Heltcorp Limited

Goole Hall

Inspection report

Swinefleet Road
Old Goole
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Tel: 01405760099

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 November 2016 and was unannounced. The home was last inspected on 9 November 2015 when we issued requirements in respect of two breaches of regulation. We were concerned about the safety of the stairs down to the basement of the home and also that health and safety audits at the home had not identified these safety issues.

The home is registered to provide accommodation and care for up to 28 older people, including people who are living with dementia. On the day of the inspection there were 22 people living at the home. The home is situated in Old Goole, on the outskirts of the town of Goole, in the East Riding of Yorkshire. The premises have three floors and the lift operates between all levels. The home is located along a drive way from the main road and sits within its own grounds. Most people have single bedrooms and 17 bedrooms have en-suite facilities. There is a communal bathroom on two floors but no shower room.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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 premises were clean but there was an underlying odour in the entrance hall and some communal areas of the home. In addition to this, some carpets needed to be replaced, the lift was very noisy, the gate at the front of the premises was open when we arrived and there were pot holes in the drive. This meant that the premises were not always suitable for the purpose for which they were being used.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009: Premises and equipment. You can see what action we asked the provider to take at the end of the full version of this report.

People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults and understood their responsibilities in respect of protecting people from the risk of harm. There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, the registered manager had not informed us when DoLS authorisations had been authorised, which is a legal requirement.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents.

Quality audits undertaken by the registered manager and senior managers were designed to identify that

systems at the home were protecting people's safety and well-being. However, we were concerned that health and safety audits had not identified the safety aspects of the main stairs. Although this was rectified following the inspection, this was only as a result of us raising this during the inspection. We have made a recommendation in respect of this shortfall.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs although the deployment of staff needed to be reconsidered over lunchtime. There were recruitment and selection policies in place and these had been followed on most occasions, although not in all. This could have resulted in people who were not considered safe to work with vulnerable people being employed. We have made a recommendation in respect of this shortfall.

Staff told us that they were well supported by the registered manager. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

Staff had received appropriate training on the administration of medication. We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home and relatives told us that staff were very caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff, and that staff had a good understanding of people's individual care and support needs.

A variety of activities were provided to meet people's individual needs, and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were very happy with the food provided and we observed that there was ample choice. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met.

The registered manager was aware of how to use signage, decoration and prompts to assist people in finding their way around the home, and good progress had been made towards making these available.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some identified issues in respect of the premises had not been actioned, such as the pot holes in the drive, the cleaning or replacement of dirty carpets and the repair to the noisy lift.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had usually been recruited following the home's policies and procedures, although they had not been followed in one instance. There were sufficient numbers of staff employed to ensure people received safe and effective support.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual dietary requirements. People told us they liked the meals at the home.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and their advice was followed by staff.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

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

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

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs, their life history and the people who were important to them, although we noted that not all documents in care plans had been completed.

Activities were provided and visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. There were opportunities for people who lived at the home to express their views about the service they received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager in post, and people told us that the home was well managed. However, notifications about DoLS authorisations were not being submitted to CQC as required by legislation.

Audits were being carried out to monitor the effectiveness of the service. However, the health and safety audits had not identified the safety risks in respect of the main stairs and some required works had not been actioned promptly.

There were opportunities for people's relatives, staff and health and social care professionals to give feedback about the quality of the service provided.

Goole Hall

Detailed findings

Background to this inspection

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

The inspection took place on 15 November 2016 and was unannounced. The inspection was carried out by 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.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. 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. The PIR was submitted within the required timescale. We also contacted Healthwatch to ask for the outcome of their 'Enter and View' visit. Healthwatch is the consumer champion for health and social care.

On the day of the inspection we spoke with ten people who lived at the home, two relatives, two health care professionals, two members of staff, the registered manager, the quality manager and the operations manager. We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

We were concerned that there was nothing in place at the top of the main staircase and only a rope across the bottom of the main staircase. This meant that there were no measures in place to reduce the risk of falls associated with the stair areas. The registered manager informed us on 30 November 2016 (and sent us picture evidence) to show that gates had been fitted to the top and bottom of the stairs.

