Dryband One Limited

Newgrove House Care Home

Inspection report

Station Road
New Waltham
Grimsby
Lincolnshire
DN36 4RZ

Tel: 01472822176
Website: www.newgrovehousecarehome.net

Date of inspection visit:
26 May 2016
27 May 2016

Date of publication:
07 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Newgrove House is registered to provide personal care for up to 40 older people, some of whom may be living with dementia. The home is a purpose built two storey service situated between Waltham and Humberston and has access to all local facilities. On the day of the inspection, there were 26 people using the service.

The service did not have a registered manager in post. The previous manager had resigned and a new acting manager had been appointed four weeks prior to the inspection. 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.

This inspection was unannounced and took place over two days. The previous comprehensive inspection of the service took place on 15 September 2014 and the registered provider was found to be non-compliant with one of the regulations inspected. We undertook a follow up inspection on 15 April 2015 and found compliance had been achieved.

There had been some staffing difficulties with a number of senior staff leaving the service in recent weeks; this included the previous acting manager and two team leaders. Although the service had tried to cover all shortfalls, staffing numbers had not been maintained on all shifts. During the inspection, we found this was being addressed and recruitment was well underway.

We saw recruitment checks were carried out, although one member of staff had started work before their references had been returned. People told us there were sufficient staff to support them and they were not kept waiting long when they called for assistance.

People's nutritional needs were met and they were happy with the quality of the meals although some felt the menus were repetitive and needed review. We found the mealtime experience for some people was not positive on the first day of the inspection but improvements were made on the second day to ensure people received more consistent support.

We found staff had access to training and support. Although formal supervision was behind schedule, staff told us they could talk to the acting manager at any time and they were available for advice.

We found the quality monitoring system was limited and had not been effective in highlighting some areas to improve and action had not been consistently taken in order to address shortfalls. Delays in renewal of the premises were evident, however a major refurbishment programme was underway which included the provision of suitable adaptations and décor to better support the orientation and safety of people living with dementia. The regional manager confirmed new quality monitoring systems were being introduced.

Staff approach was seen as kind and caring; they took time to speak to people, they respected their privacy and dignity and involved them in day-to-day decisions. Staff had developed positive relationships with people and their families. We saw people were encouraged to maintain their independence where possible.

Staff involved people and sought consent from them prior to carrying out tasks. We saw when people were assessed as lacking capacity to make their own decisions, the service worked within the law.

People told us they felt safe living at the home. We saw there were systems and processes in place to protect people from the risk of harm. Staff we spoke with were knowledgeable about safeguarding people and were able to explain the procedures to follow should an allegation of abuse be made. Assessments identified risks to people and management plans to reduce any risks were in place to ensure people's safety.

Medicines were stored safely and procedures were in place to ensure they were administered correctly. We saw people received their medicines from senior staff who had been trained to carry out this role.

People told us their needs had been assessed before they moved into the home and we saw they, or their relatives, had been involved in planning their care. The four care files we checked reflected people's needs and preferences in detail. Care plans and risk assessments had been reviewed on a regular basis to assess if the planned care was working, or if changes needed to be made. We found improvements were needed with the recording of people's behaviour that challenged the service to inform effective review.

People had access to an activities programme which provided regular in-house activities and stimulation. People told us they enjoyed the activities they took part in, but could choose not to participate if they preferred. They were particularly complimentary about the new vegetable patch and helping with the planting or sitting in the garden and watching.

The people we spoke with said they had no complaints, but would feel comfortable speaking to staff if they had any concerns. We saw the complaints policy was easily available to people using or visiting the service. We saw that when concerns had been raised these had been investigated and resolved promptly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The service had experienced staffing difficulties in recent weeks and staffing numbers had not always been maintained. However, this was being addressed and recruitment was well underway. Recruitment checks were completed although in one of the five staff files we checked this could have been more robust prior to them starting work.

