Embrace (UK) Limited

Hawkesgarth Lodge

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 28 April and 29 April 2015 We revisited to carry out further inspection activity on the 13 Aug 2015. All inspection visits were unannounced.

Hawkesgarth Lodge is registered to provide nursing and personal care for up to 48 older people including people who live with dementia. The majority of the bedrooms are on the ground floor with easy access into communal rooms and outdoor patio areas.

At the time of the original visit there was a registered manager in place. However that registered manager left on 21st July 2015. During our second visit there was a new acting manager in place who informed us they were taking up the permanent position from the 1st September 2015 and would begin the registration process then.

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.'

Summary of findings

The home provided safe care and people who lived there and their relatives told us they felt safe. Staff were trained in safeguarding requirements and could articulate what abuse was and what actions they should take if they saw or suspected abuse. The service was working within the principles of the Mental Capacity Act 2005.

There were good personal assessments of the risks associated with people's individual care. The home paid good attention to ensuring the premises were assessed to ensure that people were cared for in safe environment and carried out regular checks to keep the environment safe.

We saw that any incident was recorded and that the manager analysed those incidents to see what could be learned.

Staffing levels were determined in relation to people's individual dependencies and these levels were maintained. Staff were recruited in accordance with safe recruitment practices to ensure that people who were unsuitable were not employed.

The home had good medication procedures and practice in place and medicines were managed safely.

The service had good processes in place to minimise the risks associated with infection.

There was a positive approach to staff learning. Training was up to date and all staff said they had enough training to do their jobs well. We saw good examples of staff putting their training into practice.

People were well supported to meet nutritional and hydration needs. Appropriate assessments were undertaken, and where risks were identified relevant advice was sought and implemented

Staff were respectful in how they spoke to people and showed understanding when they interacted with them.

We saw genuine kindness; staff adjusted their tone of voice in relation to the situation and we saw staff utilising appropriate touch to offer support or to reassure. It was clear that staff knew peoples histories.

Some people were in danger of social isolation but the service offered and delivered a range of activities to help with this. We also saw that the home was persistent in seeking additional services for people to improve their quality of life.

There was a positive culture in the way that staff and people who lived there interacted. Staff knew peoples histories and interacted using kind and professional language. Staff were polite and sought answers which they verified before they undertook a task to help someone.

The manager and area manager were very open when we discussed the running of the home. They had very good systems in place to check that staff were delivering good quality care. Those systems were used by the manager and area manager to analyse how the home was performing in meeting people's needs and the findings influenced developments within the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People and their relatives told us they felt safe in the home

Staff were well trained in understanding abuse and how to keep people safe

There were good personal and environmental assessments aimed at keeping people safe.

Medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff were well trained and showed knowledge and skill when helping people.

People's rights were protected by a staff team understanding and applying the principles of the Mental Health Act 2005.

The home had good systems in place to support people with their nutritional requirements.

Good

Is the service caring?
The service was caring

People told us they felt well cared for.

Staff were observed to be very caring and kind in the help they provided people who lived there.

Staff interacted well with people and were careful to explain things clearly and seek people's responses and requirements before providing care.

Good

Is the service responsive?
The service was responsive

There were good care plans in place for people who used the service and those plans were reviewed regularly.

The plans were person centred and included information about how people had been involved in the planning process.

Staff and people who lived at this service knew how to raise a concern and were confident that any concern would be dealt with appropriately

Good

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

The home had a positive culture in the way staff interacted with people who lived there and the staff received good training and had a positive approach to improvement.

There were good systems in place so the manager could check how people's needs were being met.

Good

Summary of findings

Regular audits of the quality of the service took place and any identified shortfalls were dealt with

Hawkesgarth Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 28 April, 29 April and 13 August 2015 and was unannounced.

The inspection team consisted of an adult social care inspector, a specialist nurse advisor and an expert-by-experience with experience in nursing homes. This is a person who has personal experience of using or caring for someone who uses this type of care service.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 reviewed other information we held about the home, including any notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally required to send the Care Quality Commission (CQC) within a required timescale.

