Barchester Healthcare Homes Limited

Castle Rise

Inspection report

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Ratings

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

Overall summary

Although Castle Rise is registered to provide up to 40 people with nursing care needs, the new manager told us they never went higher than 35 people. Eight of the beds were contracted by the local Clinical Commissioning Group [CCG] as a step down measure to facilitate early discharge from hospital until support in the community was organised. The remaining 27 beds were for people with ongoing nursing care needs. Castle Rise is situated in a residential area, close to shops and bus routes into Hull. Bedrooms are provided over two floors accessed by a passenger lift and stairs. Communal rooms consist of three sitting rooms and two dining rooms. There is also a hairdressing salon. The grounds are accessible to people with mobility difficulties.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care

Summary of findings

Act 2008 and associated Regulations about how the service is run. There is a new manager in post who is currently collecting information ready to apply for registration with CQC. Throughout the inspection report they will be referred to as 'the new manager'. Our methodology is that the question 'Is the service well-led' cannot be rated higher than Requires Improvement if the manager is not registered with CQC.

There were 29 people using the service on the day of the inspection.

We undertook this unannounced inspection on the 2 and 3 November 2015. At the last inspection on 22 July 2014, the registered provider was non-compliant in the safe management of medicines. We issued a compliance action for this area and received an action plan which told us what the registered provider was going to do to address it. At this inspection we found improvements had been made and the registered provider was compliant with medicines management. We found people received their medicines as prescribed and the few minor recording issues found were discussed with the new manager to address with staff.

We found people's health and nutritional needs were met but there were some deficits in monitoring some people's fluid intake and the use of specific equipment for treating a health care need. This was being addressed by the new manager.

We found the registered provider worked within the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] with regards to making applications to the local authority when people who lacked capacity were deprived of their liberty. However, there had been at least two occasions when a person who lacked a capacity had received treatment they were unable to consent to and general MCA principles were not followed. They had not had a capacity assessment and best interest meeting to discuss whether the treatments were in their best interest. We found lots of other instances when MCA principles were followed which meant there was a lack of consistency. The recording of some decisions made in people's best interest could be improved.

We found staff were recruited in a safe way and in sufficient numbers to meet the needs of people who used the service. Two people told us they had waited longer than expected for call bells to be answered, although this was not on every occasion. The new manager told us they would monitor this situation and check out issues with people who used the service and staff.

We found the communal areas were clean and tidy; however we found concerns in one of the sluice rooms, two bedrooms and with some wheelchairs that required cleaning.

Staff had received training in how to safeguard people from the risk of harm and abuse. It was unclear if all staff in charge of shifts were familiar with procedures for alerting incidents of abuse to the local safeguarding team. The new manager told us they would address this with staff. There were assessments in place to guide staff in how to minimise risk.

We saw staff had developed good relationships with people who used the service and treated them with dignity and respect. We saw people had their needs assessed prior to admission and plans of care were produced so staff had guidance in how to deliver care that met their preferences and wishes. We saw people participated in a range of activities to promote their interests and help prevent them from feeling isolated in the service. Staff also helped them access community facilities.

Staff had access to a range of training in order to meet people's needs. They also received induction, supervision, support and appraisal in order for them to feel confident when supporting people. There was a system to identify when refresher training was required and plans were being prepared to ensure new nurses updated their clinical skills when required.

There was a quality assurance system in place that helped to identify shortfalls so action could be taken to address them. People told us they felt able to complain and staff had a policy and procedure to provide guidance in how to manage them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff were recruited safely and there were sufficient numbers on duty for each shift. However, some people who used the service described a longer than expected wait once they had called for attention. The new manager told us they would address this.

People received their medicines as prescribed. Some minor issues with recording were mentioned to the new manager to address.

Communal rooms and bedrooms were clean and tidy. Equipment used in the service was safe, however, there were issues in the sluice room and several wheelchairs required cleaning.

Staff knew how to respond to keep people safe from harm and abuse. There had been one occasion when a risk assessment and care plan had not been adhered to which had resulted in the person sustaining an injury.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were provided with a varied and nutritious diet and they had access to a range of community professionals to help meet their health care needs.

However, there were some inconsistencies regarding the monitoring of some people's fluid intake and specific use of tailored equipment. This made it difficult to check if their needs were fully met.

Generally the registered provider followed the principles of the Mental Capacity Act 2005 when assessing capacity and making decisions in people's best interest but this had not been applied consistently for everyone. Applications to deprive people of their liberty had been submitted appropriately.