The home's health and safety audit identified that the drive was full of pot holes, and this was also raised with us by a visitor to the home. We noted that work had not been undertaken to rectify this.

CQC had been made aware of an occasion where a person had been able to leave the home by pushing past a visitor and this had resulted in them being at risk. We identified that this incident was not due to the front gate being left open. However, we found the gate at the front of the premises to be open when we arrived for the inspection. This could have put people at risk as it allowed access to the road and people with dementia related conditions may not have understood the risk posed. We spoke with the registered manager who said they would reiterate to staff and visitors that the gate should be locked at all times.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, emergency lighting, fire extinguishers and the passenger lift. However, we noted that the passenger lift made a very loud noise; this was also mentioned to us by people who lived at the home, staff, visitors and a health care professional. One person who lived at the home also mentioned that the lift doors were very heavy. They told us, "I find difficulty with the lift because the doors and very heavy and I have to prop them open with my walker." The registered manager sent us information following the inspection to show that the lift had been maintained and was in working order. However, it was acknowledged that the lift was noisy. The registered provider had received a quote for the equipment that was needed to reduce or alleviate the noise, but this work had not been carried out.

We could not locate an electrical installation certificate on the day of the inspection and this was forwarded to us after the inspection by the registered manager. This evidenced that the premises were safe but there were some recommendations for improvement. The registered manager confirmed that the required works had been completed.

The maintenance log recorded the tasks that needed to be done daily; these included removing debris from the drive, checking carpets, checking the biomass boiler and checking the maintenance book. Checks on water temperatures and to manage the risk of Legionella in the water supply were also being carried out. The registered manager acknowledged that there had been no routine checks of window opening restrictors, mattresses or wheelchairs; this had been recognised by the new senior managers and these checks were being introduced.

The home was maintained in a clean and hygienic condition, although we noted there was an underlying odour in the entrance hall and some communal areas. We noted that the carpet next to the lower ground

floor fire exit to the kitchen required replacing and some other carpets were well worn and 'sticky'. We saw that lounge chairs were washable and that domestic staff cleaned these whilst people were out of the lounges having their lunch. The home had achieved a rating of 3 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available. We asked the registered manager if they had completed the required improvements following this inspection and they confirmed they had.

The concerns we identified in respect of the premises, such as the need to replace some carpets, the noisy lift, the gate at the front of the premises being opened and pot holes in the drive meant that the premises were not suitable for the purpose for which they were being used. This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009: Premises and equipment.

Most people who lived at the home told us they felt safe living at Goole Hall. One person said "It's like being in my own flat but I can call someone if I need them." Two people told us they felt less safe as another person who lived at the home had entered their rooms uninvited. In response to this they now kept their bedroom doors locked. The registered manager had identified this issue and was able to explain that this was due to the person's dementia but that they did not pose a risk to others. They also assured us that they were taking action to ensure that people felt safe.

Staff described how they kept people safe. One member of staff told us, "We make sure there are no obstructions. We use the right equipment; we don't need to use a hoist at the moment but we use handling belts." We noted that care plans recorded information about each person's mobility and how staff should assist them to move around the home and transfer safely. The healthcare professionals who we spoke with confirmed they thought people were safe living at the home.

People had a 'missing person sheet' in their care plan that included their description; this was to assist the emergency services should they go missing from the home.

Staff told us that they completed training on safeguarding adults from abuse, and that they completed regular refresher training. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager and were confident they would be listened to and that appropriate action would be taken. We contacted the local authority safeguarding adult's team prior to this inspection and they did not share any concerns with us about Goole Hall. Notifications had been submitted to CQC appropriately in respect of any safeguarding incidents that had occurred at the home.

Staff told us they would not hesitate to use the home's whistle blowing policy and that they were confident the registered manager would protect their confidentiality.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. However, we noted that one person had declared on their application form that they had no convictions, yet their DBS check recorded a conviction. The registered manager acknowledged that this had been missed during the recruitment process.

We recommend that the organisations recruitment and selection policies are always adhered to. This would ensure that only people considered suitable to work with vulnerable adults had been employed at Goole Hall.

We noted that interview questions and responses had been retained with people's recruitment records. This gave the registered manager information about the applicant's level of understanding as well as their training needs.