We also contacted the local authority safeguarding team, commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is a statutory body set up to champion the views and experiences of local people about their health and social care services. We also reviewed information from the local authority safeguarding and commissioning teams.

During the inspection we spoke with five people who used the service, three of their relative's, five staff and the manager of the home.

We reviewed five sets of records relating to people's care. These included their care plans, any associated risk assessments, review documentation and the daily records which reflected the care they received.

We examined other records within the home including five staff files relating to their support, training and recruitment, and other records held by the manager relating to the running of the service

We spoke to three external professionals who visited the home during the inspection. This included the manager of the local mental health team and two members of the local hospice support team.

Good

Is the service safe?

Our findings

People told us that they felt safe living in the home. One person told us "the staff are very rushed but I feel very safe here". Another told us "the building is very well built and there's always the staff there for you". We explored visiting relative's feelings about how safe their relatives were. All told us they felt they were safe. One visitor told us "[our relative] is safe in her room, there is one person who can lash out but staff keep a careful eye on them" Another said their "[relative] was safe especially as she could now lock her own room".

We saw training records relating to staff. All staff had been trained in how to keep people safe, how to recognise abuse and take the appropriate actions to reduce the chances of abuse, and what to do in case they saw or suspected abuse. We spoke with five staff about that, and they could all articulate what actions they would take in order to keep people safe. They spoke of having "good risk assessments", and "clear policies and procedures" about what to do with safeguarding concerns.

We looked at the care records and saw risk assessments were in place. There were risk assessments relating to moving and handling and mobility issues. For example, the safe use of wheel chairs and where staff needed to hoist someone to move them from bed to wheel chair. Assessments were detailed and gave staff good guidance about how they should do that safely with two staff assisting. We also saw risk assessments relating to helping people move around whilst minimising the risks of falling. Risks assessments were also in place where there were issues relating to how people interacted with others or exhibited behaviour that challenged others. These gave guidance to staff about how to de-escalate situations and reduce the possibilities of harm

The layout of the home, with narrow corridors which also passed through the lounge area posed risk of exacerbating behaviour that challenged for people living with a dementia who liked to walk round the corridors. These were too narrow for people to pass without contact. The manager had recognised this as a potential risk and had provided guidance to staff as to how such situations could be avoided or managed for people.

During our observations we noted how staff were managing identified risks. We saw that they managed situations well using a variety of skills and techniques to reduce potential conflict by gently guiding people away, distracting people or engaging them other activity.

We saw in the care records that people had individual personal emergency evacuation plans in place. Those plans gave guidance to staff about what actions they needed to take in the event of a fire or any other need to evacuate the premises quickly.

The home had relevant procedures to ensure they responded appropriately to any whistleblowing or general staff concerns. We saw records that showed where staff had raised concerns during their staff meetings and that they had been addressed. For example staff had asked for a new suction machine and records showed that this was obtained. This benefited people because it showed managers had listened to staff requests and it meant newer and more efficient equipment was in use for people's personal care.

The manager had systems in place to explore any accidents that took place. There were records that showed where an accident did take place, the manger referred the details on to appropriate other organisations, explored the incident and took action to reduce any further occurrences. This showed that the manager sought information that could be learned from an accident and took steps to reduce the possibility of it happening again. This helped to protect people and keep them safe.

The manager showed us how they determined the level of staffing required to run the home. They used a system where numbers and competencies of staff were measured against people's needs and levels of dependency. This meant that sufficient competent staff were on duty at all times. We examined daily staffing records over a period of three weeks. We saw that the home routinely had two qualified nurses on throughout the day and at least five care staff. Overnight we saw that there was one qualified nurse on duty and at least two care staff. We were told that should the numbers of people who used the service increase from the low numbers currently there the manager would utilise the staffing tool to increase those numbers appropriately. This meant the manager was making sure there were enough suitable staff on duty to meet people's needs. We spoke to people and visiting relative about how they felt about staffing levels. People

Good

Is the service safe?

told us that call bells were answered promptly. One person said "yes they answer the buzzer quickly especially at night". Another said "yes always within ten minutes or so". A relative told us "there always seems to be enough staff around when we visit". They also mentioned that they always seemed to see the same staff and that there was good continuity of staffing.