Staff received induction, training, supervision and appraisal to help develop their skills and experience in caring for people with complex needs.

Is the service caring?

Good

The service was caring.

Staff had developed good relationships with people who used the service. We observed staff approach to be kind and caring towards people.

People's privacy and dignity was respected and they were involved in decisions about their care and treatment.

People were provided with information and explanations to help them make their own choices.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People had their needs assessed and plans of care were developed in order for them to receive person-centred care.

There was an activity co-ordinator who helped to plan social stimulation and ensured people were involved and included in activities in-house and in accessing community facilities.

People felt able to complain and there were procedures for staff in how to manage complaints.

Is the service well-led?

Requires improvement 

The service was well-led.

There was a new manager in place, however they are not yet registered with the Care Quality Commission and our methodology is that this section cannot be rated higher than Requires Improvement until registration is completed.

The new manager had made a difference to staff morale and staff told us they felt supported and could take concerns to her in the belief they would be addressed.

The culture of the organisation was described as open and focussed on providing a quality service to people.

There was a quality assurance system in place that consisted of obtaining people's views, and completing audits, checks and action plans to address shortfalls; the system involved a range of staff.

Castle Rise

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 took place on 2 and 3 November 2015 and was unannounced. The inspection team consisted on one adult social care inspector and an Expert by Experience [ExE]. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE who accompanied us has experience for caring for someone living with dementia.

Before the inspection, the provider completed a Provider Information Return [PIR]. 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.

We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection we spoke with local authority contracts and commissioning teams and a health professional about their views of the service. There were no concerns expressed by these agencies. We also spoke with the local safeguarding team who advised there were some on-going safeguarding alerts that were still being investigated.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with three people who used the service and four people who were visiting their friends and relatives. We spoke with the new manager, a nurse and two care workers at length and three other care workers about support systems within the service.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 19 medication administration records [MARs] and monitoring charts for food, fluid, weights and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Requires improvement

Is the service safe?

Our findings

People who used the service were asked if they felt safe living in Castle Rise and whether there was enough staff to support them. People told us they received their medicines on time. Comments included, "You have only got to shout and the girls are here, but they won't let me go out on my own as I could fall", "It's not too bad, it all seems under control", "I know she is safe; the staff are so caring with her, they always have time", "There seems to be a lot of them about, some familiar faces which is good for Mum", "Staff are sociable but they don't have a lot of time" and "The staff are pretty good and keep an eye on him." People also said, "I get medicines in a morning; staff bring me them", "I get all sorts at the right times", "Staff give medications on time as far as I know" and "She gets medications and she gets given them at the right times."

One person described how another person who used the service came into their room, which upset them. They described how they rang the bell and staff responded quickly to support the person back to their own bedroom. Two people told us staff answered call bells quickly but they told them they would return in a few minutes, however this could be up to half an hour. These points were mentioned to the new manager to check out what measures could be put in place to prevent a reoccurrence of the incident and also for staff to be mindful of response times to call bells.

One relative told us they thought there was not enough staff and they were 'owed' one to one hours. We checked this out with the new manager. They told us the person had recently been awarded an increase in one to one hours funded by continuing health and recruitment was underway for a member of staff to fulfil this role. Some hours were filled by existing staff but it had not been possible to cover all the hours. The hours 'owed' would be addressed as soon as possible.

We found staff were recruited safely and all employment checks were completed prior to them starting work. This included a check of application forms for gaps in employment, obtaining references, completing disclosure and barring checks and an interview. There was a system in place to check that qualified nurses had current registration with the Nursing and Midwifery Council.

There were sufficient staff on duty to meet the current needs of people who used the service. The new manager told us they used a tool to calculate the numbers of staff required based on the dependency needs of people who used the service. Staffing rotas, which were confirmed as accurate by staff, indicated there were two nurses on duty during the day and one at night. The new manager was also a qualified nurse and worked in the service five days a week. There were six care workers during the morning shift, four in the afternoon/evening shift and three at night. An activity coordinator worked 10am to 5pm, five days a week. There were domestic, administration and maintenance staff on site. The laundry was situated on the main Castle's site and items were collected and delivered each day. The ancillary staff meant care workers could focus on delivering care tasks. As the registered provider had other service in close proximity, there was the potential to obtain staff cover to address short notice absences. A health professional said, "When I visited the service two weeks ago, there were plenty of staff on duty."