The quality manager told us that a new dependency tool had been introduced within the organisation and that this would provide an effective tool to assess the level of support each person required, and assist the service to determine the staffing levels they required.

The registered manager told us that the standard staffing levels on day shifts were one senior care worker and two care workers, and two care workers during the night. We checked the staff rotas and saw that staffing levels had been consistently maintained, as most staff absences were covered by permanent staff working additional hours.

Most people who we spoke with told us they thought the home would benefit from having more staff. A relative told us they felt their family member would eat more if staff had time to sit with them at mealtimes. One member of staff told us that staffing levels were good and they were able to respond to people's needs promptly. Another member of staff said, "We could do with an extra member of staff, especially between 9.00 am and 1.00 pm." We noted that there was always a staff presence in communal areas of the home and a health care professional told us there always seemed to be enough staff around, and said they could always find someone to assist them. We observed that the time staff appeared to be 'stretched' was over lunchtime; because some people needed assistance to eat their meals and other people needed their meal taking to them in their bedroom. We discussed this with the registered manager following the inspection and they agreed to consider the deployment of staff during meal times to ensure it was effective and met people's needs.

In addition to care staff, there was a cook and a domestic assistant on duty each day. The registered manager told us that two domestic staff worked on a Tuesday when more in-depth cleaning took place. There was also an activity coordinator employed at the home each afternoon, Monday to Friday and the registered manager was on duty in addition to care staff. This meant that care staff were able to concentrate on supporting and caring for people who lived at the home.

Risk assessments had been completed for areas that were considered to be of concern. We saw risk assessments for pressure area care, skin integrity, diabetes, falls, mobility, aggression / agitation and nutrition. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date. We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage these behaviours to diffuse such situations. One person was prescribed medication to calm them when they became agitated. This strategy had been agreed with the person's GP and was recorded in their care plan, with the message 'Monitor and record any changes'. We saw that this person was monitored throughout the day (with records kept) to check that they did not become drowsy on this medication. If they did, medication was not given.

When people were at risk of developing pressure sores, we saw that they had been provided with the appropriate equipment to minimise this risk. People also had regular positional changes to help relieve pressure on certain areas of their body. People who needed assistance to move around the premises or to be assisted with transfers by staff had been provided with suitable equipment to enable this to be carried

out safely. One person told us, "I have breathing problems and I have a wheelchair now."

We checked the arrangements in place for fire safety. There was a fire risk assessment in place and in-house checks of the fire alarm system, emergency lighting and fire extinguishers were being carried out. Each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

We observed that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in biodose packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The biodose packs were colour coded to denote the time of day when the medication needed to be administered. In addition to this, they recorded the person's name, the name of their GP and a picture of each medication prescribed.

Biodose packs and medication supplied in boxes or bottles were stored in the medication trolley and the trolley was stored securely at the 'nurse station'. The registered manager told us that it was the home's policy to date boxed medication when the packaging was opened. This was to make sure medication was not used for longer than the recommended period.

We saw that controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication held in the cabinet balanced.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the area where medication was stored were checked to ensure that medication was stored at the correct temperature. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book. There was no audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The registered manager told us they would raise this with the pharmacist used by the home.

We looked at medication administration record (MAR) charts and found that they were clear, complete and accurate. MAR charts included the name of the person, the name of their GP, their date of birth and whether they had any allergies. Most handwritten entries were signed by two people; this reduced the risk of errors occurring when transcribing information from the label on the medication to the MAR chart. We saw that there were no gaps in recording and there were protocols in place for the administration of 'as and when required' (PRN) medication.

Only the registered manager and senior staff were responsible for the administration of medication. The training records identified that some people's refresher training was overdue, and did not record the training completed by some staff. Following the inspection, the registered manager confirmed which members of staff had completed medication training, and that overdue refresher training had been completed. Records showed that medication competency checks had also been carried out by either the current or a previous operations manager. A health care professional told us that medication at the home was well managed.

We checked the accident and incident records in place at the home. Accident forms were completed in respect of each incident, and the registered manager completed a monthly monitoring form that checked staff had responded effectively when accidents had occurred and to identify if any trends or patterns were emerging.