We examined five staff files to check that safe recruitment practices were used when employing staff. We saw that people's identity had been checked, at least two references sought and that people had DBS checks in place. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups of people.

We looked at the management of medicines and found that the service had up-to-date evidence-based policies and procedures in place, which were regularly reviewed, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance.

The provider followed the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

The staff who gave out medicines were trained to do so. We saw that medicines were stored safely and that where they need to be stored in a fridge, these were in special fridges where the temperatures were checked daily and found to be kept at the right temperatures.

We were told, and saw records that confirmed, that the deputy manager and the home manager took responsibility for the annual assessment of competence of the nurses administering medicines. In addition, they told us that the provider assessed the competence of the nurses administering medicines on an annual basis. Medicines training was updated annually, via Boots e-learning.

We found that the home had good medicine processes and ensured that people received their medicines when they needed them. We saw good records about people's needs in relation to medicines, they were well assessed in relation to their medicine needs and everyone had an appropriate record (Medication Administration Record, MAR) that showed what medicines they had received, when and by whom they were administered. The records were complete with no errors or gaps.

We saw that when people had PRN medicines (these are medicines that are prescribed for people to take if and when they needed them) these were recorded on the MAR charts. We saw when people were offered them, when they requested them and when they took them. People told us they received them when they required them.

Two people received covert medicines. We saw that this was rare in the home and when the home did give medicines covertly it was in agreement with family GPs and appropriate other professionals. In those instances the home followed guidance in relation to the Mental Capacity Act 2005, by assessing people's capacity to decide if they wanted to take needed medicines, holding discussions with people and making a best interest decision with the written agreement of all of those involved where it was identified that people lacked the capacity to make such decisions themselves.

Records were in place that showed that the home followed accepted practices in relation to storing and administering controlled drugs (which are medicines which may be at risk of misuse).

There were records that show that the home regularly audited and reviewed its medication practices, including the MAR charts, to check that medicines were being administered safely and appropriately and where needed made changes to ensure people were kept safe.

We were told and the records confirmed that staff conducted a '10 point MARs check' on a daily basis to identify any errors or omissions so that these were dealt with immediately. This also helped ensure there was accountability for any errors. Staff told us that a medicines audit was conducted by Boots in 2015. We were also told that medication reviews were undertaken every 6 months via the Practice Nurse allocated to the home.

The home looked and smelled clean and fresh. We saw that the manager had systems in place to ensure that the home was kept clean and infection was controlled. There was guidance for staff about reducing the chance of infection and cross infection. We saw from records that checks were carried out weekly and monthly. Those checks included details about what was expected from staff for example use of hand cleanser and cleaning their hands properly. There

Good

Is the service safe?

were also checks that there were sufficient supplies of equipment such as gloves and aprons and that staff used them. There were also daily checks of the cleanliness of kitchen areas.

The home had a set of processes that ensured that bedding and personal clothing was cleaned to an acceptable level and in such a way that kept soiled clothing away from clean clothing. This was important because it helped reduce the risk of cross infections.

The home had a health and safety inspection by the local authority in June 2014 and achieved good ratings for that inspection with only very minor changes suggested. We saw that those recommended changes had been implemented.

Good

Is the service effective?

Our findings

Staff told us they had been trained well for their role. One senior care worker told us "I have had very good training and feel able to fulfil my role well because of that training". Another new member of staff told us "the induction had been brilliant; as this is my first role in working in care I was a little anxious about being able to do it. The induction programme was great in preparing me for the basics, and the ongoing e learning I am doing is improving my knowledge".