People who used the service were protected from the risk of harm and abuse. Staff had completed training and knew what to do if they had any concerns. Risk assessments were completed and regularly reviewed.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People accessed a range of health professionals to ensure their day-to-day health needs were met. The monitoring and recording of people's behaviour which challenged the service needed to be more consistent to provide a clearer picture of the effectiveness of their care support and medication regime.

Although people's nutritional needs were met and they told us they liked the meals, their mealtime experience could be improved with closer staff supervision and support.

People were able to make their own choices and decisions. When people were assessed as lacking capacity to make their own decisions, the registered manager mostly worked within the principals of the Mental Capacity Act 2005. We found capacity assessments had been completed, best interest meetings recorded and staff used least restrictive practice.

Staff had access to training, supervision and support to help them feel confident when supporting people.

Is the service caring?

Good

The service was caring.

We saw staff were kind, patient and caring to people, and they seemed relaxed in the company of staff.

Staff demonstrated a good awareness of how they respected people's preferences and ensured their privacy and dignity was maintained. People's independence was encouraged where possible.

A good range of information was provided to people in the service on noticeboards, via newsletters and in meetings.

Is the service responsive?

Good

The service was responsive.

Assessments were completed and care plans were produced in a person-centred way which helped to guide staff in how to support people in the way they preferred. People and those that mattered to them were encouraged to make their views known about their care, treatment and support.

An activity coordinator encouraged people to participate in meaningful activities and occupations within the service. People were enabled to maintain relationships with their friends and family.

A complaints policy and procedure was in place. People were aware of how to make a complaint and told us any concerns would be dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The regional manager had started to make improvements to the quality monitoring programme to ensure all areas of the service were properly assessed and any shortfalls addressed within acceptable timescales.

Meetings were held to enable people who used the service, their relatives and staff to express their views about the service.

People we spoke with told us the acting manager was approachable and always ready to listen.

Newgrove House Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 26 and 27 May 2016 and was carried out by one adult social care inspector.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service, such as notifications. We also contacted the local authority safeguarding team, the contracts and commissioning team and Healthwatch for their views of the service. The commissioning team provided us with information from their recent monitoring visit. We did not request a Provider Information Return (PIR) for this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well, and improvements they plan to make.

At the time of our inspection visit, there were 26 people living at Newgrove House. We used a number of different methods to help us understand the experiences of the people who used the service. We used the Short Observational Framework for Inspection (SOFI) in the lounge and dining areas. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with six people who used the service and seven relatives. We spoke with the regional manager, the acting manager, two team leaders, a care worker, a cook, a domestic worker, an activity person and a maintenance person. We also spoke with three visiting health care professionals.

We looked at four people's care records. We looked at 26 medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as

lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf. We looked at a selection of documents relating to the management and running of the service. These included five staff recruitment files, the training record, the staff rotas, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records. We also completed a tour of the premises.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe and staff treated them well. Comments received included, "Yes, I'm very safe here, we are all looked after very well" and "I am definitely safe, the doors are locked and the staff check round everywhere." Relatives we spoke with also had no concerns regarding the safety of their family member and spoke highly of the staff team.

The majority of people we spoke with considered the staffing levels were satisfactory. Comments included, "Usually enough on but a few have left recently which they are replacing", "There's always someone about if you need help" and "The staff are quite busy in the mornings, but always find time for you." One person considered the staff seemed 'stretched' which we discussed with the regional manager.

Staff confirmed staffing levels were generally sufficient to meet people's assessed needs but told us of the difficulties experienced in recent weeks with staff leaving and staff sickness. They were confident the shortfalls were being managed. Comments included, "If all the staff are in, it's usually okay. It's difficult to cover short notice sickness, but they try and get the staff", "The new staff are just starting and that will make a difference; the staffing was fine until a few weeks ago" and "The management are dealing with sickness issues. It depends who is on shift, but some days it's too busy and we could do with more support in the mornings."

The regional manager explained that a number of staff had left in recent weeks including the previous acting manager, two team leaders and a care worker. A new acting manager had been appointed and two staff had been successful with internal promotions to senior care positions. Recruitment to fill all vacancies was in progress with some new staff having started and more due to start. The administrator was due to leave the day after the inspection and a new administrator had been recruited and was working alongside them for orientation to the role.

