Care Quality Commission

Hessle Properties (The Weir) Limited

# The Weir Residential Care Home

**Inspection report**

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North Humberside, HU13 0RU
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## Ratings

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

## Overall summary

We carried out this inspection on 30 December 2015 and 5 February 2016. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection was unannounced; which meant that the staff and registered provider did not know that we would be visiting.

The Weir Residential Care Home is registered to provide personal care and accommodation to older people, including those living with dementia related conditions. It is situated in the small town of Hessle, in the East Riding of Yorkshire and is close to local amenities. There are a number of communal areas where people can choose to spend the day and bedroom accommodation is provided in single rooms, some with en-suite facilities.

The registered provider is required to have a registered manager in post and there was a registered manager at

# Summary of findings

this service. 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.

We found that staffing levels occasionally fell below the level the registered provider had identified as a safe number to effectively meet the needs of the people living in the home during busy times of the day. This included the morning when people required the highest levels of support with personal care. We have made a recommendation regarding staffing levels within the home.

People lived in a safe environment. Staff knew how to protect people from abuse and equipment used in the service was checked and maintained. Staff made sure risk assessments were carried out and took steps to minimise risks without taking away people's rights to make decisions.

Medicines were stored, administered and disposed of safely. However we found when medication was refused this was not always accurately recorded. Training records showed the staff had received training in the safe handling and administration of medicines.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the home deemed essential, such as safeguarding, moving and handling and infection control and also home specific training such as dementia awareness. Staff told us they felt well supported, received regular supervision and attended staff meetings.

The manager understood the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) (2005) guidelines had been fully followed.

People's nutritional needs were met. People told us they enjoyed the food and that they had enough to eat and drink. They told us that drinks were provided throughout the day but one person told us you sometimes had to request these. People told us there was only one choice of hot meal at lunchtime and sandwiches were the only alternative.

People told us they were well cared for. We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the home. People were able to make choices and staff supported them to maintain their independence.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health care professionals based in the community.

The home employed an activity coordinator and they offered some activities for people to be involved in. However due to staffing levels in the home they were often required to support the care staff. We found that there were limited dementia friendly activities.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were appropriately actioned.

We found the provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not always safe.

We found there that staffing levels occasionally fell below the level the registered provider had identified as a safe number to effectively meet the needs of the people living in the home.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people living in the home.

Medicines were stored, administered and disposed of safely. However we found when medication was refused this was not always accurately recorded.

**Requires improvement**

**Is the service effective?**
The service was not always effective.

The manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the MentalCapacity Act (MCA) (2005) and guidelines had been fully followed.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

People's nutritional needs were met. People told us they enjoyed the food and that they had enough to eat and drink. However they also told us they only had one choice of hot meal at lunchtime.

People who used the service received, where required, additional treatment from healthcare professionals in the community.

**Good**

**Is the service caring?**
The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs. People's independence was promoted.

People were offered choices about their care, daily routines and food and drink whenever possible.

**Good**

**Is the service responsive?**
The service was responsive.

**Good**

# Summary of findings

We found the home employed an activity coordinator and we saw that some activities were offered. However people told us that not enough activities took place.

Care plans were in place outlining people's care and support needs. These were being reviewed and updated by the manager. Staff were knowledgeable about people's support needs.

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

**Is the service well-led?**

Good

The service was well led.

The home had effective systems in place to monitor and improve the quality of the service. However in the registered manager's absence the home was allowed to occasionally operate with staffing levels that were below the levels identified by the registered provider.

Staff and people who visited the service told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

# The Weir Residential 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 30 December 2015 and 5 February 2016 and was unannounced. The inspection team consisted of two Adult Social Care (ASC) inspectors at the first visit and one ASC inspector at the second visit.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned as requested.