Records showed that all staff had received appropriate training and apart from one new starter all training was up to date. One professional however did say, "Although all the staff have a basic understanding of the needs of people living with dementia, and some have a very good understanding of it, I would like to see more staff having much more detailed training in it". However, during our observations we saw staff dealing with potentially volatile situations with care and compassion and skill and they demonstrated good understanding of the needs of people who lived with dementia.

During our observations we also saw staff applying the training they had received. For example, we saw staff using hoisting equipment correctly and confidently. One person told us "I feel safe when staff have to hoist me".

We spoke to five members of staff. They confirmed that they received regular supervision (one to one meetings with a manager where they discussed their practice training needs and any other issues). One member of staff told us they found supervisions "informative and helpful" in developing the way they worked. We saw records of those meetings in the staff files.

Staff also told us that they had received an annual appraisal of their work and we saw records of these in staff files.

We saw that the home used a variety of ways to ensure good communication was maintained with people who used the service. For example we saw pictorial as well as written menus were posted daily in dining areas. We also saw boards with images depicting what was available and what choices people could have, and a member of staff showing a person images of food choices so that person could select what they wanted by pointing. We heard staff adapting the way they spoke with people and check understanding by seeking affirmation about what had been communicated.

The staff we spoke with understood the requirements in relation to people's mental capacity and the need to ensure peoples human rights were protected. We saw that where needed mental capacity assessments had been undertaken and information from those assessments clearly recorded in care plans. Where the person had been assessed under the Mental Capacity Act 2005 (MCA) as being unable to make some decisions for themselves, there was clear evidence of best interest's decision making. Relevant professionals were involved and, where appropriate, family and friends were also consulted.

Where best interest decisions had been made, these were situation specific and we saw that staff encouraged people to make a range of decisions for themselves, such as what they wanted to wear, what they wanted to do or what they wanted to eat. In this way the home was protecting people's rights to make choices about their care where they were able to do so.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards exist to ensure people are only deprived of their liberties if it is within their best interests. The manager understood the home's responsibilities under the Mental Capacity Act 2005 and following a recent court ruling regarding DoLS in care settings had arranged to attend a meeting with the local authority to discuss the new requirements. We saw that the home ensured people were only deprived of liberty when it was essential and no other course of action could be taken. Appropriate procedures were followed and good records were kept to ensure peoples mental capacity was assessed in relation to the need to deprive them of their liberty and that this was done via best interest decision making with local authorities, other professionals, the GP, and relatives. Where required authorisation from the local authority was in place. The records in relation DoLS were clear, person centred and thorough. They were in place where people needed them, approved by the Local Authority and reviewed in a timely manner.

There were no records that showed any person needed restraint and we did not observe any event that could have been construed as restraint.

Good

Is the service effective?

We saw records that showed that people were consulted and where possible they either signed records of discussions and agreements or their opinion was recorded. Where people could not sign when participating in any decision making due to their mental capacity we saw that suitable relatives were involved and signed records.

People told us the food was good and they had plenty of choice. We saw that the home provided snacks and drinks in a round between meals, but would also provide them outside of those rounds if people wanted them. People told us that they enjoyed the food. One said “the food is good you get two choices”, another mentioned “the food is good, I get a choice and staff know what I like”.

There were good assessments on file showing which people needed assistance to maintain a healthy diet. Where people were at risk of malnutrition, the home had used the Malnutrition Universal Screening Tool (MUST). This is a screening tool to help staff assess when people may be at risk of suffering malnutrition and ill health due to their diet. Where this indicated concerns, referrals had been made to dieticians and the speech and language therapy team (SALT). Where the dietician had recommended special diets we saw that the home had recorded this within the care plan and passed that information on to the kitchens so, if needed, specially fortified food or drinks could be supplied or any other requirements met.

Where the dietician had requested weight monitoring we saw records that showed the home had done this. In every case we saw that people had gained weight as needed.