Staff told us there were four care staff on duty during the day and three at night. We found cooks were employed to support all meal times and kitchen assistants provided support for breakfast and lunch meals. During the first day of the inspection, there was no kitchen assistant or activity co-ordinator on duty. A care worker had taken sick leave and cover had been found for the shift. We found there was little staff presence in the lounge areas in the morning to monitor people and provide support and also in the dining room at lunchtime. However, there were improvements noted on the second day and more staff were available to provide support.

We spoke with the regional manager about staffing numbers. They confirmed there had been some staffing pressures recently due to staff leaving, staff sickness and planned admissions. Checks on the rotas for the previous week showed there had been some shortfalls on night duty, but the current and new rotas confirmed staffing numbers were maintained. We found staff completed detailed assessments of each person's dependency each month, the regional manager confirmed this information was used to help calculate staffing numbers. They told us they had recently improved the staffing tool to support the provision of effective numbers of staff at the service. They also confirmed recruitment of new staff had been

positive with the majority of vacancies now filled.

We saw there was a recruitment and selection policy in place. We looked at the personnel records for five members of staff and found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and references, were obtained before staff began work. Although we found one newly recruited member of staff only had verbal references in place, their written references were provided during the inspection. The regional manager confirmed there had been delays with the provision of written references and pressures on staffing; they would ensure the organisational policy was always followed in future.

We found medicines were obtained, stored, recorded, administered and disposed of appropriately. Records showed staff were trained to manage and administer medicines in a safe way and had their competency formally assessed. Medicines were stored in the clinic room and we found this area was clean, organised and the room temperature well-managed. Controlled medicines were stored correctly and checks showed these were managed safely. We saw the medication administration records showed a small number of gaps where there was no signature to support administration or code used to identify the reason for non-administration. We also noted one person had regularly refused their medicines at specific times of the day. The regional manager confirmed they would follow up the recording issues with staff and arrange a medication review with the person's GP.

We saw people were given their medicines safely and in a sensitive and caring manner, which included allowing the time they needed to take these. The member of staff explained to people what medicines they were taking, offered extra prescribed medicines where appropriate, such as pain relief and gave people a choice of drink.

We spoke with staff about their understanding of protecting people from harm and abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns including reporting to external agencies. Staff spoken with said they would not hesitate to report any concerns they had about care practices to senior members of staff. Safeguarding procedures were on display on the notice board in the reception area. We looked at the safeguarding records and notifications sent to us from the service and found appropriate measures were put in place to protect people who used the service from abuse.

Staff had a good understanding about the whistle blowing procedures and felt that their identity would be kept safe when using them.

Staff demonstrated a good understanding of people's needs and how to keep them safe. They described how they encouraged people to stay as mobile as possible while monitoring their safety. We saw care workers moving people using hoist equipment and helping them move around the home in a safe and reassuring manner. They took time to explain what they were about to do and why this was necessary.

Care files we checked showed records were in place to monitor any specific areas where people were more at risk, and explained what action staff needed to take to protect them. We saw risk assessments covered topics such as falls, behaviour, choking, medication and moving and handling people safely. Where there were concerns about an individual's risk management, the service had involved appropriate agencies for advice and support. For example, some people's swallowing ability had been assessed by the speech and language therapist and their records contained clear guidance to support people safely.

Equipment used in the service was in working order and was checked and serviced in line with the

manufacturer's instructions. These included a passenger lift, moving and handling equipment, fire safety equipment, gas and electrical appliances, window restrictors and hot water outlets. We identified the nurse call system did not have an emergency call facility which may impact of staff response times. The regional manager confirmed they would ensure the impact of people's safety was assessed and managed and they would request review from the contractors.

Requires Improvement

Is the service effective?

Our findings

People told us their health needs were met and they were able to access health professionals when required. People also told us they liked the meals provided but some felt the menus could be updated and changed. Comments included, "The cooks are good but it would be good to have some different meals now and then" and "There's always a choice, the meals are well cooked and tasty." Comments from relatives about the meals included, "Sometimes a change of meat on Sundays would be appreciated, such as chicken", "Yes, they make something else if she [relative] doesn't like the choice" and "Not bad but the menu could do with a few changes."

