

Bluebell Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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

Bluebell Residential Home Limited is registered to provide care and accommodation for up to a maximum of 40 people. The service supports older people, people living with dementia and people who have a physical disability or a sensory impairment. The service is located in Hessle, on the outskirts of the city of Kingston-upon-Hull. There is parking on-site for visitors and staff and access to the premises is suitable for people in wheelchairs.

This inspection was unannounced and took place on 5 May 2016.

The last inspection took place on 20 January 2015. At that inspection we identified breaches to Regulation 17: Good Governance and Regulation 18: Staffing. After the comprehensive inspection on 20 January 2015 the registered provider wrote to us to say what they would do to meet the legal requirement in relation to the breaches of regulation. During this inspection we found that these actions had now been completed.

The registered provider is required to have a registered manager in post and there was a manager who had registered with Commission and who had been in post since May 2015. 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.

The recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following robust recruitment and selection processes. We found the service to be clean and hygienic, although some aspects of practice could be improved.

Improvements were made to the number of staff employed in the service. Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service. Staff did not appear rushed on the day of our inspection and there was a good atmosphere in the service.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

Improvements had been made to staff training. People that used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the home.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback from people who used the service and staff was obtained. The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not always safe.

The recording and administration of medicines was not being managed appropriately in the service.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures. There were sufficient numbers of staff on duty to meet people's needs.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

We found the service to be clean and hygienic, although some aspects of practice could be improved.

Requires Improvement ●

Is the service effective?

The service was effective.

Improvements had been made to staff training and staff now received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People reported the food was good and that they had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People told us that they received appropriate healthcare support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting these.

Good ●

Is the service caring?

Good ●

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff and this was confirmed by the people with whom we spoke.

The people who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Good ●

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences in order to provide a personalised service.

The people who used the service were able to make choices and decisions about their lives. This helped them to be in control and to be as independent as possible.

The people who used the service were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good ●

The service is well-led.

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback from people who used the service and staff was obtained.

The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the changes taking place in the service.

Bluebell Residential Home Limited

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 was 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 5 May 2016 and was unannounced. The inspection team consisted of one Adult Social Care (ASC) Inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert-by-Experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. Both teams had no concerns about the service. We reviewed all of the information we held about the service, including notifications, inspection reports and the action plan sent to us by the registered provider which outlined the action they would take regarding the shortfalls and areas of non-compliance we had identified at the January 2015 inspection.

We asked the registered provider to submit a provider information return (PIR) in 2015 and this was returned in December 2015 within the given timescale. The PIR 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.

During the inspection we spoke with the registered provider, the registered manager, the deputy manager, three members of staff, seven people who used the service and four relatives.

We looked at three people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental

Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for three members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment. We also completed a tour of the premises to check general maintenance as well as the cleanliness and infection prevention and control practices.

Is the service safe?

Our findings

We asked people if they felt safe in the service. One person told us, "It is lovely; you are not frightened to move around. You are not told to 'sit there and don't move'. I have made friends with other residents." One relative told us, "I feel [Name] is safe and secure, I've never felt [Name] was not." We saw that the entry to the service was controlled by staff and the outside doors used a key code entry system.

The corridors and hallways on the ground floor were busy with staff, visitors and people moving around with walking frames. However, we saw that staff supported people to move around and assisted them in a safe manner. Some people living at the service had gates at their bedroom doors so that they could leave the doors open, but were not disturbed by the people who spent a lot of time walking the corridors. The use of these gates was risk assessed and recorded in people's care files.

Everyone we asked told us they thought there were enough staff on duty although sometimes they were very busy. One person reported having to wait for care, but others said, "They always rush to you if you need something. Sometimes they get tired, they must, but they seem to cope," "I've not had to wait for much" and "Yes they are busy but not too busy to sit and chat." A relative told us, "You get busy periods and people have to wait, but on the whole it is good."

Discussion with the staff revealed that people who used the service had diverse needs in respect of at least one 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.