Good

Is the service effective?

Our findings

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that some applications submitted to the local authority had been authorised and there was a record of when the applications needed to be resubmitted to renew the DoLS in place.

The training record showed that staff had completed training on MCA / DoLS. Staff who we spoke with understood the principles of the MCA and DoLS and confirmed they had completed training on this topic.

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that recorded people's consent to their care plan, photography and to information being shared. One person had not signed their consent form as they did not have the capacity to make these types of decisions. However, the form recorded that consent had been given by their relative and there was no evidence that the relative had lasting power of attorney (LPOA) or power of attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. We discussed with the manager how they needed to determine whether family members had the authority to make decisions on a person's behalf, and this was acknowledged.

One person's care plan included information about a best interest meeting that had been arranged to assist them with making a decision about permanent residential care, as they did not have the capacity to make this decision for themselves. The meeting had been attended by the person concerned, a relative and a care manager.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "I would show people different choices of clothes, and might describe meals to them rather than showing them pictures of meals." We noted that care plans recorded people's choices such as the time they would like to go to bed and get up and whether they liked the light on during the night. People who lived at the home told us they could choose whether to spend their day in their own room or in communal areas of the home.

Staff carried out an induction programme when they were new in post. Staff confirmed that they had induction training before they commenced working 'on the rota' and that this included shadowing an

experienced member of staff. The registered manager told us that new members of care staff had commenced the Care Certificate; the Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

We checked the home's training record and this showed that the training offered by the organisation included moving and handling, infection control, challenging behaviour, safeguarding adults, health and safety, MCA, DoLS, food hygiene, fire safety, first aid, falls awareness, dementia awareness, end of life care, the control of substances hazardous to health (COSHH), equality and diversity, nutrition, catheter care and pressure ulcer prevention. Records showed that staff had completed this training, although a small amount of refresher training was overdue. The training record also recorded how often staff were expected to carry out this training, either annually or three yearly.

The training record showed that 8 staff had completed either Qualifications and Credit Framework (QCF) training or National Vocational Qualification (NVQ) training at Level 2. QCF has replaced the NVQ award and is the national occupational standard for people who work in adult social care. A further five staff had started to work towards this award. The registered manager and senior care worker had completed this award at Level 3. The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. A health care professional told us that staff had good knowledge and that they highlighted relevant issues.

Staff told us that they had supervision meetings with the registered manager and they felt well supported. The supervision matrix we saw in the manager's office showed that each member of staff had attended three supervision meetings during 2016, with another meeting booked before the end of the year.

Any communication from the NHS was retained with people's care records so that it was available for staff. We saw that some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place and that these had been signed appropriately by their GP. People told us that they could see their GP whenever they needed to. One person told us, "I had a problem with swelling on my leg. I showed it to a carer and they contacted the doctor to call to see me. I then got a prescription."

We saw that any contact with health care professionals was recorded in the person's care plan. One record showed that the person's GP had recommended that they be referred to the specialist dementia nurse. The dementia nurse was at the home on the day of this inspection so it was clear this advice had been followed. Health care professionals told us that staff asked for advice appropriately and then followed that advice. One health care professional told us, "I trust them to do so."

We saw that people's nutritional requirements were recorded in their care plan; this included any special dietary requirements to meet health care needs and their likes and dislikes. The dietary requirement care plan took the form of a list of questions, such as, 'Does the service user have difficulty swallowing?', 'Has the service user's clothing become loose?' and 'Does the service user often have a drink instead of eating meals?' One person had been seen by a dietician and the speech and language therapy (SALT) team and their care plan recorded, 'Requires Stage 1 thickened fluids and a softer diet'. We were shown the separate folder that was kept in their room that included more detailed information from the dietician about food and fluid intake. This meant that the information was easily accessible for staff.

Charts were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored. Fluid had been recorded in millilitres although it had not been totalled for the day. This made it difficult to see at a glance if the person had taken sufficient fluids. In addition to this, some forms had been not dated. This meant that the monitoring of food and fluid intake

was not as effective as it could have been. However, a community nurse who we spoke with told us about one person who was not eating or drinking. They said, "[Name] is now eating and drinking – they have done a good job with them." This demonstrated that advice received about people's nutritional needs was being followed by staff.