Relatives told us they were happy with how the staff supported people's health care needs. They said, "Very good with contacting the GP if they are concerned about anything and they always let us know" and "Yes, they are very good at monitoring her [their relative]."

Observations during the first day of inspection showed organisation of staff needed improving to provide a more positive mealtime experience for some people in the dining room and to ensure people had access to drinks in the lounge areas during the morning. We mentioned these issues to the regional manager and found improvements had been made on the second day; a member of staff was allocated to the dining room to provide assistance where needed and monitor people's nutritional intake. We also found improvements had been made with the provision and support of hot and cold drinks for people during the mornings.

We were told how GPs, dieticians and the speech and language team had been involved if there were any concerns about meeting people's dietary needs. We saw people who were at risk of poor nutrition or dehydration had a nutritional screening tool in place which indicated the level of risk and their weight was monitored regularly.

The regional manager confirmed they were in the process of reviewing the menus following consultation with people who used the service. They were hoping to have them in place within a few weeks. The cook demonstrated a good knowledge about special dietary needs such as blended, fortified and diabetic meals. We also saw specially adapted cutlery and plate guards were available to help people eat independently.

The care files indicated that people who used the service had access to a range of health and social care professionals. These included GPs and consultants, district nurses and community psychiatric nurses, dieticians, social workers, chiropodists and opticians. Records were completed when the professionals visited and what treatment or advice they provided. In discussions, staff described how they recognised the first signs of pressure damage, chest infections and urine infections, and what action they took to ensure health professionals were made aware.

We received some mixed feedback from health professionals we spoke with. Community nurses considered staff followed their directions and provided a good quality of care. A mental health practitioner considered the staff did not always record incidents of challenging behaviour consistently to assess the effectiveness of

the care and medication their patients received. When we checked the care files we found some gaps in the behaviour monitoring charts. The regional manager confirmed they would address this with the staff to improve the record keeping.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw care files included mental capacity and best interest assessments and decisions. We checked whether people had given consent to their care and decisions, and where people did not have the capacity to consent, whether the requirements of the Act had been followed. We saw they had; we found assessments of capacity had taken place and best interest meetings held for specific people and particular issues, for example, decisions about end of life care.

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). At the time of the inspection, there were three DoLS authorisations in place and the service was waiting for assessments and approval for the remaining eight applications they had submitted. The DoLS were in place to ensure those people get the care and treatment they need and there was no less restrictive way of achieving this.

Throughout the inspection, we heard or observed staff gaining people's consent before care and support was carried out. In discussions, staff described the different ways people who used the service provided their consent and explained how they always observed their body language if they were not able to communicate verbally. All staff confirmed they did not use any physical interventions when they provided care and if people refused support they would respect this and report it to the senior care worker.

The training record showed staff had completed a range of essential training and this included; moving and handling, health and safety, safeguarding vulnerable adults from abuse, fire, infection prevention and control, medicines management, dementia care, MCA, food hygiene, dignity and prevention of pressure ulcers. We spoke with the regional manager about training for staff in conditions common to older people such as stroke awareness, arthritis and Parkinson's disease and they confirmed they were looking to include these courses in the training programme and provide a resource file for staff.

The staff we spoke with told us they had undertaken a structured induction when they started to work at the home. This entailed completing an induction workbook and essential training. The regional manager said new starters also shadowed an experienced member of staff until they were assessed as competent in their role, which was confirmed by the staff we spoke with. A newly appointed care worker told us, "Most of the training is through videos, but you get a knowledge test at the end to make sure you have understood it all." We found there were some delays with new care workers receiving practical moving and handling training or having their competency assessed whilst awaiting the course to ensure they were safe. The regional manager confirmed they would address this. Records showed new staff completed the Care Certificate. Staff were then encouraged to undertake external professionally recognised qualifications such as diplomas (previously National Vocational Qualifications [NVQ's]) in adult social care. The continued development of staff ensured the care they provided was effective and in line with current best practice guidelines.