The registered provider had policies and procedures in place to guide staff in safeguarding people. The registered manager had completed the local council's safeguarding training and checks of the staff training plan indicated that the staff had completed safeguarding training as part of the registered provider's programme of learning and development. The registered manager and the members of staff on duty were able to clearly describe how they would escalate concerns, both internally through their organisation or externally should they identify possible abuse. Discussion with the local council's safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service.

We found during the inspection that although we had received notifications for safeguarding alerts raised with the local authority, there had been two other incidents assessed using the risk assessment tool that had not been reported to CQC. Discussion with the registered manager indicated they had yet to complete the local council's risk assessment training for safeguarding; part of our discussion centred on the need to report safeguarding issues to CQC even when they did not meet the local council's criteria for an alert when using the risk assessment tool. The registered manager assured us that they would book this training as soon as possible and that all issues would be reported following on from the date of the inspection.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe, but also ensured they were able to make choices about aspects of their lives.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. They completed an analysis of these to identify any trends or problems within the service. We saw that the analysis for April 2016 showed there had been a total of 23 incidents; fourteen incidents required no further action as no injuries were sustained, eight incidents occurred where people sustained minor injuries and on two occasions people were given a check-up at hospital. Appropriate care and treatment had been given to people following these incidents; people had received input from their GP or the district nurse as needed. One person had been referred to the falls team and one received hospital treatment. The accident figures for the last four months was much lower than that for April 2016, but there were no indications as to why the latest figure was higher.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety, portable electrical items and the gas supply system. We saw that the electrical wiring certificate was due for renewal and we were sent confirmation from the registered manager that this was booked in for 16 May 2016. An electrical socket near to the sink in the laundry room was a cause for concern. We were notified the day after the inspection that this had been blanked off to ensure staff safety. We saw that there was a risk assessment in place for Legionella, which is a water borne virus and this had been reviewed in November 2015. The service did not have any passenger lifts to the upper floor, but there was a stair lift which had been serviced in April 2015 and was in good working order.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the staff for hot and cold water outlets, fire doors and call points, emergency lights and window opening restrictors. These environmental checks helped to ensure the safety of people who used the service. The registered provider told us that they had organised for window restrictors to be fitted to all window openings since our last inspection in January 2015. We saw some of these in place during our inspection.

We looked at the registered provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. However, the plan did not identify the arrangements to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. The registered manager was aware of what to do in these circumstances and assured us the plan would be updated immediately.

We found that the fire risk assessment was reviewed in November 2015 and a fire drill was carried out in December 2015 and April 2016. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were held in a file in the registered manager's office and were up to date.

Information we were given by the Commissioning team at East Riding of Yorkshire Council (ERYC) prior to this inspection indicated that in November 2015 they made a recommendation about the appropriate staffing hours for the service. At this inspection we checked the staffing hours and found that these had been

increased since our last inspection (January 2015). The registered manager told us that they were currently recruiting for one full time care assistant.

The registered provider gave us a copy of their dependency tool used to determine the staffing levels required to meet the needs of people who used the service. This had last been completed on 19 April 2016. Checks of the last four weeks of rota showed that in a morning there were between five and six care staff on duty, in an afternoon this reduced slightly to five care staff until the two night staff came on duty at 9pm. At the time of this inspection there were 37 people living in the service, eight of whom had a diagnosis of living with dementia. The deputy manager explained that there was an on call system for the service through the night, so if there was an emergency a member of the management team would attend the home.

Staff told us, "The levels of staff are good. We have enough on duty to enable us to offer people the support they need and carry out day to day tasks in the home." We saw rotas indicated which staff were on duty and in what capacity. The rotas showed us there were adequate staff on duty to support people safely and enable them to take part in activities. The staff team consisted of a deputy manager, care staff, a chef, domestic staff and office staff. The registered manager told us that the care staff also carried out laundry duties. We observed that the service was busy, but organised. Staff worked in and around the communal areas throughout the day and we found that requests for assistance were quickly answered.