During the inspection we spoke with four members of staff, the registered manager, the assistant manager and three people who lived in the home. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, handover records, the incident / accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

Requires improvement

# Is the service safe?

## Our findings

When we arrived on the first day of the inspection we found the early shift was covered by the assistant manager, one member of care staff and the activity coordinator, who due to staff sickness, was included on the rota as a member of care staff from 9am. There was also a member of domestic staff and two members of kitchen staff on shift. We looked at the rota for the day of the inspection and we saw that it had not been updated and it was therefore not fully reflective of the people who were on shift. For example, it included the registered manager who had been off work for a number of weeks and also a member of care staff who was not in the building on arrival. The rota identified that there should be a minimum of four care staff on duty on any early shift. For example, The registered manager or assistant manager, one senior carer and two care staff. The activity coordinator was supplementary to this number.

This meant that on the first day of the inspection there was only the assistant manager and one care staff on duty during one of the busiest periods of the day, although this increased to three staff at 9am. We discussed this with staff who felt that three staff was not enough during the busy period in the morning, especially when one member of staff is required to administer medication which can take between 30 and 45 minutes.

When we returned on the second day of the inspection we found that the registered manager was again absent and the assistant manager was not on duty. A senior carer was responsible for running the home supported by two other members of care staff. When we looked at the rota we found that four staff were rostered on for the shift reducing to three after 5pm. We discussed this with the staff on duty and they told us that they felt they were able to effectively meet the needs of people with three staff on a late shift although the support of the manager to deal with enquiries would obviously have been beneficial.

We asked people about staffing levels and whether there was an issue with staff calling in sick. One person who lived in the home said “There are not enough staff on in the morning as a lot of them just ring in sick. This means they struggle to cover the breakfast rush.” Another said “There are normally enough staff, but they’ve been short recently, I think they have a lot off on sick.”

The staff we spoke with gave us a mixed response telling us “A lot of people ring in sick on a Monday.” And “There are usually enough staff.”

We asked people if they felt the staff were able to respond quickly enough to their requests for support and again we received a mixed response. One person said “When I press the buzzer someone will come eventually, this could be a staffing issue but there are a lot of people who need more support than me.” Another said “I saw somebody fall outside my room and I rang the bell. The staff came straight away.” And another said “I have a buzzer in my room and staff always come quickly.” One person who was visiting a relative in the home said they talked to other visitors and relatives and “Everyone seems to be happy with the care, no-one has raised any concerns to me and the staff are friendly and I think staff respond quickly.”

The staffing rota identified that five members of staff including either the manager or assistant manager and the activity coordinator should be on shift between the hours of 9am and 5pm. We viewed the rotas for the week beginning 1 February and saw that on five occasions there were only three care staff on duty on the early shifts. On one of these days we saw that two members of staff were both working a double shift which lasted 14 hours.

We discussed these concerns with the registered manager who confirmed that they had three staff members who were off work on long term sick and they had also been off themselves which they acknowledged had added to the pressure on the staff team. They told us that the manager from the sister home had also being providing support during this period to try and ensure the smooth running of the home. They explained that the staff team were incredibly flexible and willing to cover shifts at short notice and when they were unable then they would use agency staff to ensure safe numbers are on duty. We saw that on both our visits there were no staff covering shifts and the service had not hired any agency staff either to cover shortfalls in staffing. The registered manager told us that they had advertised for new staff, as they have three vacancies that need filling and are hopeful that when new staff are in post this will alleviate some of the pressure.

**We recommend that the registered provider reviews the staffing levels in the home to ensure that safe levels of staffing are maintained at all times.**

Requires improvement

# Is the service safe?

All of the people we spoke with told us they felt safe. One person told us "I feel very safe when I'm in my room and in and around the home, it's much better than my previous home." Another said "I feel safe and I can lock my door if I want some privacy." A relative we spoke with said "I've never had any reason to be worried or concerned.". They also told us "I visit the home at different times of the day and [Name] is always quite happy." A member of staff told us "We make sure people are safe. We make sure gates on stairs are locked, medicines are locked away, fire escapes are clear and rooms have the appropriate adaptations."