Where people had difficulty swallowing referrals to the SALT team for assessments had been made, and the home had implemented any recommendations made by them. For example where one person was nursed in bed, there were specific instructions about how that person should be positioned in order to eat safely. There were also pictorial instructions on that persons room wall guiding staff about how to support that person and we saw that staff implemented that guidance.

Good

Is the service caring?

Our findings

During our inspection we saw an attentive and caring staff team who had people's wellbeing at the heart of what they did.

This was confirmed when we spoke to people about their experience of living in the home. One person told us "Staff are marvellous, they get on with things" Others said the staff were "Humorous and make me smile", "They are caring most of the time" and "Helpful but I don't see much of them". People expanded on those comments to say the staff were always "very busy". They went on to say the staff are "Efficient cheerful and thoughtful" and that they were "Caring-great" and that "They always get what I ask for, pleasant staff".

We saw staff dealing with people in a kind way. We saw care and attention where people needed it. For example we saw a member of staff reach out and hold a person's hands when they started to get upset using soothing and reassuring words to support them. In another instance we saw a member of staff hug a person who asked for hug.

We observed staff interact with people to ensure their privacy and dignity was maintained. For example we saw one person come out of their room with their upper clothing in disarray. A member of staff quickly and quietly intervened taking them aside and assisting them with their clothing. We saw that staff were careful to close doors behind them while they delivered personal care.

When we spoke to two people who lived there about how their independence was encouraged, one told us we were told that "I am a very independent person". The other said "I do my own thing".

We explored those issues further. One relative mentioned that their parent had wanted further contact with their own local church. The home arranged for members of that community to visit and organised for that person to attend the services of their choice with the support of their home church community.

During observations we saw that staff offered people choices and encouraged them to make decsions for themselves. We saw staff ask people what they wanted to do in relation to activities, they were encouraged to participate, but the decision they made was respected. We saw one person ask for help in the garden and that staff responded by assiting them there.

We saw staff take time to explain things to people and ask their opinion on day to day decisions such as what they wanted to do, what they wanted to eat or if they were warm enough. It was clear from care records that people and their relatives were involved in their care. For example where people were able they countersigned their care plans we saw other records where relatives had signed care on peoples behalf. We saw that some people had been assessed as needing special advocates and that these had been provided via the local authority. Those IMCA advocates (Independent Mental Capacity Advocate) were put in place for a variety of reasons such as when a person who had been assessed as lacking capacity to make their own decision had a serious medical issue to deal with or decisions about where they should live needed to be made. The IMCAs responsibility is to represent the person if needed and gain their views as best they can and support them in ensuring their rights are protected.

People's personal records were carefully stored so that they could not be accessed by anyone who did not have a right to see them.

We spoke to the hospice support team about how end of life care was managed within the service. They told us that they had seen some "very positive changes over the last six months". They said that the home was much more engaged with their team and that they provided good end of life care.

Good

Is the service responsive?

Our findings

We saw good evidence that thorough care planning had taken place. There were assessments within care plans relating to a range of needs such as communication, eating and drinking, continence, mobility, hoisting, skin integrity, risk of falls, mental capacity, wellbeing, medication, and pain management.

Where necessary extra assessments relating to individual issues had been undertaken working with other services such as the mental health team, occupational health, and speech and language teams. The plans were person centred, well written and detailed. They set out people's needs clearly and gave staff relevant guidance about how to meet those needs.

People and their relatives told us they were involved in care decisions about them.

We saw evidence within the plans that people were involved in their planning processes, with either the person's signature or the signature of a close relative indicating their agreement.

Plans were reviewed in a timely way and any changes that need to be made because of changed needs were clearly recorded.

The home had an activities coordinator. There were display boards that showed what was on offer and we saw staff engaged in activities with both individuals and groups of people who lived there.