We looked at the recruitment files of three members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

The senior care staff informed us that they had received training on the handling of medicines and had competency checks of their practice carried out by the registered manager. This was confirmed by our checks of the staff training plan and staff training files. We saw that the medicines policy and procedure had been reviewed in January 2016, but it required some further amendment to ensure it followed best practice with regard to administering medicines within a care service.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). Medicines, including controlled drugs (CD's) were ordered, stored or disposed of safely. CD's are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

Medicines were stored in locked trolleys in a dedicated room. We saw that medicines were obtained in a timely way so that people did not run out of them, administered on time and disposed of appropriately. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature. We expressed some concern to the registered provider that the temperature of the room was at 23.5 degrees centigrade on the day of the inspection. The maximum safe temperature for storing medicines at is 25 degrees centigrade. We were informed that a fan was available to cool the room and would be implemented straight away.

We found that the recording of medicines administered by the staff was not always consistent and there were two areas where staff could make improvements; these were on the completion of topical medicine charts and dating refrigerated items when the boxes or bottles were opened. We saw that two of the topical

medicine charts had not always been signed when staff had administered the gels, creams or lotions to people who used the service. For example, one person's ointment was to be applied one to two times a day. However, the staff had only signed once each day on the chart. The other topical chart had no record of the cream being used, but the staff assured us that it was being applied. This could potentially lead to errors being made. We also found one bottle of eye drops in use that did not have an 'opened on' date. This meant one person had a potential risk of having out of date medicines administered to them. The senior care staff took immediate action to dispose of the undated, but opened, items and the registered manager said they would speak with the staff on duty about the need to complete the topical medicine charts correctly. The registered manager assured us that regular checks would be carried out to ensure the charts were up to date and accurate.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We found the level of cleanliness in the service was satisfactory. However, there were some areas of the service that needed attention including the laundry area and feedback was given to the registered manager. These were of low risk to the people using the service and had a low impact on their daily lives. The service employed domestic staff who completed cleaning schedules each day. However, we found the sink in the laundry room was dirty and needed a deep clean and we noted there was no written evidence of a risk assessment of the dirty to clean flow of laundry to ensure cross contamination risks within the laundry were kept as low as possible. We saw cobwebs around the light fittings in one bathroom and the floor of the walk-in shower room was stained and dirty.

The toilet near to bedroom 10 had no liquid soap or paper hand towel dispenser in place, which would make it difficult for anyone using this facility to effectively wash their hands. We noted that a number of clinical waste bins around the service were missing lids or were not foot operated as is best practice for preventing cross infection. Infection control audits had been carried out on a two monthly basis leading up to our inspection, but the issues we noted had not been identified. We gave feedback to the registered manager that they needed to monitor their auditing process to make sure their practices were effective.

The registered manager acted on our feedback immediately where able, and sent written confirmation following the inspection that further action had been taken to ensure all areas discussed were reviewed and updated.

Is the service effective?

Our findings

At our last inspection in January 2015 we found that people who used the service were not cared for by staff that had received appropriate training in dementia care. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 5 May 2016 we found that the registered provider had followed the action plan they had written following the January 2015 inspection and sufficient improvement had taken place to demonstrate that the breach had been met.

Improvements had been made to staff training. The registered provider had an induction and training programme in place and staff were receiving regular supervision. Staff told us they enjoyed the training they had completed and felt they had the skills and knowledge needed to look after the people using the service. People who spoke with us said they had confidence in the staff looking after them and that staff were well trained and gave them good support.

We saw that the staff team had access to a range of training deemed by the registered provider as mandatory. Evidence in the staff files showed us that staff had completed training such as fire safety, medicine management, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. We found that the staff training and development was delivered by a mix of external trainers (including East Riding of Yorkshire Council), internal training which included use of DVD's and workbooks and some distance learning courses from the local college.