We spoke to staff about safeguarding and they all told us they had completed training in safeguarding vulnerable adults from abuse. We viewed the staff training records and saw that all of the staff had completed safeguarding training in August / September 2015. Staff were able to tell us the different types of abuse, how abuse could be identified and what steps they would take if they ever witnessed or heard about abuse taking place within the home. All members of staff knew how to escalate concerns if they did not feel they had been appropriately managed. One member of staff told us "If a resident told me they felt unsafe I would talk to them about it. If they told me something had happened I would speak with the senior or the manager." Another member of staff said "I would report anything to the manager, the owner or would get in touch with CQC, it would depend what it was about." This showed that the staff knew how to identify abuse and what steps they would take to prevent it from happening again.

We looked at people's care plans and found they contained risk assessments that were individual to each person's specific needs. This included, for example, an assessment of risk to the individual on/about nutrition, personal hygiene, medication, mobility, tissue viability and continence. These assessments identified the level of risk and described in good detail how the risk should be reduced. For example, one person was identified as being at high risk for 'tissue viability', we saw they had a plan in place to minimise the risk of developing pressure sores which required them to be repositioned every two hours. Interventions of this type helped to reduce the risks that people living in the home were exposed to.

All accidents and incidents were collated, accurately recorded and audited on a monthly basis. This provided opportunity for the registered manager to monitor whether any patterns were developing and put in appropriate interventions to minimise the risk of them occurring again.

We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks 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 children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them.

We looked at the homes maintenance records and saw that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the all gas installations, electrical circuits, fire alarm system, fire extinguishers, emergency lighting and all lifting equipment including hoists and the passenger lift. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

The registered manager told us that senior care staff and the management team completed medication training on an annual basis. This was confirmed by our checks of the staff training plan and staff training files.

Requires improvement

# Is the service safe?

We looked at how medicines were managed within the home and checked a selection of medication administration records (MARs). The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We saw that medicines were stored safely in a secure cabinet within the medication room which was locked at all times. We found that there was an air condition unit running in the medication room to ensure that the temperature of the room and the designated medication fridge did not exceed the safe temperatures. We saw that when keys were exchanged at handover they were signed for by both members of staff to ensure that the keys were accounted for at all times. These steps ensured that medications were stored safely within the home.

We found that medication was obtained in a timely way so that people did not run out of them and that it was administered on time and disposed of appropriately. We saw that a medication stock audit was completed twice daily to ensure that all medication was accounted for and that controlled drugs were countersigned by staff at the point of administration. However, we found that there were some gaps on the MARs where the reason for not administering medication had not been recorded. We discussed this with the registered manager who told us that this issue was also identified through the homes own medication audit and had been discussed with staff. The registered manager told us they would address this matter again with staff during supervision.

We were told that where possible people were able to self-medicate and we found two people living in the home who self-medicated some part of their medication. One person told us as they went out of the home unaccompanied they needed to take their angina spray. If they ever needed to use it then they told the staff when they returned to the home and this was then recorded in their medication file. This enabled the person to maintain their independence.

During the inspection we found the home to be clean, tidy and mostly free from any odour. The only area where there was a slight odour was along a ground floor corridor of the home. We discussed this with the manager who was aware of the problem and had requested that additional cleaning be carried out. When we returned on the second day of the inspection we noted that the odour in this area had improved.

We looked in the bathrooms and toilets in the home and we found that hand wash was missing from two of the bathrooms and also from the laundry. This meant that people would not be able to effectively clean their hands following the delivery of personal care during bathing or after handling any laundry. We saw that hand wash was in place in the toilets within the home. We also noted that the laundry room was very untidy with broken laundry baskets on the floor and a layer of thick dust on top of and behind the washing machines. We also saw that items of clothing, razors, slippers, sponges had fallen behind the washing machines, but had not been retrieved. However, we saw that clothing was well organised and there was an effective system in place for the handling of dirty and clean laundry.

