable about the dietary requirements of people using the service. They were aware of people's likes and dislikes and told us how they adapted the menu for people who were unwell to ensure that they were offered foods they found palatable. They explained how one person had recently lost weight so they were providing them with a high calorie diet by adding cream and butter into meals and also through the use of supplement drinks. The cook told us "We work hard to ensure that no food is wasted. This means we listen to what people want to eat so we don't have to throw any food away. Because we are not wasteful it means I can buy whatever ingredients I want" and "I go out of

my way to ensure people are offered food they like; I've had some really good feedback which makes it worthwhile." One person who used the service told us "The food is marvellous, it's the highlight of my day" and "You can have a second helping if you want." Another told us "There's a choice of sandwiches on a night and you can also have fish fingers and chips and things like that." A visiting relative told us "The food is gorgeous" and "The soup is amazing."

We saw that the kitchen had daily, weekly and monthly cleaning schedules in place and that the temperature of fridges and food was taken daily. 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.

Nutritional risk assessments were completed by the service and we saw that these took into consideration 'people's weight', 'appetite', 'the support people required to eat', 'skin condition' and their current 'mental condition'. A score was given for each area and people were scored high, medium or low risk, with each rating triggering a new nutritional care plan. We did note that there was an error on the document and discussed with the registered manager that this could be a good opportunity to introduce the malnutrition universal screening tool (MUST), which is a more recognised nutritional assessment used in care settings. The registered manager told us they would consider this when reviewing the current assessment tool. We saw that people were weighed monthly or weekly depending on the plan they were currently on. When weight loss was identified, we saw that referrals were made to the GP or dietician.

People's care plans recorded their current health care needs, including details of their prescribed medication. Records we saw evidenced that health care professionals such as speech and language therapy (SALT) services, community nurses and chiropodists were involved appropriately in people's care. We saw that any contact with health care professionals was thoroughly recorded; this included the reason for the contact and the outcome. For example, where it was identified that a person required specialist pressure care, they received this from the district nursing team who visited the home twice weekly.

Good

Is the service caring?

Our findings

All of the people we spoke with told us the staff were kind, caring and knowledgeable about their needs. One person said "The staff are spot on as a whole." A visiting relative told us "The people here are nice, it has a personal feel to it" and "It's a home from home for him." Another relative told us "I think it's lovely" and "They are doing a great job."

Throughout this inspection there was a calm and comfortable atmosphere within the service. We observed staff interact positively with the people who used the service, showing a genuine interest in what they had to say and responding to their queries and questions patiently and providing them with the appropriate information or explanation. We saw people who used the service approached 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 they were given a choice about how their care was provided. They told us they were able to choose what time they got up in the morning and what time they went to bed. They told us they were given a choice of meals, where they sat and who they spent their time with. They also said they were able to decide what activities they wanted to join in with. One relative told us "[Name] decides what he wants to do; he decides when he gets up, when he goes to bed and what activities he wants to do."

We saw that staff were quick to assist people when they showed signs of distress. For example, during lunchtime we saw one of the people eating started to cough and became anxious. We saw staff approached the person calmly and spoke with them in a reassuring manner, rubbed their back and asked if they were okay. This reassurance enabled the person to settle and continue to enjoy their meal.

People who used the service were encouraged to express their views about the care they received. People we spoke with told us they would not hesitate in talking to someone if they felt unhappy about anything. Regular resident meetings took place and quality assurance surveys were distributed. People were also allocated a key worker who would meet up with the person every three months to discuss if they had any issues or concerns. We saw a photograph of the person's key worker was displayed in their room so they knew who to speak with if they needed anything.

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified state. They also ensured that they did not provide any care considered to be personal in the communal areas. People's rooms had their name and photograph on their door and on the back of the picture was a notice to inform other people that personal care was been carried out. This prevented people entering the room whilst people may be in a state of undress and encouraged people who did need to enter to knock before doing so. We saw a dignity and respect audit was completed by the registered manager. This was measured through observing staff interactions with people using the service.
We saw that people's rooms were personalised and contained photographs, pictures, ornaments and other

items that were important to them. We saw that if people wanted they were able to have a fridge in their own room to store items of food that they or their family had purchased on their behalf and this meant they could access these without having to rely on staff providing them. This promoted peoples independence and protected their dignity.

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.

Relatives and visitors were welcome at the home, were free to come and go as they pleased and stay as long as they liked. Some family members and friends chose to spend time in the home with their relatives, whilst others liked to take people out for lunch, a drink in a local café or to do some shopping in the village. One relative told us "I have a good relationship with the manager and the staff. They always offer me a drink when I visit, which is most days."