The activities programme included bingo, singalongs, gardening, karaoke and trips out. We observed one group activity called Oomph where seven residents and four staff participated. It was an activity where people used pom poms and to music and undertook physical movement. The staff were enthusiastic and encouraged people to participate. It was clear that people taking part enjoyed the programme; there were lots of smiles and laughter. One person spontaneously got up and started to dance.

In a person's care file, we noted an activities support plan which stated "one to one time, music to be on in their room and sensory activities". On entering the person's room we heard music and saw a mirage of stars twinkling on the ceiling, which created a calming effect.

We spoke to the activities coordinator and they explained the programmes they had in place and others they were planning. They were keen to get more people out and about and were planning various trips. They explained that they recorded the participation of people in each activity and sought people's opinions about how things had gone. The coordinator then used that information to evaluate the success and value of the activities on offer. From observations and written records it was clear that people were given choices of activity in their day to day lives.

We saw that staff asked people what they wanted to do and that people were confident in asking for things they needed. We saw one person asking to go and do some gardening which staff quickly facilitated and we saw the person enjoying that activity for over an hour with staff assisting from time to time.

We spoke to a visiting health care professional they told us "I have, not witnessed anything which had given cause for concern"; They also commented on how staff had worked hard to get an appropriate wheelchair for one person to improve their quality of life. We saw a copy of the proposal that the clinical lead put forward to the local authority which detailed their rationale in relation to the authority providing a suitable wheel chair. Their requests included "It would enable [person's name] to be up out of bed and not isolated in their room 24 hours a day. [That persons] quality of life appears very poor due to their isolation, no stimulus and also reoccurring chest infections/aspiration". This showed that the home was persistent in getting help and support for people from other services.

All of the staff we spoke with knew what to do if anyone complained to them. They said they would try to deal with the situation but if they couldn't or the matter was serious they would report it to the manager. When we spoke with people who used the service, they knew how to make a complaint. One person said "yes I would tell them" another said" I would go straight to the top-the manager"

The home had a compliments and complaints policy in place. People felt confident that their complaints would be listened to and dealt with effectively. One person told us "you can usually catch it before it gets to a complaint". A relative said complaints were dealt with "efficiently and acceptably". We examined the complaints records There was one on file and there was a record that showed it had been dealt with to the full satisfaction of the family in line with the company policy.

Good

Is the service well-led?

Our findings

We saw a pervasive positive culture within the home. Staff were caring, considerate and kind in their dealings with people. We saw that they spoke to each other in the same respectful way. People spoke about staff being "cheerful", and "caring". People told us that staff knew their likes and dislikes. One person said "there's lots of chitter chatter going on, they will do all sorts for you, they are always willing to help". When asked if there was one thing they would change they replied "I would give all the girls a pay rise".

We saw a positive attitude to personal learning and development. Staff viewed training as helpful and that it allowed them to improve the care they could give.

Staff mentioned that the manager was always approachable and if not there was always an experienced senior around to seek guidance from. One member of staff told us "You can approach [the manager] about anything at any time". Another said "[The manager] doesn't just sit in her office but gets out and about seeing what's going on". Staff told us they could approach the area manager when they were on site and that they saw them regularly and they attended some staff meetings.

We gained information about how open and transparent the management team was. For example we noted in the records of staff meetings that the staff had raised concerns about their future employment and that the manager had responded by explaining the steps they were taking to increase the numbers of people who lived in the home.

There were examples of where staff contributed to the service they provided and improved peoples experience whilst living the home for example we noted that staff had raised a concern that hourly checks for all people who lived there was unsettling and disturbed those people who didn't need them. We saw that agreement was reached that the nurses would assess those people in need of hourly checks in terms of risk and we saw that those risk assessments were in place.

During all three days of inspection we saw good evidence of how the manager kept programmes up to date. For example we saw schedules that showed when people needed supervision. Records in staff files showed that the manger had kept to those schedules. We saw another chart that indicated the current situation with DoLS applications and when renewals were needed and that those applications had been put into the local authority in a timely way.