When we returned on the second day of the inspection, we saw that the laundry had been tidied and a board had been put in place to prevent items of clothing falling behind the washing machines. We also found that the laundry and bathrooms had hand wash available.

The registered manager told us there was an ongoing programme of refurbishment to improve the environment and that they had recently replaced the flooring in the lounge and they were due to start replacing worn carpets in people's bedrooms.

Good

# Is the service effective?

## Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that three applications for DoLS authorisations had been submitted to the local authority at the time of the inspection and all paperwork was satisfactorily completed. We saw that DoLS monitoring charts were in place and this enabled the registered manager to keep a log of any incidents or behaviours that may be of use during the DoLS assessment.

Staff told us that they had completed a thorough induction before they started working in the home. One member of staff told us "I did my induction, and then I had to shadow the other staff for two weeks to get used to what tasks needed doing and it also gave me chance to get to know the residents." We saw that all new staff completed an organisational induction and were then expected to complete the Care Certificate within a twelve week period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives. It covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity and infection control. Following the completion of the Care Certificate staff were then enrolled on the NVQ level 2 in care and the registered manager told us staff were then encouraged to also complete their NVQ level 3. Training records confirmed this.

Staff told us they received regular training. One member of staff said "I have received training on end of life care, medication, health and safety, manual handling and lifting." We viewed training records and saw that staff had completed training in a variety of topics that would enable them to effectively carry out their role. However we did note that there was no specific Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) training completed. We saw that elements of this legislation had been included within other training and during our discussions with staff, we found that they had the appropriate levels of knowledge regarding MCA for their roles. The registered manager told us that restraint was not used in the home and this view was supported by the staff we spoke with. Staff had completed training on understanding dementia and challenging behaviour and this enabled them to effectively manage behaviours that challenged the service.

Staff told us they felt well supported and that the management team were approachable. One member of staff told us "The manager and assistant manager are both approachable and if I have any issues then I would go to them." Staff also told us they attended regular staff meetings and they received regular supervision from either the registered manager or the assistant manager.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice.

We saw that all staff had signed a supervision contract; this ensured that staff were aware of how often to expect supervision and also what would be discussed at each supervision session. This enabled them to prepare for supervisions to ensure they were a worthwhile process. We also saw that staff signed the completed supervision notes to indicate they were happy with the content of the record. Staff also received an annual appraisal which assessed their strengths, areas for improvement and any training needs.

Good

# Is the service effective?

At breakfast time we saw that people were offered a choice of cereals, toast and hot and cold drinks. We saw that drinks and refreshments were also provided mid-morning. One person told us "We get coffee mid-morning at about 11am." However, another told us "There used to be a drinks trolley that came around every morning, it would have tea, coffee and biscuits on it, it's been over a year since that stopped. If I want a drink I have to ask for it." Staff told us they continually offered drinks throughout the day and we saw that hot drinks and jugs of juice were made available throughout the day. A member of staff said "I always make sure everybody has got a drink to try and avoid people getting dehydrated." Another said "If people ask for a drink or something to eat then we always make sure they get it."

People told us they enjoyed the food but there was a lack of choice as there was only one hot meal offered at lunchtimes, although, sandwiches were offered as an alternative. One person said "The food is decent quality; they don't buy the cheap stuff. But, there is only one set choice at lunch, if I don't like it then I get a sandwich." Another said "The food is very nice, but you get what they bring you. You don't get a choice but it's always lovely, I've no complaints." We discussed this with the registered manager and they told us that there was always an alternative if people didn't like the food, though they agreed that at lunchtime this was always a sandwich.

Observation of the lunch time meal showed that people were given a choice of where to sit in the dining room and lounge areas; some people chose to eat in their bedrooms. We saw that the tables were set with tablecloths and placemats and there were condiments on each table. Portion sizes were adequate and where people didn't want the hot meal option they were offered a sandwich as an alternative. We noted that each meal met with the person's dietary needs/requests.