All staff had attended a dementia awareness course in 2015 and 2016. Discussion with three members of staff indicated that they found the course useful and the care staff were able to give us examples of how this learning had made them more aware of the difficulties that people living with dementia faced on a day-to-day basis. Our observations of the service showed us that there were good relationships between staff and people using the service. We saw staff being patient and understanding with those who had memory impairment and others in the home.

We asked the registered manager about best practice within the service looking at external awards, dementia work and research. The registered manager confirmed there were no best practice systems in place, the only input came from the dementia care training given to staff. However, as part of our inspection we looked at diabetic care in the service and found the service did incorporate some elements of good diabetes care into their practice. This included the availability of hypoglycaemia kits in people's bedrooms (where appropriate) and evidence that people living with diabetes were able to access diabetes specialists such as nurses and dieticians. We spent time discussing how this good practice could be developed further to include screening of new people on admission (urine testing), the production of a risk assessment tool for diabetes foot disease and individual care plans. Four members of staff had completed diabetes awareness training, but this would be useful for all care staff to complete.

We looked at induction and training records for three members of staff to check whether they had

undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the service. The registered manager showed us the induction paperwork completed for staff in their first three months of employment. We found that the registered provider used the 'Care Certificate' induction that was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource.

Checks of the staff files showed that they received regular supervision from the registered manager and had a yearly appraisal of their work performance. Records seen indicated that supervision meetings were held every one to two months and we found that the supervision sessions were written in detail and included action plans. Staff told us that they found the supervision sessions beneficial as they could talk about their concerns and were given feedback on their working practice. This was confirmed by the records we looked at. This meant that staff practice was monitored and reviewed to make sure people who used the service received a good standard of care.

People told us that they had access to other healthcare professionals directly in the home and they had regular visits from opticians, dentists and the chiropodist. We saw professionals in the service from the district nursing team during our inspection. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). We contacted local commissioners of the service and safeguarding teams before our inspection. None of the individuals we contacted raised any concerns about how people who used the service were supported to maintain their mental health and physical wellbeing.

The staff monitored people's health and wellbeing. We asked people who used the service what happened if they did not feel well and they told us, "The staff are lovely, they would arrange for us to see our GP or the district nurse straight away." We observed one incident in the service when a person who liked to walk around appeared to be having difficulty walking. When this was queried by a member of staff, another member of staff said that the person often said their legs weren't right and they were probably okay. However, the first staff member continued to talk to the person and did not dismiss their distress. The person was taken to their room to rest. We discussed with the registered manager the importance of all staff listening to what people were saying and taking appropriate action to look at the reasons why they may be in distress.

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.

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. Records showed that one person had an authorised DoLS in place. An application to renew this had been submitted to the local 'supervisory body' and the registered manager was waiting for them to assess and approve the documentation. The registered manager displayed a good understanding of their role and responsibility regarding MCA and DoLS. Staff told us they had received training on MCA, DoLS and human rights legislation, which had given them more confidence in the way they approached people who used the service. This was evidenced in their

training files. They were able to tell us about how they used this knowledge in their daily practice.

Staff told us, "If a person does not have capacity then some decisions could be taken for them after a best interest meeting. Day to day life decisions can still be their own. You can involve a person's GP or community psychiatric nurse (CPN) if their mental health needs are deteriorating. You would always assume capacity and offer daily life choices."

People who used the service were able to tell us that staff always asked for their consent before carrying out any care or support. We asked people if they felt they could make decisions about their daily life and people told that they had a choice of what time to get up and what time they went to bed. A relative told us their family member often went back to bed after breakfast. This was a concern to them so if they did go back to bed staff would visit their room regularly to check on them and encourage them to get up and spend more time with others.

Staff within the service monitor and review risks relating to people's mental and physical wellbeing. We found no evidence that people who used the service had behaviours that challenged the service or others. The registered provider told us that when new people were assessed for potential admission, one of the criteria to be met was how well the individual would fit in with those already living in the home. The staff told us that restraint was not used within the service.