Some people who used the service received one to one support funded by health or the local authority. We saw there were separate rotas for the staff who supported with one to one care.

We found people received their medicines as prescribed. This had been a concern at the last inspection in July 2014, however we found improvements had been made. We saw each person had a laminated sheet at the front of their medication administration record [MAR]; this included information about the person, their photograph, any allergies, who their GP was and importantly how the person took their medicine. A copy of the most recent prescription was held with the MAR as well as any specific information such as blood tests results that affected the dosage of some medicines. We saw, on the whole, there were protocols in place to guide staff for the use of 'when required' [PRN] medicines. One person lacked a protocol for a medicine prescribed for PRN use when they were agitated and there was some confusion over the date to reduce another person's short term medicine. However, we saw staff had contacted the GP for directions and were awaiting a reply. The lack of a protocol, and some minor recording issues, were mentioned to the new manager to address. Medicines were stored appropriately and systems were in place to make sure people did not run out of them.

Requires improvement

Is the service safe?

Nurses checked stocks and administration of controlled drugs and recorded these accurately. A health professional said, "The MARs were completed properly and treatment rooms, where the medicines were kept, were locked."

Risk assessments were completed for the environment and for individual people's needs. These included moving and handling, falls, the use of bed rails, nutrition, choking, skin integrity and issues affecting behaviour. Staff told us they were aware of risk assessments and important information was handed over to them when shifts changed over each day.

There were safeguarding policies and procedures to guide staff in how to safeguard people from the risk of harm and abuse. In discussions, staff knew the different types of abuse and what the signs and symptoms could be. Some staff were not sure about the alert procedures with the local safeguarding team should they be in charge of shifts. This was mentioned to the new manager to address with staff. The new manager was aware of local safeguarding procedures; they told us they were to attend the next available training course on the use of the safeguarding risk matrix tool. They had completed alerts to the local safeguarding team as required. We saw there had been an incident when staff had not followed risk assessment and care plan guidance for one person which had resulted in an accident and injury to them. The new manager had informed the local safeguarding team about this and put measures in place to prevent a reoccurrence such as supervision and re-training for staff.

We found communal areas and people's bedrooms were clean and there were no malodours. We found some minor issues in two of the bedrooms which were mentioned to the new manager. However, we found some areas of concern in the sluice room and one of the two bed pan washers had been out of action for some time; this had led to staff overfilling the remaining washer which had affected the efficiency of the machine. Some of the commode pans ready for use were dirty. The new manager told us quotes had been obtained for the repair of the second machine and they were awaiting this to be completed. It was highlighted that some wheelchairs were in need of cleaning and these were put on the schedule of actions for maintenance personnel. We saw the service had policies and procedures on how to manage infection control. Staff had completed training and were familiar with guidance on preventative measures. There were hand hygiene signs near sinks as a reminder of good hand washing techniques and a range of personal protective equipment was available.

Equipment used in the service such as the nurse call, fire safety, moving and handling, bed rails, air flow mattresses, the lift and gas and electric appliances were serviced and maintained. Maintenance personnel completed checks on hot and cold water outlets to ensure the correct and safe temperatures were maintained.

Requires improvement

Is the service effective?

Our findings

People who used the service said they were able to make choices about aspects of their lives and they felt staff knew how to look after them. Comments included, "I am in control as I have got all my faculties", "I can go to bed anytime", "I have seen them ask her permission", "Yes, I am involved", "They always ask me; I leave everything to them, they are the people who know what they are doing", "I think the carers know what they are doing; I don't see them use the hoist as I leave the room; from what I have seen they are pretty good" and "Carers help him with everything." One visitor said, "I think some staff know what to do; I feel they could do with a lot more dementia training." The new manager told us a review of the dementia care training was currently underway.

People told us they liked the meals. Comments included, "I get breakfast any time I want", "The staff come and ask what I want for lunch and tea; the food is good", "Last night's meal was nice." Visitors said, "There are good choices and it always looks very nice." One person told us their meal was cold one evening and there was no custard sent with the desserts on one occasion so they had to go without. Another said they didn't like carrots but they kept getting them. We observed two people's lunch were placed on a table in front of them but it was cold before they got round to eating it. One visitor raised a concern that it was recorded their relative was offered a sandwich when they were on a soft diet and they were concerned about their fluid intake. Another visitor felt their relative should have more fluids. When we checked fluid monitoring records, the person had received low amounts of fluids on some days. It was unclear whether staff had not documented all the fluids the person had received on specific days or whether they had been offered and declined. These points were mentioned to the new manager to check out and also to ensure staff accurately recorded people's fluid intake when this was being monitored. The new manager stated they were aware it was sometimes very difficult to ensure the specific person had all the fluids they required and they will discuss with staff how this could be improved.