Staff told us they were supported in a variety of ways including one to one meetings, team meetings and annual appraisals. The acting manager confirmed staff had not always received regular supervision in line with the organisation policy but a more structured programme was being put in place which they would

monitor. For new staff, annual appraisals were to be carried out once they had been employed for over a year.

There was a works programme in place to ensure the building was suitably maintained, decorated and adapted for people who used the service. Areas of the service such as the entrance hall, lounge, conservatory and dining room had been redecorated and new flooring provided with positive results. There was a new activity room and a themed salon for people to visit to have their hair and nails done. The corridors had new flooring and were in the process of being decorated, with the use of colour contrast on doors and grab rails. There was also a good use of colour contrast on bathroom fittings to support orientation for people living with dementia. There was some signage around the service and the regional manager confirmed further work would be done to provide memory boxes on people's bedroom doors and other suitable adaptations and décor. Efforts have been made to provide age appropriate pictures and ornaments around the home, and there were some homely touches like a new dresser in the dining room. People who used the service, relatives and staff were complimentary about the changes. Comments included, "The redecoration of the home is an improvement", "Improvements in the dining room but new crockery and cutlery would be good" and "Better decorated and flooring. The hairdressing salon is a nice place."

Good

Is the service caring?

Our findings

People who used the service told us staff treated them well and respected their dignity and privacy. Comments included, "Always kind and caring", "Very good with toilet privacy" and "The staff are lovely; we are well-looked after here."

People's relatives told us staff were caring and compassionate with their family member. They said, "Staff are kind and attentive", "Yes, very caring, when one of our family members died we were asked to be present when they [their relative] were informed", "Very friendly [staff] and will sit and have a chat when they have time" and "Mostly I think the staff are quite fond of my mum."

We saw people chose where they spent their time, with some people choosing to stay in their rooms while others sat in communal areas; staff respected these decisions. Relatives we spoke with said they could visit without restriction. We saw visitors freely coming and going as they wanted during our inspection visit. They were very involved in supporting their family member by helping with drinks, snacks and joining in activities. A relative told us, "I'm very happy with the care here, the staff involve us and I like to continue to help looking after my mum."

We observed the chiropodist visited the service and supported some people with their treatment in the conservatory area; this could be overseen by the people sat in the adjacent lounge and the two people already sitting in the conservatory. We mentioned this to the acting manager who provided a screen to protect people's privacy and dignity. They explained that treatments were usually carried out in the person's room or the activities room and gave assurances that this would be the case in future.

People's needs and preferences were recorded in their care records. Staff were able to describe the ways in which they got to know people, such as talking to them and their families, and reading their care plan. They were able to tell us about individual people's preferences and demonstrated that they knew them well.

People who used the service, and the visitors we spoke with, told us staff involved them in decision-making and respected their decisions. They confirmed they had been consulted about things that happened in the home. For example, they had been consulted about the recent decoration programme and had chosen the paint colour for their bedroom door.

People who used the service looked well-cared for, clean and tidy. Their clothes and hair were well-kept and their fingernails were manicured. We saw staff treated people with dignity and respect and the people we spoke with confirmed this. One member of staff said, "I treat people like I would a member of my family. I make enough time for them." Another member of staff told us, "We always ask people about their care and make sure we support them in private. We close doors and curtains and give them time on their own in the toilet and bathroom; we would wait outside if they want that."

Whenever staff entered a room or walked by a person they said hello and asked them how they were. This resulted in warm and friendly interactions between staff and the people they cared for. It was clear that

people liked the staff and interacted well with them. We watched how staff gently supported people who became disorientated, encouraging them to move to the lounge areas or their rooms, offered drinks and stayed with them until they settled.

We observed staff supported people to make choices about their care and maintain their independence where possible. At mealtimes, people were offered clothes protectors and some had equipment such as slip mats, adapted cutlery and plate guards to assist them. Condiments were provided on the dining tables and we saw some people serving themselves.