In discussion, staff were able to say which people had input from the district nurse or dietician; they also knew what health problems each person had and what action was needed from them to support the person. Entries in the care records we looked at indicated that people who were deemed to be at nutritional risk had been seen by dietitians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We saw that the service was working with the dietetics team in the community who had introduced the 'Nutrition Mission' to encourage people not to have supplements in their diet, but look at 'fortified' diets to increase their calorific intake. In response the service had introduced milkshakes, smoothies, fresh fruit and full fat yoghurts, as between meal snacks and drinks.

People who spoke with us were positive about the food provided by the service. Comments we received included, "The food is good for me. If you want anything they will get it for you", "The food is okay and we always have a choice" and "The food's pretty good." People had a choice of where they ate their meals. There were two dining areas, however some people preferred to stay in their bedrooms or stayed in the lounges. Lunch was served quickly and very efficiently with the staff working very well together as a team. Staff offered drinks several times during the meal and commented on the warm weather and encouraged people to drink. Jugs of juice and water were on hand in the communal rooms and hot drinks were served regularly.

A blackboard gave details of the day's menu. There was only one main course for lunch, but staff and people told us that an alternative was always available, especially if the meal was a less traditional choice. Additionally, each month they had themed evenings such as a Mexican night with Mexican dishes. These themed events had been discussed in recent resident meetings and people had been asked to choose which countries they would like included and what food they would like to try from each country.

The service had eight people living with a diagnosis of dementia out of a total of 37 people living in the home. This meant 20% of the people using the service had specific needs around loss of memory and sensory impairment. However, we saw there were no specific designs or adaptations to the property to aid these people in their activities of daily living. Simple changes such as good signage, plain carpets, coloured doors and toilet seats would help people living with dementia navigate around the service. We accept that

the people we met in the service were able to move around easily and no one complained to us that they found this task difficult, but good environmental design and effective dementia care complement each other and maintain people's health and wellbeing.

Is the service caring?

Our findings

People who spoke with us were very satisfied with the care and support they received from the staff and made a number of very positive comments. People told us, "The staff are brilliant. You only need to ask for something and they try their best to get it. They always give you time, they never hurry you", "The carers are marvellous" and "The staff are very friendly and have helped me feel settled."

People were able to move freely around the service, some required assistance and others were able to mobilise independently. One person told us, "I am very independent and if I need help I ask." We saw that people and staff had a good rapport with each other. Observations of people in the lounge, dining room and around the home indicated that individuals felt safe and relaxed in the service and were able to make their own choices about what to do and where to spend their time.

We saw that people enjoyed chatting to each other and staff and that conversations included everyone even those who had communication difficulties. There was lots of laughter and appropriate banter between people and staff. One person told us, "The staff are all very good. They are always pleased to see you. If you want anything, they try to get it. They do what they can." Another person said, "It's very jolly here. I get looked after. I cannot fault it."

Staff were patient with residents and gave them choices and appeared to ask permission if they needed care. We overheard one exchange after lunch. A person had spilt food down their front; when a staff member spotted this they suggested that they should take the person back to their room to change their top. The staff member explained why and said to the person, "Is that okay with you?" before taking them to their room. People told us, "The staff are excellent, everybody's very kind" and "They are lovely, they always listen to me."

There were no restrictions on visiting times and people told us that they often went out with their families. However, one family member told me that if they came at lunch time they had to wait in their relative's room rather than in the lounge or dining room. We discussed this with the registered manager who said, "If visitors arrive during the meal time we ask that they do not disturb people whilst they are eating as they can sometimes not finish their meal. This is particularly important for people living with dementia who are easily distracted during meal times." As people used the dining rooms and the lounge to eat in, these were the key areas where interrupted meals would occur.

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. People who used the service told us that staff respected their wishes and would listen to them when they wanted to change things around. One person said they felt the staff knew them well; if they were feeling under the weather staff always recognised this and would take them to one side and say, "You're not yourself" and that they would listen to anything that was concerning them.