Meals were prepared in the main site kitchen and delivered to the service in hot containers. We saw there were menus which provided choices and alternatives at each meal. There was also a selection of food in tins, boxes of cereals and ingredients for sandwiches held in the kitchen in Castle Rise to extend choice for people. A 'grazing tray' was sent from the kitchen each day with finger foods. There was a juice machine and water dispenser in the dining room downstairs. We also saw fresh jugs of water and juice were delivered to people who remained in their bedrooms and we observed hot drinks provided to people throughout the day. We saw people were supported to eat their meals in a sensitive way and at a pace appropriate to their needs.

People's nutritional needs were met via the menus and with food supplements when prescribed. Risk assessments regarding nutrition were completed and dieticians involved when required. People were weighed in line with the risk identified in their assessment. Some people were unable to take their nutrition orally and received it instead through a tube directly into their stomach. The nurses monitored these people and set up the feeds each day or night. They liaised with a specialist gastrostomy nurse and dieticians to ensure the feed regime continued to meet people's needs.

We saw people had their health care needs met. People who used the service told us they were able to see their GP when required and the nurses dealt with some issues. Comments included, "They have called a GP, as she has some discomfort in her lower back", "They saw a doctor about a month ago" and "He sees a GP if needed and saw him this morning, and he sees a physio too." One person told us they had not had to see a GP yet but they had complained their feet were swollen and the nurse had provided a foot stool to use. Care records indicated people who used the service accessed a range of health care professionals. They also attended outpatients departments for tests and to see consultants when required. We saw one person required to have leg splints on for several hours a day, however some staff were more vigilant than others in recording when this took place so it was difficult to audit properly. The new manager told us they would address this with staff.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. We found the registered provider generally followed the principles of MCA but had not done so on two occasions for one person

whose care records we looked at. For example, their care file indicated they had had their ears syringed this year and a screening procedure carried out last year and they would not be able to consent to these procedures. There was no record an assessment of capacity had taken place regarding the person's ability to understand these procedures and consent to them and no best interest meeting had taken place.

We also found capacity assessments had taken place for other people but the record to evidence decision-making under best interest did not have a clear decision documented. The new manager had compiled a list of which relatives had lasting power of attorney [LPA] to make decisions for people who lacked capacity for either, or both, finances and health. When we checked the care records for one of these people, whose relative had made a decision on their behalf, we could not locate the LPA so it was difficult to check the extent of the powers conferred on them. The new manager told us they will request copies of all LPAs.

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 the registered provider had appropriately submitted applications to the 'Supervisory Body' for authority to deprive specific people of their liberty and were awaiting authorisation. Most staff had received training in MCA and DoLS.

Staff confirmed they had supervision meetings and appraisal. They told us they completed a range of training considered essential by the registered provider and also those related to the needs of people who used the service; each member of staff had a personal development plan. A record identified when refresher training was due. There had been a change of nursing staff recently and some had not completed specific clinical training; this was being arranged. There was an induction booklet for new care workers and a separate one for nurses. These included what training had to be completed, competency checks and reviews at intervals to assess progress. The care worker induction booklet was linked to induction standards as part of the new care certificate.

We found the environment was suitable to meet people's needs. There was pictorial signage for bathrooms and toilets and bedroom doors had names and pictures on to assist people living with dementia to identify their room. The service was accessible to people who used wheelchairs and who had mobility difficulties; there was a lift to the second floor, wide corridors and easy access to the garden. There were assisted baths, shower rooms, and grab rails and aids in most of the bathrooms and toilets. We did notice one communal toilet was without any aids such as a grab rail or a raised toilet seat, which was mentioned to the new manager to address.

Good

Is the service caring?

Our findings

People told us they liked living at the service and staff treated them well. They also said staff respected their privacy and dignity. Comments included, “I would give it eight out of ten; the lasses work bloody hard and they are very efficient”, “The staff are really good, they wash me”, “Every time they come into the room they knock”, “The way they do things for me, they are caring” and “I think they are all caring.” Relatives said, “He seems quite happy here; the staff are nice”, “I do [think staff are caring], they all seem to have a lot of time for people - you can see the way they talk to her”, “I generally would say the staff are caring by the way they talk to her”, "They are all so friendly and I am pleased at how he is improving” and “They always shut the door when personal care is done; he is comfy with the staff.”