We saw that the registered manager recognised the importance of good planning for the care of people at the end of their life. An end of life champion had been appointed and their role was to ensure, when people using the service or their families wanted to discuss their end of life care, that this was accurately recorded. This information was recorded on an 'End of Life Care: Holistic Assessment'. The assessment examined people's personal information including whether the person had made any specific requests regarding who they wanted to be contacted, whether family wanted to be contacted during the night, what the persons physical / psychological needs were, any special needs or requests and also any spiritual needs, including, whether there were any associated rituals during the end of life process and following death. One person told us "I've made my plan; well they [the staff] need to know what you what want don't they."

We also saw the registered manager had implemented a 'Reflective Debriefing' document that was completed following the death of a person who used the service. The purpose of this document was to enable staff to reflect on how the person's death was managed and how this difficult process could be improved in the future. Staff were encouraged to consider what the person was like, what they remembered about them, what happened leading up to their death, what went well, what did not go well and how this made them feel. It also examined what could have been done differently and what the service needed to change as a result of the reflection. This showed us that the registered manager recognised the importance of seeking people's wishes for end of life care and for reviewing their systems and processes to improve the quality of care during the end of life process.

Good

Is the service responsive?

Our findings

We saw that pre-admission assessments had been completed by the registered manager or a senior care worker before people moved into the home on either a permanent or temporary basis. The registered manager told us, where possible, these were carried out with a relative or representative present to ensure that the information gathered was accurate. We were told that people were encouraged to visit the home before moving in to ensure that it was to their liking.

From the initial assessment we found that person centred, individual and very detailed care plans were developed. These were based on a care needs assessment tool that identified whether a person needed assistance with an area of care and whether this was a high, medium or low dependency need. Areas addressed in the assessment and care plan included personal support, moving and handling, mobility, continence, medication, mental health / challenging behaviour, mental capacity, decision making and DoLS, communication, religion / cultural needs, family and social relationships, management of money and pressure area care. Assessment tools had been used as part of the care planning process, including a nutritional assessment, pressure area assessment and a mental capacity assessment to identify a person's ability to make informed decisions. We saw that care plans were reviewed monthly or following any change in the person's needs.

In people's rooms we saw that there was a care plan summary on display, which provided a brief description of the person's care needs including roles for night staff, whether a DNAPCR was in place, important people in their lives, likes and dislikes, any activities they enjoyed and what they previously did for employment. This ensured that staff were aware of the person's needs and also had prompts to start a conversation if the person was new or the staff member had not met them before. A member of staff told us "The care plans contain lots of useful information."

We were told that the staff team delivered activities within the home and that people were kept up to date with any daily activities and upcoming events through an activity list which was displayed throughout the home and also in people's rooms. This ensured there was a visual reminder for people of what was happening. We looked at the activities on offer in February and saw it included an outside entertainer, quizzes, taster menu's, pancake day, giant jenga, bingo, pamper activities, cheese and wine afternoon, ball games, pub lunch, boccia and a shopping trip. We found the grounds of the home were well maintained and we saw that bird tables and feeders had been placed in the garden and also on people's windowsills to enable people to watch the birds feeding.

We noted there was not any day trips planned and discussed this with the registered manager. They told us that they had found that people did not always want to go out for the day when the weather was cold and wet so the service hired a minibus from March onwards to enable people to go out for day trips. They said that they still planned time for people who wanted to go out locally and this was included on the activity planner. This was confirmed through our conversations with people who used the service and visiting relatives. One person told us "We have a minibus that takes us out. We go out to places like Bridlington, Hornsea and stately homes, although the last outing was cancelled" and "They take me out into Hessle when the weather is nice." A relative told us "They will take him out if I ask them to. They take him to watch

the rugby."

We saw an activity log completed on a daily basis. This recorded the type of activity, who was involved, who declined the activity and comments on whether people had enjoyed the activity or the reason why they had chosen not to be involved. This enabled the staff to monitor and adjust the activities provided to try and offer something for everybody; although they acknowledged that some people were happy to watch television, read a book or listen to music.

We saw that people were encouraged to maintain positive relationships with members of their own family, their friends and also with the people they lived with. There were different areas within the home for people to sit in and we saw that people with similar interests chose to sit and spend time together and had become good friends. This was actively encouraged by the staff who had learnt the routines of people and were able to ensure that these friendships were appropriately supported. For example, two people liked to spend time together in one of the lounges. We saw that staff recognised they liked to have lunch together, so ensured that they both had their meals served at the same time. This helped promote companionship.

We saw that the service made efforts to capture the views of people who use the service. Quality assurance surveys were completed six monthly and we saw these had been completed regularly since 2007. The surveys included questions on what people thought of their rooms, the laundry system, care staff, management, food, garden, entertainment, hairdressing and they also asked what people would like to change. This provided people an opportunity to raise any issues that they felt the survey had not covered. People made a number of suggestions including, 'more outings', 'I wish we could have a pet dog or a cat' and 'I think we need more staff'. There were also positive comments made such as 'it's a change to be looked after instead of me doing the looking after'. We also saw records of resident meetings which were held three monthly. This was an additional opportunity for people using the service to express their views. We saw that discussion took place around key staff, care, support, and food. Although we were told that issues raised were followed up, we noted that this was not always recorded with a clear outcome.