We observed the serving of lunch in the dining room. We noted that staff created a social atmosphere and encouraged people to chat to each other. Tables were set with tablecloths, napkins, glasses, condiments and cutlery, and that there were flowers on each table. The serving trolley included a variety of choices for people; scampi, tuna pasta bake, fish fingers and fish cakes. There was only one choice of dessert but staff told us there were alternatives available if people requested them. People were offered a choice at meal times (rather than being asked earlier in the day) and staff told us that there was ample food available so that people's choices could be provided.

We observed that one person chose one dish, decided they did not like it and a care worker asked if they would like another choice. This was provided and they proceeded to eat the full meal. We saw that people were able to eat at their own pace and staff gently encouraged people who were reluctant to eat. People told us they enjoyed the food provided at the home. One person said, "It is improving and they ask us what we like and are bringing in a new menu."

We saw there was a four week menu on display and there was a notice to inform visitors about protected mealtimes. This is when visitors are encouraged not to visit their family and friends at mealtimes so that people are able to concentrate on eating their meal and receiving adequate nutrition.

We saw that there was signage to assist people to find toilets and other areas key areas of the home, such as the lift and bathrooms. Doors were painted in different colours and had the person's name and room number on them. The activities coordinator had made signs for people's doors that included a picture that meant something to the person, such as a boat, gardening tools and cars. Handrails were painted in a contrasting colour so they were easy for people to identify. These prompts helped people who were living with dementia to orientate themselves within the home. The registered manager acknowledged that carpet needed to be replaced as they were currently patterned, and research shows that people with cognitive difficulties find plain flooring less distracting and confusing.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Their comments included, "The staff are magnificent", "I love it here, I get better attention here than in hospital" and "Apart from the odd one, they are all ok." More than one person mentioned a female staff member by name. They told us, "She is lovely." A health care professional told us, "I have never heard staff moan. They genuinely care. They are upbeat, 'clued up' and positive. They want the best for the residents." A relative told us, "The girls are brilliant."

Staff told us they were confident everyone who worked at the home genuinely cared about the people who lived there. One member of staff said, "Staff definitely care. I really enjoy caring for the people who are living with dementia."

We saw positive interactions throughout the day between people who lived at the home and staff. We noted that people were comfortable in the presence of staff, and that staff were attentive, compassionate and patient. People who lived at the home told us that 'the right kind of people' were employed. One person said, "The staff know what they are doing."

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve. We observed a community physiotherapist working with a person, advising them how to regain their mobility following a stroke. This person told us afterwards, "The carers encourage me to do the exercises as well." One couple lived more independently in a flat situated on the lower ground floor.

A health care professional told us that people were allowed to move around the home freely. However, we saw that one person was being cared for in their bedroom. They were at risk of choking due to their difficulty with positioning in a chair and so remained on 'bed rest' until they had been assessed by an occupational therapist (OT) for a special positioning chair. This meant that their movement around the home and within their bedroom was restricted until this assessment could take place. However, it was clear from the records we saw that the registered manager had informed the OT service that this referral was urgent, but the person remained on a waiting list for an assessment.

People's care plans recorded whether they preferred to be assisted with personal care by a male or female care worker. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. Staff told us that they respected people's privacy when they were assisting them with personal care, such as making sure doors were closed and by covering people up when they were undressed. A health care professional told us they always saw people in their own rooms to protect their privacy.

We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery.

There were two bathrooms at the home but no shower. A relative told us that their family member would

enjoy a daily shower. The registered manager told us that they had requested that a shower room be provided and anticipated that this would be actioned.

At the staff meeting in May 2016 the introduction of champions for dementia, infection control, first aid and medication were discussed but we did not see any information around the home to indicate people had been allocated to these roles. It is the role of champions to take a special interest in their topic and share good practice amongst their colleagues.