The service had a key worker system in place that enhanced communication and trust between people using the service, families and staff. Staff acted as key workers for specific people and link workers where they stood in for another member of staff if they were on leave. The staff told us they had a good relationship with families which they felt was very important. They said they would let families know if there were any changes in a person's health and wellbeing and updated their care plans. We saw that the key workers wrote weekly and monthly reports in the care files to show how people were progressing both mentally and physically, and gave input to or attended people's care reviews.

Care plans included information about a person's previous lifestyle, including their hobbies and interests and the people who were important to them. This showed that people and their relatives had been involved in assessments and plans of care. Some people had signed their care plans to show they agreed to the contents. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager.

Discussion with people who used the service indicated that they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. We saw staff respond straight away when people asked for assistance with personal care or getting up out of their chairs. People and visitors confirmed to us that staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when completing care tasks. Those who received personal care told us that they felt dignified while that happened. Talking about taking a shower one person said, "It's a very sociable event. We usually have a sing song."

We noted that one toilet door and the shower room did not have locks on the door, which meant people could not be confident of their privacy when using these facilities. This was discussed with the registered manager at the end of the inspection and immediate action was taken to contact the maintenance person and arrange for locks to be fitted.

Is the service responsive?

Our findings

The staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People who used the service told us there were few or no restrictions on their daily life, although risk assessments had been completed and care plans were in place to make sure people stayed safe and well. Evidence in the care files showed us that people's views were sought and listened to, and that families were also involved in reviews of people's care.

Most people who used the service and their relatives, were aware of the care plans and told us that they were involved in regular reviews. One person said, "Oh yes I see it (the care plan), I usually have a family member with me and we all discuss it together." A relative told us, "I'm very happy. Just recently had a review of [Name's] care plan and I think things have got better for my parent."

Care plans were written in a person centred format. However, because the staff had such a good knowledge of each person's needs, wishes and choices some details in the care plans lacked clarity as staff relied on what they knew to fill in any gaps. For example, one care plan said the person needed specialist pressure relieving equipment of a hospital bed and an air flow mattress, but did not say what pressure setting the mattress should be kept at and there were no records to indicate when or if this was checked. Discussion with the registered manager and staff showed that they knew exactly what pressure the mattress needed to be set at and confirmed that they checked it daily. The registered manager told us that they were working with staff to make the care plans more detailed to enable continuity of care should new or existing staff be delivering their care and support.

Although the majority of the care files were well written we were concerned that the terminology used in two care files was not appropriate. For example, one care plan used the word "Feeder cup" and another used the word "Wandering" to describe the person's walking habits. This wording was old fashioned and not very respectful and staff should avoid using it both when writing and talking about people's care. The registered manager was able to answer our queries around each person's care and support and gave assurances that the care files would be reviewed and rewritten immediately.

People were encouraged to be as independent as possible and they were able to continue doing small household tasks within the service as wished. For example, one person told us that staff had told them, "There is no such thing as you can't do it." They went on to explain that, "The staff encourage me to do things. I go to a day centre two days a week. When I'm here I set the tables for lunch, breakfast and tea. I wipe the tables down and clear the dishes. I like to do jobs just to keep me going." They also told us, "It's very relaxed, you do what you want. I don't have to answer to anybody. I'm never disturbed by others."

One staff member was responsible for organising activities for one and a half hours on each day that they

were working, which was usually every week day. If they were not available the task was then allocated to another member of staff. They told us, "The time is always protected. There is an amenities fund which is used to pay for materials or equipment I need."

Fund raising events took place throughout the year with coffee mornings and fairs. Activities included quizzes, reminiscence activities, boccia and games. Outings to garden centres and the local theatres were taken in a hired minibus.

The staff member had not received any formal training in activities for people with dementia, but told us they looked for ideas online. They said that they tried to do one-to-one activities with some people, but their time was limited. All the activities were recorded showing who took part and on what day. These records were available for our inspection.