We noted that there was no menu board on display. Menu boards assist people to make an informed choice about what they would like to eat and also allow them to inform staff at the earliest opportunity if they require an alternative meal preparing. One person told us "I wouldn't know what was for lunch unless I asked." We discussed this with the registered manager and they told us they would request that menus were prominently displayed.

One person told us that they liked to go out for the day especially when the weather was good. They told is that the staff always provided them with a packed lunch to take with them to ensure they did not miss a meal.

We saw the staff used the Malnutrition Universal Screening Tool (MUST) to help assess people's nutritional needs and determine what 'plan' a person should be on in relation to their current weight and body mass index (BMI). The MUST is also used to inform the staff when a referral to the GP or dietitian is necessary to fully assess a person's nutritional status. The manager told us that people were weighed monthly unless they were deemed to be nutritionally at risk, in which case they were then weighed weekly. We saw that people's weights were recorded in their care plans and if a weight loss was indicated we saw that people were referred to the GP or dietitian for a full nutritional assessment.

Peoples health needs were supported and were kept under review. We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentist. Where necessary people had also been referred to the relevant healthcare professional. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). One person told us "If I needed to see my GP I would just ask staff to arrange this. I have seen staff call for an ambulance if people fall."

When people needed to attend the hospital we saw they had patient passports in place. Patient passports explained how to care for people should they be admitted to hospital. These included key information regarding whether the person had any allergies or any habits that would enable the hospital staff to provide more personalised care.

Good

# Is the service caring?

## Our findings

All of the people we spoke with told us they were happy with the care and support they received from the staff. One person said "Staff are caring and gentle." Another said "They look after me, it is a job I couldn't do." One person spoke enthusiastically about a member staff stating "[Name] is marvellous. She cleans and I chat to her. Nothing is too much trouble, [Name] goes above and beyond they are lovely." A relative told us "[Name] is quite happy; the staff are friendly and are always talking to [Name] and looking after them." A staff member told us "I really care about all the residents and making them smile is very rewarding."

We saw that there were good interactions between the staff and people living in the home, with friendly and supportive care practices being used to assist people. We observed one person being given one to one support with having a morning drink and this was performed in a manner that maintained the person's dignity. The member of staff spoke with the person throughout and this created a relaxed and pleasant atmosphere.

We saw that people's privacy and dignity was respected. One person told us "I feel I have my own privacy, I have a lock on my door and can use it if I want to." We saw that one person had chosen to have their meal in their room at lunchtime. We saw staff bring the meal to their room, knock on the door and wait to be invited in before entering. The staff member asked if there was anything else the person would like before leaving.

People who used the service told us their relatives were welcomed into the home. One person said "Whenever anybody visits me they are always made to feel welcome. Staff always offer them a cup of tea." We saw people who were visiting their family and friends in the home were obviously familiar to the staff and were able to enjoy respectful and positive communication whilst enquiring how their relative had been or if there were any issues that they needed to be aware of. We saw visitors were welcomed and they told us there were no restrictions on the times they could visit the service.

The staff we spoke with displayed knowledge about people's care needs, choices and decisions. They told us they could read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships, their likes and dislikes and their usual daily routine. We saw that staff knew how to engage with people in different ways. They knew who they could laugh and share a joke with and also who they needed to communicate with in a more formal way.

We saw that staff engaged and interacted with people living in the home who could not communicate verbally and we saw conversations take place between staff and people who lived in the home, whereby they enjoyed a laugh together, which raised their sense of well-being. One person who used the service told us they could chat with the staff. They said, "Just like with friends, we have a laugh" and "Nothing is too much trouble".

Staff told us they tried to give people as much choice as possible. One member of staff said "Resident's decide what clothes they want to wear, what they want to eat and drink, who provides them with their care and when they go to bed and when they want to get up." They also told us "If people want to have a lie in, I leave them for a little while and then go back later on and see if they are ready to get up."