The designated dignity champion was the acting manager. They confirmed the champion's role included ensuring staff respected people and looked at different ways to promote dignity within the home. They showed us supervision records with new staff that had focussed on supporting people's dignity. A staff meeting about promoting dignity had been held in April 2016. We also saw that for National Dignity Day in February, they had celebrated in the service with a party and provided people who used the service and their friends and family with foods from around the world. Feedback from relatives we spoke with was very positive about the event.

We saw a good range of information was provided in the entrance hall and on notice boards in corridors for people who used the service and visitors. This included information on how to keep safe, dignity awareness, menus, activities, staff photos and how to make a complaint. There were meetings for people who used the service and relatives and the minutes of the meetings were put up for people to read.

If people wished to have additional support to make a decision, they were able to access an advocate. The regional manager confirmed advocacy services were accessed for people where necessary.

Staff kept information and records secure. Staff described how they ensured people's private information remained confidential. Confidential information was stored in the acting manager's, administrator's and team leader's offices. The registered provider had a confidentiality policy in place to refer to as required.

Good

Is the service responsive?

Our findings

People we spoke with said they were happy with the care provided and complimented the staff for the way they delivered care and support. One person told us, "I get everything I need. I get help showering and have my meals in the dining room. We have activities and there's always someone to have a chat with. I can't fault anything." A relative told us, "The care is good here; when she was at home she was falling and not eating properly. Her health has improved and she's stronger, we are really pleased." People told us they enjoyed the activities on offer. Comments included, "We do games and have our nails done" and "I enjoy sitting in the garden and watching them do the planting."

Relatives told us their concerns and complaints were dealt with effectively. They said, "Yes, I've made a complaint once and it was dealt with by the manager", "We would know who to speak with but we have never had to" and "When I've mentioned concerns, they have dealt with things very well." Relatives told us they were informed about activities and entertainments and invited to participate. One person told us the activities were well-organised but they considered more frequent trips out to local places of interest could be arranged. We mentioned this to the acting manager.

Care records showed needs assessments had been carried out before people had moved into the service and further developed on admission. Staff told us information collated had been used to help formulate the person's care plan. We found assessments had been fully reviewed and updated regularly which ensured people's changing needs were being monitored closely.

We saw good evidence that people's life histories and preferences were discussed with them and researched with families as appropriate. This meant staff were able to discuss people's life with them, understand what their likes and dislikes were and develop meaningful relationships with them.

Care files contained detailed information about the areas the person needed support with and any risks associated with their care. The care plans were person-centred and included what was important to the person, how best to support them, their likes, dislikes and preferences. For example, one person's care plan detailed how they preferred finger foods and loved chocolate, jam tarts and cups of tea. Daily records were maintained and we saw these were in place to monitor any specific areas where people were more at risk and explained what action staff needed to take to protect them. We found people's care and treatment was regularly reviewed to ensure it was up to date. Daily handovers ensured new information was passed on at the start of each shift. This meant staff knew how people were presenting each day.

We saw staff used distraction techniques and their knowledge of people's family lives or their hobbies and interests to re-direct people and successfully avert any potentially challenging situations. We observed one person, who was anxious and calling out, settled when staff sat with them and gave them reassurance.

People were encouraged to follow their interests and take part in a range of activities. We saw photo collages of people taking part in activities in the service and enjoying celebrations such as birthdays. The service employed an activity co-ordinator for four hours each week day to facilitate social activities and

stimulation. On the second day of the inspection, we observed people were supported with a range of individual or small group activities such as reminiscence, listening to music, bingo, gardening and a game of skittles.

The activity co-ordinator explained the range of activities in the programme included: painting and craft work, bingo, dominoes and other games, ball games, pampering sessions, reminiscence and seasonal crafts. The records were not available. One person we spoke with told us they preferred to stay in their room and would like to see the activity co-ordinator more regularly, which we passed on to them. Staff told us entertainment was arranged occasionally and there had been a trip out for a meal.