The registered provider had a complaints policy and procedure in place and we saw that all complaints received had been investigated, responded to in writing and stored accordingly in the service's complaint file. We saw that one person was unhappy with how the staff had managed their relative's catheter. The registered manager investigated and found that the management of the catheter was not at an acceptable standard and put interventions in place to improve this element of care. This included additional training for staff, provided by the district nurse, and pictorial guides of how the catheter should look and also information on how to troubleshoot a blocked catheter. We looked in the person's room and saw that these were in place. This showed that complaints were taken seriously, investigated and used to improve the quality of care provided.

All of the people we spoke with told us they knew how to make a complaint and had confidence that it would be appropriately followed up. Staff told us they knew how to manage complaints and one member of staff told us they had reported a complaint to the manager, was aware that it had been recorded in the complaints file and that it had been actioned. Another member of staff told us "I've never received any complaints; if I did, I could look at the complaints procedure or just speak with the manager."

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since 2003. 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 could check that appropriate action had been taken.

The service was well organised and this enabled staff to respond to people's needs in a planned and proactive way. The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations 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 saw there were clear lines of communication between the registered manager and the staff and that a number of communication methods had been developed. These included team meetings, supervision, appraisals and a handover book. The registered manager told us they still worked care shifts to cover staff sickness and annual leave and this provided them with a clear insight into each person's needs. From our observations, we could see the registered manager clearly knew the needs of each person who used the service and throughout the day they spent time checking that people were okay and asking if they needed anything. People were comfortable in the registered manager's company and they had clearly developed a good rapport.

We asked staff if they felt able to discuss issues or concerns with the registered manager and we received positive responses. One member of staff told us "The manager is lovely. I have identified some issues in the past and they have always followed them up and made sure they were sorted out" and "They understand issues." A visiting relative told us "If I have any issues I speak directly with [The registered manager], they are very approachable and quick to address any concerns."

Relatives we spoke with told us that they were kept up to date with any issues relating to their family member. We saw communication with people's families was accurately recorded in the person's care file and relatives told us they felt confident contacting the home stating "[Name] loves watching western films. I check to see when they are on TV and phone the home to tell them to put it on for him." Another told us "It's always easy to get in touch" and "They let me know what is happening."

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. They told us there were regular residents meetings and keyworker meetings in place for people who used the service. They explained that while some people were quite happy to contribute in a larger meeting, others were more reserved and preferred a less formal, one to one setting in order to express their views and opinions. We saw that these meetings were recorded and any issues raised were addressed by the registered manager.

In addition to team meetings and supervision, we saw that annual appraisals were held for all staff. We saw these reviewed the staff's attributes relating to their role. This included reliability and commitment, quality of work, initiative and enthusiasm, ability to follow requests, attendance and training, attitude and ability to deal with responsibility. Feedback was provided which identified areas for improvement and also highlighted areas of strength.

There was a quality monitoring system in place that consisted of weekly, monthly and annual audit tasks, meetings, questionnaires and analysis of the information collated from these, followed by action plans being produced to address any areas identified as requiring improvement.

Stakeholder surveys were carried out for people using the service, relatives, health care professionals, and staff. We saw that the results were largely positive, and where negative feedback had been received, we saw plans had been put in place to address this. However, it was not always clear what timescale had been set and whether the intervention put in place had resolved the issue. We discussed this with the registered manager who agreed that they would ensure that this was addressed. We also noted the last staff survey was completed in 2013. Although other methods were available for staff to express their views, we spoke with the registered manager about how the anonymity provided by a staff survey could provide more honest and useful feedback.

We saw audits were carried out to ensure that the systems in place at the service were being followed and that people were receiving appropriate care and support. Audits included infection control, dignity and respect, nutrition, end of life, accidents and incidents, pressure care, hospital visits, equipment maintenance, care plans, recruitment, end of life and medicines. 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.

Resources were available to develop the staff team and drive improvement within the service. We saw that staff were required to complete their NVQ Level 2 and were encouraged to complete NVQ Level 3. We saw that there were opportunities for staff to develop their skills and take on roles that carried greater responsibility. A senior carer we spoke with said, "I am currently doing a team leader course" and we also saw that another of the senior staff had recently started to work alongside the registered manager for two days per week to learn about the day to day running of the home and provide some support with the home's administrative tasks. We saw feedback forms had been introduced to enable people looking around the home with a view to moving in, to comment on what they thought. We were told that this provided additional insight into people's initial opinion of the home and had helped raise standards.

The registered manager told us they worked closely with relevant healthcare professionals such as the speech and language team, district nurses, occupational health and community psychiatric nurses (CPN) to ensure people received care and treatment in line with best practice guidance.