People were encouraged to be as independent as they were able. We saw that one person living in the home enjoyed going out on their mobility scooter and this provided them with the freedom to come and go as they liked. We also saw that those people who were able to self-medicate were given the opportunity to do so, after they had been risk assessed, although their medication was continued to be monitored by the staff.

Records showed that people were supported to access and use advocacy services to support them to make decisions about their life choices. The service used an organisation called "Care Aware" that offered Advocacy Services to people.

Good

# Is the service responsive?

## Our findings

An activity coordinator was employed for 28 hours per week and they worked Monday to Thursday. They offered a variety of activities including cards, chess, draughts, arts and crafts, film afternoons and also provided manicures and painted people's nails. One person showed us their nails and told us they had been painted the day before. We were also told that staff tried to engage people in activities and that they had taken people out of the home for a walk in to the local village. As it was Christmas some of the people living in the home had been taken to the Christmas fayre and to see the lights in Hessle.

On the first day of the inspection we observed people sitting in the main lounge watching TV for fairly long periods of time. Some people were clearly enjoying the programmes but others appeared disinterested or were sleeping. We found that when there were no activities being provided by staff there was little to stimulate people in terms of activities for those people living with dementia, such as rummage boxes, twiddle muffs or items for initiating reminiscence conversations. When we visited the home for the second day of the inspection it was a Friday so the activity coordinator was not on duty and we again found people sat in the lounge watching TV with no obvious alternative available.

The people we spoke with told us they did not feel that there were enough activities taking place within the home. One person told us "No activities take place in the activity room." They showed us a box of activity items and we were told "I've never seen them used." Another person told us "We don't do any activities. I would like some as it would get people going." One relative told us "I've never seen [Name} do any activities, although they just like to walk around the home and talk with other people."

On the first day of the inspection we saw that due to a shortage of staff the activity coordinator had been required to support the care staff in ensuring that people's care needs were met. This meant they did not have as much time to spend on delivering activities as planned, especially during the busy morning period. We saw that this was not an isolated occurrence. This meant that during this period when staffing levels were reduced there was insufficient activities taking place in the home to satisfactorily occupy people who had different interests. We have covered the staffing issue in the section 'Is the service safe'?

The registered manager told us that before people moved to live in the home either on a permanent basis or in a 'time to think' (TTT) bed, a pre-admission assessment was completed to ensure that the home could effectively meet the needs of the person. This was always completed by the registered manager or the assistant manager.

We saw from the information gathered during this initial assessment and also from information obtained from the person's family, social worker or other people involved in their care, that people's needs were evaluated. Individual and detailed care and support plans were then developed. This included, for example, information on a person's mobility, nutritional needs, personal care, communication, tissue viability and medicines. Where a risk was identified an appropriate assessment was completed to minimise this. Care files contained information regarding people's likes and dislikes, family history and daily routine. This enabled staff to get to know the person better, which in turn helped them, settle more quickly into their new home.

Care plans were reviewed on a monthly basis and updated when required based on the information shared during handovers, the information recorded in people's daily records and information gathered by the person's key worker. One member of staff told us "I am a key worker for three residents, so if I notice any changes then I report them to the manager so they can update the care plan." We noted that one care plan was not fully reflective of the person's needs and we addressed this with the registered manager who acknowledged this and agreed to amend it.

We saw that when a person's needs changed due to a short term illness or following a fall, then a temporary care plan was developed to ensure staff knew how to care for the person during this period of illness. The registered manager told us that if the person made a full recovery then they would revert back to the previous plan. This showed that staff were responsive to people's changing needs.

People told us they were aware of their care plan and its contents. One person told us "I have seen my care plan once and I know it gets updated regularly."

We saw that meetings took place for people living in the home and that these provided an opportunity for them to discuss any issues that they may have. We saw that one of the topics discussed was the menu. We saw the cook and kitchen assistant had attended the meeting and asked about people's likes and dislikes. This led to the staff trying

Good

# Is the service responsive?

different themed nights including an American night, Curry night, Chinese night and an Italian night. Other issues that were discussed included the daily papers arriving at the home late, which the registered manager had already resolved and also an issue previously recorded regarding the laundry, which appeared to have improved.