Organisations have a legal duty to inform the Care Quality Commission of certain things. Before we undertook this inspection we examined our records to check that we had been informed of the occurrences we need to hear about. When we cross checked with the home we found they had fulfilled their duties by informing us where necessary.

There were records that showed that the manager considered the culture within the home and took note about the way staff interacted with people and gave guidance when necessary. There was a daily round sheet the manager completed looking at specific areas and functions within the home. In staff meeting records we saw that discussions about meeting some basic needs such as showering had been had, and how if staff didn't record those events how could anyone know they had taken place. Discussions went on further about staff ensuring that all records were kept up to date and completed fully for example turn charts or the need for more information about peoples wellbeing and how staff were meeting people's needs in the notes section. This was important because it showed the manager was checking things and giving guidance to staff about what was expected of them.

There were records that showed the manager had placed an expectation on staff about improving the choices during meal times and how staff could encourage people who lived there to widen their choices. That discussion with staff followed on from some people who lived there asking for increased choices.

We saw that the home had clear lines of responsibility and that staff could articulate where they would go to report any issues or concerns. During our initial and final visit clinical governance was provided by the registered manager and the acting manager who had nursing backgrounds. Auditing systems under their clinical duties were in place for example there were very good checks and controls in place to ensure people received their medicines safely and when need or directed by the GP.

Good

Is the service well-led?

Although there were no recorded incidents of whistleblowing there was a whistleblowing policy in place that gave clear instructions about the expectations placed on staff in relation to public disclosure and the need to take action outside of the home if needed.

The provider had systems in place for the manager to report any issues about running the home or support the manager needed in responding to them. The manager told us that they had very good support from the regional manager.

We saw that the home had links with the community and utilised those links well. There was clear evidence that they worked with local services such as GPs, occupational health, mental health teams, hospice support, and the local authority.

We were told by the hospice team and the manager that they provided a critical resource for the local Whitby community. They were an area resource for the health authority, and kept two syringe drivers at the home, should people require the equipment to administer medicines in that way. Many strong painkillers (strong opioids) can be given by a syringe driver. A syringe driver is a small, portable pump that can be used to give you a continuous dose of your painkiller or other medicines through a syringe. You may use one if you're being sick or you can't swallow. The home provided this resource and also supported the local hospice by keeping syringe drivers for community use on the premises.

During our first visits the home had fulfilled its registration requirements and had a registered manager in place. However that manager had left in the interim between inspection visits at short notice. The provider had appointed a manager to cover that short fall and intends to register that manager when they take up the full time post on September the 1st 2015.

We saw that there were good systems in place to ensure consistent care was being provided. For example daily notes were comprehensive and information was recorded regarding basic care delivered and details of interactions with the person, information about behaviour, mood or presentation and involvement/recommendations of healthcare professionals. There was a daily record kept of handovers where staff provided detailed information about people's conditions and current needs. Those records were thorough and included person specific information about such things as named nurse, named carer, General Practitioner, next of kin, brief medical history, together with their level of mobility/needs, fluid/hydration needs, care delivered and details of interactions with the person.

Throughout all of our inspection we saw good systems in place to monitor the quality of the services they provided. We saw that the manager undertook many audits of the services they provided and used the data from those to guide development within the home. The information drawn from those audits and checks was reviewed by the area manager on behalf of the provider every three months.

Those audits included kitchen areas, pressure ulcer management, medication, laundry, health and safety of the premises, fire safety checks, fire system checks, door holders, fire doors and exits. Water temperature was checked monthly and unused water systems were flushed to reduce the chance of bacterial build up. There were records of shower head cleaning, checks on nurse call systems, bed rails and profile bed checks and suability of wheelchairs. Some of these were checked weekly, monthly or quarterly. There were clear schedules for all of those audits and checks and the records we saw, showed that they were undertaken rigorously. Records also demonstrated that any deficits and shortfalls identified were rectified. We noted that issues from audits were passed over to staff during the daily handover meetings.