We saw that there was information displayed in the home about advocacy services should people require independent support with decision making. There were also notices to inform people about the support that could be offered by the Alzheimer's society, Deprivation of Liberty safeguards, care home funding and end of life care.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

However, we noticed that some care plans included inappropriate language that had been recorded by staff. We brought this to the attention of the registered manager, who assured us they would raise this with the staff members concerned. It was acknowledged that some staff might need further training or support to understand the use of respectful language.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included physical health, personal support / hygiene, dietary requirements, pressure area care, night care and mobility. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, a falls assessment, the Malnutrition Universal Screening Tool (MUST) and an oral health assessment. This recorded whether the person had their natural teeth, their abilities around tooth / mouth care, whether they were registered with a dentist and whether they had received a dental health check. When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

Each person's care records included information about their GP, their daily routines and their medical conditions. Staff told us, "We try to ensure any family are involved in developing the care plans for our residents." Each person's 'one page profile' included information about how they liked to spend their time, such as 'Enjoys his family visiting and chatting with staff'. We asked staff how they got to know about people's individual needs and they told us they read care plans and spoke with relatives. This information helped care staff to get to know the person.

We saw that some documents in care plans had not been completed, including arrangements in the event of death, the Waterlow risk assessment, consent to care plan, patient passports and the missing person sheet. However, there was no evidence that this had led to people not receiving appropriate care and support.

We saw a list of care plan reviews in the manager's office. This recorded that eight care plans had been reviewed in September 2016 and that other care plans were due to be reviewed in December 2016. This was in addition to the routine monthly reviews. One person's care plan recorded details of a care plan review undertaken by a care manager. They had suggested that staff should consult the person's GP about 'build up' drinks and monitor the person's dizzy spells. The health care professional contact sheet evidenced that the person's GP had been contacted about fortified drinks and these had been prescribed. This showed that the registered manager followed up any suggestions made during care plan reviews.

A relative who we spoke with confirmed they felt there was good communication between themselves and staff at the home. They said they visited regularly and received up to date information each time they visited.

A member of staff told us they encouraged people to engage with the local community and to get the public to visit the home. They said, "We had a garden party in the summer and invited the public as well as family and friends of both the residents and staff." They added, "We also try to encourage residents to go out with their family if they feel up to it." We saw that the home was located with its own grounds although there were no obvious outdoor seating areas that were easy for people to access. One person told us, "There is no-

where to go outside, even when the weather is warm. It would be nice to go outside sometimes." A relative said, "There is no-where to take people out in a wheelchair. The grounds are not useable." We discussed with the registered manager how the outside space could be utilised safely.

Relatives told us that they could visit the home at any time and were made to feel welcome. This was confirmed by the people who lived at the home who we spoke with.

There was an activities coordinator working each afternoon, Monday to Friday. One person told us, "I look forward to [Name] coming" and another said, "I love bingo, whether I win or not." However, a health care professional and a relative told us that more activities would be beneficial.

The up to date complaints policy and procedure was displayed around the home. The complaints folder included forms ready to record complaints and compliments and a form ready to audit any complaints received. The log showed that there had been one complaint and one concern received during October 2016. A meeting had been arranged to discuss the concern received from a family. The family concerned, staff and the person's social worker had been invited, and the registered manager told us that this situation had now been resolved.

People who lived at the home told us that they felt able to express their concerns, and they told us who they would speak to. One person said, "I'd tell a carer and they'd tell [Name of registered manager]" and another person told us, "I'd tell [name of senior care worker]. She would sort it, she never forgets anything." One relative said, "We have no complaints. As long as [Name of family member] is ok then we are, and he is happy here." Another relative told us they had not needed to raise any concerns about care practices and they were confident that the registered manager would listen to any concerns and try to rectify them. However, they had raised a complaint about the pot holes in the drive. They said that they had travelled in an ambulance along the drive and it was an uncomfortable journey. This had been identified in the quality audits undertaken by the registered manager.

A satisfaction survey had been distributed to people who lived at the home and relatives in October 2016. This had not been analysed by the organisation but we checked individual surveys and saw that one person had said, "Things have improved since [Name] has become the manager." One person raised concerns about food sometimes not being served hot. On the day of the inspection we saw that food was stored in a heated trolley until it was served, and that the food served was hot.