Other staff appeared to be very familiar with people as individuals and spent time with them during our inspection. We saw one person becoming distressed and staff members took them away from others and spent time talking and reassuring them until they were more settled.

People were able to personalise their own bedrooms with furniture and pictures that they liked, which made each bedroom individual and reflected their personalities. However, all the corridors were decorated in the same manner with very little signage to enable people to navigate to their bedrooms or recognise their door or bedroom. Discussion with the registered manager indicated work had begun to improve this with families being asked to bring in objects or photographs that people would recognize and these were to be placed outside each person's bedroom.

We saw that there was a complaints policy and procedure in place for the service, but this needed to be more detailed about the complaints process that would be followed from start to finish, including the fact that people would receive a written response to their concerns, with the timescale for this to be delivered in. There was also no information about the contact address for the registered provider or the local authority (East Riding of Yorkshire Council). This would help people have the right information should they wish to take their concerns higher than the registered manager.

We saw that the registered manager had investigated two formal complaints in the last year; these were well documented and showed that the registered manager had responded to each person making the complaint and these were now resolved.

No-one we asked had ever made a formal complaint. Some people had raised issues and these had been dealt with immediately. Everyone said they thought that they were listened to. People commented that, "They're only trifling things but they always listen to us and take it on board" and "I've not complained about anything! There's nothing to complain about."

We saw evidence of people's satisfaction with the service in the form of written cards and letters sent in by their families. In the last six months people had commented, "Thank you for your help and encouragement, laughter and kindness", "First class, comfortable care home for my respite stay", "Magnificent care and attention" and "Thank you for support and the wonderful carers."

Is the service well-led?

Our findings

At the last inspection on 20 January 2015 we found that people were not protected against the risks of inappropriate or unsafe care and treatment because of the ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 5 May 2016 we found that the registered provider had followed the action plan they had written following the January 2015 inspection and sufficient improvement had taken place to demonstrate that the breach had been met.

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback from people who used the service and staff was obtained. The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the service.

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and said that the registered manager sought ideas and suggestions on how care and practice could be improved. The registered manager was described as being open and friendly and there was an open door policy as far as they were concerned.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC by December 2015. This was completed and returned with the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

There was a registered manager in post who was supported by a deputy manager, senior staff and the registered provider. Everyone who spoke with us was able to tell us the name of the registered provider and the registered manager and were confident about raising any issues with either one of them. People told us they felt the service was well run and they were happy there. The service had a calm atmosphere about it on the day of the inspection and the registered manager told us they aimed to provide people with a pleasant and relaxing place in which to live.

The registered provider of the home was very involved in management of the home and people knew who they were. When asked about the registered manager people told us, "We talk to each other and they respond well to problems" and "Oh, they are lovely they makes me laugh." We spoke with the family of one person who had just moved into the home. They told us, "The manager has been very helpful. The whole thing has been a very positive experience for all of us. It's very clean, [Name's] got a nice room with a good view in nice surroundings."

People told us that meetings were held regularly and that they were asked if they wanted anything to go on the agenda. On the main notice board were copies of minutes of meetings, newsletters and dates of the next meetings. We saw other ways that the registered manager used to obtain people's views of the service. This included a suggestion/comment box in the entrance hall and satisfaction questionnaires that were given out every six months to professional visitors, families and friends, people using the service and staff. Feedback received by the registered provider was then discussed at each resident meeting and documented in a "You Said, We Did" format. For example in April 2016 people said they were not always aware of who their key worker was. In response the service put the pictures and names of key workers in people's bedrooms.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The registered manager carried out monthly audits of the systems and practices to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in April 2016 and covered areas such as reportable incidents, complaints, staffing, safeguarding and health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified.

We discussed with the registered manager at the end of this inspection that there remained some areas for improvement in the auditing of the service, in particular around medicines and infection control and care plans. The registered manager acted on our feedback immediately where able, and sent written confirmation following the inspection that further action had been taken to ensure all areas discussed were reviewed and updated.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity.</p> <p>Regulation 12 (1) (2) (g)</p>