One visitor told us that when her relative was admitted, care staff sat with her from 5pm to 11pm to help her to settle in. They also said the new manager had taken home the clothes she had brought with her from the hospital and washed them for her.

One visitor told us how their relative had long nails that could have been cleaner and they indicated their face could be washed more thoroughly. This was discussed with the new manager to ensure staff were more vigilant and documented when care was declined so relatives could be informed.

We observed staff involving people who used the service and positive interactions between them. The staff knew people’s names and those of their relatives and were observed speaking to people in a kind and patient way. Staff gave explanations to people prior to performing any tasks, for example we observed a nurse give people their medicines; they spoke to people, provided a drink for them and coaxed them to take them in a professional way. During lunch, staff were supporting people to eat their meals at an appropriate pace, chatting to them and encouraging them where possible to be independent. This was achieved by providing special plates with raised sides and we saw staff assist one person by placing food on their fork and handing this to them so they could manage themselves.

A health professional said, “I have witnessed staff engaging with service users; there have been no concerns from families.”

Staff spoke to us about how they promoted people’s privacy, dignity and independence and gave examples of good practice. They said, “We keep people covered and curtains closed during personal care”, “We try to get people to do as much as they can for themselves and not assume they can’t wash parts of their body” and “We keep things confidential.” We saw staff asking people if they wanted large napkins as protectors for their clothes at lunchtime and we observed staff knock on bedroom doors prior to entering. We saw doors were closed when personal care was taking place inside bedrooms and bathrooms. We saw two people had voile curtains in place at the doorway to their bedroom. This was because the occupants liked to have the door open when they were in bed but there was the potential for covers to be kicked off, which could affect their dignity.

We observed there was a potential to compromise people’s dignity during personal care tasks as some bedrooms, bathrooms and shower rooms did not have privacy locks. This was mentioned to the new manager to address with signage until locks could be installed. There were two stall-type communal toilets on each floor but the new manager told us funding had been agreed to replace and update them.

We saw care plans reminded staff to respect privacy and dignity. We also saw care plans indicated when people were able to do specific tasks for themselves to maintain their independence. The care plans involved people in decisions and it was clear they had been written following discussions with people who used the service and their relatives. The care plans contained preferences, likes and dislikes. The service had a ‘life skills’ kitchen at one end of one of the dining rooms which had low work surfaces; this was used to assist people in regaining specific skills prior to returning home or for those people who wished to take part in activities such as baking.

We saw people were provided with information. There were notice boards in the entrance and corridors with information about staff, activities, advocacy services and how to make a complaint. Menus were on a stand in the entrance, some of which were in pictorial format. There was a payphone in the entrance and coffee machine facilities for visitors. We saw the new manager had displayed the Care Quality Commission’s overall rating for Castle Rise which was awarded after the inspection in July 2014.

Good

Is the service caring?

The new manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. People's care files were held securely in one of the staff offices. Medication administration records were secured in the treatment rooms. The new manager confirmed the computers were password protected to aid security. Staff records were held securely in lockable cupboards in the new manager's office.

Good

Is the service responsive?

Our findings

We asked people who used the service [and their relatives] whether they received care that reflected their preferences and whether there were activities for them to participate in. Comments included, "Care seems okay but I have only been here a few days", "They ask her and they try to persuade her; I have seen this", "I see him every day and I make sure he gets the care", "Carers take him out shopping and they have taken him to the Cinema", "They have not been in long; hopefully they are taking her out today" and "None, [activities] but I've only been here a few days."

We also checked with people whether they felt able to raise concerns. Comments included, "I would tell the nurses but have never had to", "I would see [new manager's name]; I have no complaints" and "I would find the manager." Two visitors felt staff listened to them but it took longer than expected to address some issues.

We saw people had assessments of their needs and risk screening prior to admission, which were checked and updated following admission. Full risk assessments were completed during the first few days of admission as staff got to know people. There were some people who were admitted into health-funded step-down beds directly from hospital and the new manager told us it was not always possible to complete a full assessment of their needs but they always completed documentation to provide them with sufficient information to establish that their needs could be met within the service. Some dates were missing from assessments so it was difficult to audit when they had actually been completed. This was mentioned to the new manager to address with staff. We saw the assessments had been completed with relevant people such as the person themselves, relatives and health and social care professionals. We saw copies of assessments completed by social workers included in people's care files.