We saw staff were responsive to people's needs and worked well together as a team. In discussions, staff confirmed this. They said, "The last few weeks have been tough with staff leaving, but we've worked together as a team and supported each other" and "Some of us have worked here a long time and we work well together to ensure good standards of care are maintained."

There was a complaints procedure which was displayed in the service. This described how people could make a complaint and how to escalate it if required. The staff had access to a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome. Records showed the service had received four complaints in the last 12 months and these had been responded to within the appropriate timescales.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with were aware that there had been a recent change in manager and said they were happy with the care and support provided, and how the service was run. One relative commented, "There have been improvements with the environment in recent months, they were overdue but they seem to be cracking on with things now." Another relative told us, "This home has a nice atmosphere. It's very homely. The management and staff are very easy to talk to." Other comments included, "It's tidier everywhere and more organised. The changes in the hall are a big improvement, much more welcoming and no odour" and "The manager has changed recently, but they are always available if we need to discuss anything. I go to the resident's meetings when I have time and they do listen to our comments and suggestions."

The regional manager explained how a new acting manager had been appointed and been in post for four weeks prior to the inspection. The previous acting manager had left before completing their registration with the Care Quality Commission (CQC). The new acting manager had worked at the service as a team leader for many years before their promotion. They were being supported in their new role by the regional manager and an experienced registered manager from one of the registered provider's other services in the area.

The service had a basic quality monitoring system in place, with themed audits completed monthly, bi monthly or quarterly. We found the format and content of many of the audits were minimal and required updating and further development to support a more robust approach to quality assurance and continuous improvement. For example, the infection control audit had not identified the damaged flooring in the laundry could compromise standards of hygiene and the storage of clean clothes there may pose a cross contamination risk. The audits of people's care files had not identified the gaps in some people's behaviour management documentation to ensure an accurate and contemporaneous record was maintained.

We also found some parts of the monitoring system had not been effective in highlighting areas for improvement. In the main, this concerned the environment; there was evidence there had been significant delays in decorative improvements in the service but these were now being addressed. An 'environmental action plan' had been put in place and work had started in January 2016. We noted that not all decorative improvements needed had been detailed on the plan, such as toilets and people's rooms. The regional manager confirmed some major works to the roof and replacement of the boiler had been completed and an up to date, more comprehensive action plan, detailing specific rooms was currently being devised.

Records showed accidents and incidents were recorded and appropriate, immediate actions taken. Analysis of the cause, time and place of accidents and incidents was completed each month but this analysis was reviewed less frequently which meant there could be a delay with the identification of patterns or trends. The regional manager confirmed they had identified improvements were needed with the management of quality, risk and safety in the service. They were in the process of looking at suitable systems for the organisation and new more structured quality assurance and incident monitoring systems would be introduced in the near future.

The findings from recent external audits by the care home liaison team in relation to pressure damage prevention and infection prevention and control (IPC) had been positive. The home had achieved 100% in the pressure damage audit and 82% for IPC. An audit of medicines in January 2016 by the pharmacy provider identified some minor improvements were needed to the systems and we found these had been addressed.

The views of people who used the service and their relatives were sought at meetings and through surveys. The findings from the most recent relative survey in September 2015 showed generally positive responses were received but improvements could be made with activities, décor and laundry. Records of resident meetings identified these areas were discussed and feedback on any progress made was given. Surveys were also given to staff and stakeholders for feedback; we noted all respondents to the stakeholder survey made positive comments. Some mixed comments were received from staff in the February 2016 survey in relation to team work and training; the acting manager confirmed they would be following these up.

Manager's meetings for all the registered provider's services have now been arranged to provide support for each manager, share good practice and provide a more consistent management approach throughout the group of services.

The acting manager and team leaders were aware of their responsibilities in notifying the CQC of any accidents or incident that affected the safety and welfare of people who used the service.

The service had undergone assessment by North East Lincolnshire Clinical Commissioning Group in 2014 and 2015 where quality standards were reviewed within the authority's Quality Framework Award. Overall, the service had met the criteria for a 'Bronze' rating which was a positive achievement.