People told us they knew how to make a complaint if they wanted to and one person said "If I had a complaint I would go to [Name] the manager, I can talk to her." One relative told us "If I wanted to complain I would speak with the manager but I've not needed to." Staff explained what action they would take if a person told them they wanted to make a complaint. One member of staff said "If a resident made a complaint I would write it down and take it to the senior who can handle it or take it to the manager if needed." Another said "If anybody complained I would take it straight to the manager to discuss."

There was a complaints procedure in place and we saw this was on display in the entrance hall. We looked at the complaints file and found that the complaints the service had received so far were audited on a monthly basis. We saw that when complaints had been received they were investigated and responded to in writing by the registered manager to the satisfaction of the complainant. The registered manager told us that any minor issues were dealt with immediately, however these may not always be recorded. We discussed this with the registered manager and they stated that all complaints would be recorded from now on to provide a fuller picture of any issues within the home and to help prevent any reoccurrences of the same issue.

Good

# Is the service well-led?

## Our findings

The registered provider is required to have a registered manager in post. At this inspection there was a registered manager in post who registered with Care Quality Commission (CQC) in November 2013. We sent the registered provider a provider information return (PIR) that required completion and return to CQC before the inspection. This was completed and returned within the given timescales.

We found that the registered manager had been away from the service for a number of weeks prior to the inspection taking place. We found that during this period the home had been allowed to occasionally operate with staffing levels that fell below the required number as identified by the provider to effectively meet the needs of the people living in the home. We have covered the staffing issue in the section 'Is the service safe'?

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found the registered manager of the service had informed the CQC of most significant events in a timely way. This meant we could check that appropriate action had been taken. However, we had not been notified of the Deprivation of Liberty Safeguards (DoLS) that had been approved by East Riding of Yorkshire safeguarding team. We have covered this in the section on 'Is the service Effective?' above.

All of the people we spoke with told us the manager was approachable and supportive. Staff told us they enjoyed working at the home. One said "I love it here, the staff get on, it's great. The team are supportive of each other; it's a good place to work." Another said "I really enjoy it here, we all get on and I enjoy coming to work." One relative told us "I know that if there were any issues the management would contact me."

The registered manager told us they were able to continually review the day to day culture of the home as they were often working alongside the staff team. They found that this was beneficial in terms of monitoring practice and also providing an opportunity to discuss any issues as and when they were raised. Communication with the staff team was possible via handover files, staff meetings, and supervisions. The registered manager also told us that they operated an open door policy which provided staff regular access and opportunity to discuss any issues they may have. This meant that staff were kept informed of any issues that may affect them and also provided opportunity to discuss any concerns.

We saw that regular staff meetings were held and these were used as an opportunity to discuss a number of different topics. For example, staff had stated they were too warm wearing the uniform provided, this was discussed and an alternative, which was agreed with the management, was offered. We saw that training, supervision, activities and holidays were also discussed.

Quality assurance questionnaires had been distributed to people living in the home, the staff and also to people's relatives. These covered resident care, management and staff, premises, information about the home and additional comments. We found that the feedback received was largely positive. However, we noted that the information gathered needed collating and summarising for it to be a more worthwhile process. This would enable the registered manager to compare results with previous years and assess the impact of any changes that had been made.

Audits were carried out to ensure that the systems at the home were being followed and that people were receiving appropriate care and support. These included, for example, housekeeping, medication, catering, care, training, social activities, admin, infection control systems and accidents/ incidents. We saw that when audits identified any areas for improvement, actions were taken to rectify the problem and where necessary systems were altered to prevent any reoccurrence of the shortfalls. For example, a housekeeping audit identified that the carpets in the extension required replacing. This was then actioned by the registered provider.

We found the records kept on people that lived in the home, staff and the running of the business were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people's personal and private information remained confidential.