We saw staff developed care plans from the information gathered during assessments. The care plans for people in long term care contained information about how risks were to be managed, how people preferred to be cared for, what their likes and dislikes were, and what they were able to do for themselves. The care plans were written to guide staff in providing person-centred care. For example, one care plan described how the person's finger nails were to be well-maintained as their skin was fragile. Another described the distraction techniques staff were to try to support the person with a specific issue. A third had a short term care plan to guide staff in how to support the person following an injury to their leg. We saw one person remained in bed every day due their physical health condition but a recent assessment by occupational therapist had resulted in the ordering of a specialised chair for them. The new manager told us it had been a long wait for the chair and they were looking forward to the time when the person's quality of life could be improved.

Staff told us they were responsive to people's needs and were mindful of their right to make their own choices. For example, they said some people often chose to remain in bed until late morning. They said they always ensured they had a drink and were offered either a late breakfast or other food throughout the day to make up for not having breakfast if they arose too near lunchtime.

The care plans for people in hospital step-down beds were not as developed as their admission was short-term. The one we saw could have included more information about care needs; however, this was addressed straight away by the new manager.

There was an activity co-ordinator who worked at the service five days a week. Records indicated the range of activities available for people. These included, activities in-house such as bingo, film sessions, reminiscence, games, music and sing-a-longs, nail pampering, craft work, quizzes, card school, baking and entertainers; these were carried out in groups or one to one with people. The new manager told us they had 'butterfly days' which involved short activity bursts to support people living with dementia who had difficulties with maintaining concentration. We saw some people had also been out shopping, to the cinema, to Hull fair, on trains to Beverley, to a small animal farm at a local park and bowling. Seasonal parties and activities were arranged such as pumpkin decoration for Halloween, a Christmas party, singers, and a trip to the theatre was planned to see a pantomime. The activities that people participated in were recorded in their care files. It was clear some people participated in more activities than others.

We heard the activity co-ordinator asking people if they wanted to play bingo and advising them there was a craft activity in the afternoon; they also asked if anyone wanted to go out to the shops. We observed a game of bingo taking place with eight people who used the service and three care workers; the staff were talking to people and assisting

Good

Is the service responsive?

them to play. We also observed the activity co-ordinator confirm to a person they would take them out the following week to see the new James Bond film. On the second day of the inspection, we observed staff playing dominoes with people.

We saw there was a 'resident of the day' schedule. This was to ensure each person who used the service was able to voice a specific wish or activity and staff would endeavour to complete it to make the day special for them. This may be a trip to the cinema or a specific meal.

The new manager told us visitors were welcomed at any time and they encouraged people to maintain contact with family and friends.

We saw bedrooms were individualised with pictures, ornaments and personal items. Some bedrooms had additional small pieces of furniture, shelves and fridges. Bedroom doors had names and personalised pictures on.

There was a complaints procedure on display in the service. This described how people could make a complaint and how to escalate it if required. The staff had a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome. There had only been one complaint in the last 12 months as a result of anonymous information sent to the Care Quality Commission. We found this had been checked out thoroughly by the new manager in a timely manner and we were sent an outcome report. We were happy with the way the complaint was investigated and recorded. People who used the service and staff told us they felt able to raise concerns.

Requires improvement

Is the service well-led?

Our findings

There had been several changes to the management of the service in the last 18 months; this had led to inconsistences. However, a new manager had been in post for seven weeks at the time of the inspection. Our methodology is that the question 'Is the service well-led' cannot be rated higher than Requires Improvement if the manager is not registered with the Care Quality Commission [CQC]. This is because it is a condition of registration that the registered provider must have a manager that is registered with CQC for this service.

People who used the service and their relatives knew who the new manager was and how to access them when required. Comments about how well the service was managed included, "Yes, they are pretty good all round", "It seems okay but I don't know enough" [the person had only recently been admitted], "I think [manager's name] is wonderful; she has always got time for me and I can ring her day or night" and "I suppose it is well-managed."

One visitor told us there was a poster in their relative's bedroom stating who their key worker was but they felt this was incorrect. They said, "This carer has little to do with mum." This was mentioned to the new manager to check out if all the key worker posters in bedrooms were accurate.