We saw that meetings were held for people who lived at the home. The most recent meeting was on 4 November 2016. Eighteen people who lived at the home attended the meeting. Activities and outings were discussed and people were asked if they were happy with the care they received. They all responded positively. People commented that the food provided was good, but they would like more choice at tea-time and that they were happy with the activities provided. Comments from people included, "The staff are brilliant" and "[Name of registered manager] is always willing to please and has a lovely personality too." These meetings gave people an opportunity to express their views, make suggestions and ask questions about care provision.

Relatives told us that they were aware of relatives meetings although the most recent one had been cancelled as the registered manager was unwell. They said that they would not hesitate to raise issues and were confident they would be dealt with. There was a notice in the entrance hall stating that the registered manager was available to speak to people at any time. However, to formalise this they had advertised 'surgeries' on 14 November 2016 and 12 December 2016 when people had been invited to visit the home to speak with them about any concerns.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications', apart from notifications to inform CQC when DoLS applications had been authorised. The registered manager submitted these notifications following the inspection.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notifications of other incidents. We will deal with this breach of regulation outside of this inspection process.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. The judgements from the most recent inspection were on display, as required by regulation.

We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that these interactions were positive and friendly. It was clear the registered manager knew all of the people who lived at the home well. Health care professionals told us that the service was well managed. One person said, "[Name of registered manager] has blossomed."

We saw a daily plan that included checks of staff handover records and a walk around the home displayed in the registered manager's office. There was also a list of quality audits displayed. These included audits of accidents, health and safety, medication, care plans, pressure area care and the kitchen. Some were carried out on the first of the month and others were carried out on the 14th of the month. We saw completed audits for the kitchen, food hygiene, infection control, infections, care plans, pressure ulcers and health and safety.

In addition to this, the quality manager carried out audits (home visit reports) each month. This audit included a walk around the home to assess first impressions, the welcome, cleanliness, if people looked well cared for and whether call bells were answered promptly. Any required actions were recorded, along with who was responsible for undertaking these actions and a completion date. We saw there was an annual report that recorded the outcome of all audits carried out, and there was an action plan in place for areas that required improvement.

However, we were concerned that quality audits had not identified the safety risks in respect of the main stairs. Although this area of the home was made safe following our inspection, we were concerned that action had only been taken when we had raised this as a health and safety issue.

We saw the maintenance action plan dated November 2016. This recorded repairs that needed to be completed and refurbishment that was required. We noted that most of this work had not been carried out, although the new flooring that was required for one person's en-suite facility had been fitted in October 2016. We also identified that the registered provider had been made aware that the drive to the home was full of potholes and therefore unsafe, but appropriate action had not been taken. The registered manager told us that temporary repairs had been made to the drive but they had not been successful.

We recommend that quality audits are made more robust so they identify all health and safety issues, and that any identified shortfalls are actioned promptly.

Staff described the culture of the home as "Friendly", "A good environment" and "Good team work". One member of staff told us, "It is like a family working at Goole Hall."

Staff meetings were held periodically and staff told us they could ask questions and make suggestions at these meetings. We saw the minutes of the staff meeting held in October 2016. The topics discussed included care plan updates, documentation / recording, the recording of activities, laundry, domestics, staff supervision, the use of mobile telephones, cleanliness and staff uniforms. A Halloween party and Christmas party had been arranged and the registered manager told staff that they needed to book trips out for anyone who wanted to go Christmas shopping or to see the Christmas lights. The previous staff meeting was in May 2016 when privacy and dignity and the introduction of staff champions were discussed.

Staff had also been issued with a satisfaction survey; this was not dated so we could not determine when the survey took place. The information had not been analysed so we surmised that it was a recent survey. The registered manager told us that they were aware that the current process for managing satisfaction surveys was not ideal and improvements were being made.

A separate meeting had been held in May 2016 for senior staff to discuss training on the new medication system that was being introduced. A manager's meeting had taken place in October 2016 and we saw the topics discussed included the stakeholder survey, menus, new audits, activities, the new supervision form and the introduction of the 'resident of the day' scheme. This is when one person receives particular attention for the day, such as inviting their relatives for lunch or going out somewhere special.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Not all areas of the premises and equipment used by the service provider was clean or suitable for the purpose for which it was being used. Regulation 15 (1)(a)(c)