The new manager told us systems had been put in place to ensure they received adequate support during their induction phase. Registered managers, from the registered provider's other locations nearby, and senior managers visited the service to discuss how they were settling in and to talk through issues. The new manager described the culture of the organisation as supportive and open; the vision of the organisation focussed on quality and 'providing our residents with first class care'. The new manager said, "Staff feel there is support and structure and relatives feel this", "People are treated as individuals; staff encourage choice are very good at going and getting things for people" and "I am approachable and firm but fair; I do expect everyone to be looked after as if they were my own mum."

The new manager said that staff were valued by the organisation and there were some reward schemes to help retain them. These included a bonus if a member of staff showed a potential resident round the service and they then chose to be admitted. There was long service recognition for staff at 10, 15, 20 and 25 plus years. Staff received a £250 voucher, a buffet was organised for them and they were presented with a small commemorative gift. The new manager told us staff morale had improved.

Staff spoken with were very positive about the changes the new manager had made in such a short time. Comments included, "It's totally different now; we feel more supported", "[Manager's name] has high standards and is implementing changes", "We have raised concerns and she has done something about them; she is on the ball", "The manager is more consistent and she keeps things confidential" and "She is approachable and you know you are listened to." There was an on call system to support staff out of usual working hours.

We saw staff were able to raise concerns in meetings and supervision sessions. There had been meetings in July 2015 and one in October 2015 after the new manager started. The meetings included full staff meetings and also those for clinical staff. The minutes showed us the topics discussed were the staff survey, policies and procedures, dementia care training review, introduction of a care practitioner role and daily update meetings. The new manager told us they had '10 at 10' meetings; these were short catch up meetings for ten minutes for specific staff on shift to exchange information and update the nurse in charge and new manager. A representative from the domestic team attended these short meetings. There were other means of cascading information and communicating issues such as shift handovers and a communication book.

There were joint meetings for people who used the service and their relatives. We saw very few relatives attended the meetings, which may have something to do with the timings of them or they were happy with the service and didn't feel the need to attend. The minutes of these meetings showed us issues such as activities, upcoming events, outings, plans for Christmas and an opportunity to express concerns were discussed. One visitor told us, "I attended one relative's meeting; I think they are once or twice a year and they tell us about outings." Two relatives told us they had not completed any surveys. The new manager told us they were looking at alternative ways of seeking the views of relatives other than at annual care plan review meetings. They spoke about setting up 'exit surveys' to find out people's experience of using the

Requires improvement

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hospital step-down beds and respite service. We saw some suggestions made by people who used the service and their relative were displayed in the service in a 'You said, we did' poster.

We saw there was a quality assurance system in place that consisted of audits and checks by staff at different levels. For example, there was a schedule of audits and qualified nurses had specific lead roles. Topics included health and safety, medicines, infection prevention and control, 'the lived experience' for people who used the service and documentation. The new manager completed a 'manager's quality assurance tool' every three months and the registered provider's quality team completed bi-monthly 'Quality First' visits over two days at the service. We saw a central action plan was produced from the audits and timescales set for achieving goals. A traffic light system was used to prioritise actions and the plan was visited by the new manager at intervals to check progress. The new manager said this central action plan was reviewed by the organisation's quality team to ensure steps were taken to address shortfalls. The action plan was also accessible to the registered provider's chief executive officer.

The new manager showed us records of two unannounced spot check visits she had completed to the service in October 2015. These included checks on safety of the premises, accidents, staff uniform, medicines records and monitoring charts for food, fluids and repositioning. She said it was important staff understood she would make checks at any time and expected good standards of care.

The new manager was aware of their responsibilities in reporting to the CQC, incidents that affected the welfare of people who used the service. They also understood the importance of analysing accidents and incidents to learn from them. They told us the registered provider's quality team monitored the accidents that were recorded on the computer system and contacted the new manager to check out how they had been managed.

We saw systems had been set up to ensure a smooth transition of people when they moved between services, for example when they were discharged to Castle Rise from hospital into step-down beds. Links had been made with continuing health care professionals, occupational therapists, hospital discharge liaison nurses and hospital and community social work teams. The new manager told us sometimes people can have to wait in step-down beds until care packages in the community are organised for them; the length of time can depend on the availability of community support services. They also told us that they considered the impact of people being admitted to Castle Rise and tried to ensure issues such as equipment, dynamics of current people living at the service and staff skills were resolved beforehand.