Arrow Healthcare Limited

Alexandra Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 25 April 2017 and was unannounced. This is the new registered provider's first inspection since they registered with the Care Quality Commission in October 2015. At the time of the inspection, there were 77 people using the service.

Alexandra Court provides nursing and personal care for a maximum of 84 people. It is situated in a residential area in East Hull close to local amenities and has good access to public transport. The service has 84 single bedrooms which are located over three floors; each bedroom has an en suite which consists of a shower, a sink and a toilet. There are rooms for communal use on each floor such as sitting rooms, dining rooms, bathrooms and additional shower rooms and toilets. There is also a hairdresser's salon on the ground floor. There are two lifts and stairs for access to the upper floors and a large enclosed, landscaped garden and patio, which provides a secure area for people to enjoy the outdoor space.

The service had a registered manager in post. 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.

During the inspection, we found some concerns regarding quality monitoring which had resulted in shortfalls being missed when audits were completed. Examples included gaps in care plans, supplementary charts for recording food and fluid intake and accident analysis.

There was some inconsistency with the application of mental capacity legislation. Some people had assessments of capacity and records in place when restrictions were in place, but this was not consistent throughout the service. We found some people may meet the criteria for a deprivation of liberty safeguard but this had not been completed.

People had care plans in place, however, we found these were not always person-centred and missed important information regarding how staff were to care for them. This meant that important care could be missed.

You can see what action we told the provider to take regarding the above three areas at the back of the full version of the report.

We observed staff demonstrated a kind and caring approach when supporting people who used the service. They were attentive and patient throughout the day and in discussions, they gave examples of how they would promote values such as privacy, dignity, confidentiality and choice. People who used the service and their relatives confirmed staff were caring and compassionate.

We found staff knew how to protect people from the risk of harm and abuse. They had policies and

procedures to follow and had received safeguarding training so knew what to do if they witnessed any concerns. Risk assessments were completed to ensure staff had information about how to minimise risk.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs. There was a concern about the deployment of staff in the residential unit in the early evening. However, the registered manager told us they had received confirmation from the registered provider of an additional member of staff between 6 and 10pm, which would resolve the issue.

Medicines were managed safely and people who used the service received them as prescribed. People told us their medicines were administered to them in a timely way.

People who used the service had their health care need met either from the nurses on duty or from access to community health care professionals. Staff made referrals to health care professionals in a timely way and knew how to recognise when people's health was deteriorating.

We saw the menus provided people with a choice of nutritious meals. People told us they liked the meals provided to them and staff were flexible if they wanted an alternative to the main menu choices each day. We observed drinks and snacks were served between meals. Staff completed assessments of people's nutritional needs and monitored their weight. They referred people to dieticians when required.

Records evidenced that staff received appropriate induction, training, supervision and support, which enabled them to feel skilled and confident when supporting people who used the service.

Staff, people who used the service and their relatives, told us the registered manager had an open-door policy and was available to speak with them when required. There was a complaints procedure on display in the service and it was included in information given to people. Staff knew how to manage complaints and people spoken with felt able to raise concerns.

We found the environment was clean and safe, and equipment used was serviced regularly and maintained on a day to day basis. Checks were completed in important areas such as fire safety equipment, bed rails, window restrictors, hot water outlets and the nurse call. There was a policy on infection prevention and control and staff had access to personal and protective equipment such as gloves, hand sanitiser and aprons. There was a business continuity plan which gave staff guidance in what action to take in emergencies such as floods or a failure in utilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of harm and abuse. Staff knew how to recognise abuse and poor practice and what to do if they had concerns.

Staff were recruited safely and in sufficient numbers to support people. There was soon to be an additional member of staff for the early evening shift in the residential unit which would enhance the support provided.

People received their medicines as prescribed. Medicines were obtained, stored and disposed of appropriately.

The service was clean and tidy and staff knew how to control the spread of infections.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards, which meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions. However, we found staff were clear about how they gained people's consent to day to day care and support.

Staff received training essential to their role and had supervision and support to enable them to feel confident when meeting people's needs.

People's nutritional needs were met and menus provided a varied diet. Staff monitored people's weight and nutritional needs and referred to dieticians when required.

Staff liaised with community health care professionals to ensure any needs people had were met in a timely way.

Is the service caring?

Good

The service was caring.

We saw staff had a kind and caring approach and people spoken with confirmed this.

Staff treated people with dignity and respect and supported them to make their own decisions and choices.

Staff maintained confidentiality and stored people's personal and medical information securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People who used the service had risk assessments and care plans but there were some areas of their needs that had not been identified in them. This meant staff may not have full guidance to support people and important care could be missed.

People had access to a range of activities.

The registered provider had a complaints policy and procedure and people felt able to raise concerns knowing they would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality monitoring system in place which included audits and seeking people's views about the service. However, the system was new and the audits had not always identified shortfalls or when they had been identified, these had not been resolved in a timely way. There was limited analysis of accidents and incidents in order to learn and prevent reoccurrence.

The culture of the organisation was described as focussed on the needs of people who used the service, being open, listening to people's views and being supportive to staff.

Staff felt able to raise concerns and said the registered manager had an open-door policy.

Alexandra Court Care Centre

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 inspection took place on 25 April 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had completed a Provider Information Return (PIR). 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. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service. We also received information from health professionals who visited the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with 10 people who used the service and six people who were visiting their relatives. Eight other relatives completed a short questionnaire during the inspection. We spoke with the registered manager, the deputy manager and the night manager who are all qualified nurses. We also spoke with another nurse, seven care workers, one of which was a senior, the activity co-ordinator and a laundry assistant. We spoke with a GP, a chiropodist and two community nurses who were visiting people who used the service.

We looked at seven care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 40 people and monitoring charts for food and fluid intake, weights, behaviour and pressure relief. 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 documentation relating to the management and running of the service. These included recruitment files for two new staff, training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service and they were happy with the cleanliness of their environment. They also said they received their medicines in a timely way. A comment about one person's medicine was addressed on the day by the registered manager meeting with the person and their family. Comments included, "I like it here; I have a single room and my stuff is safe. I feel safe because there's plenty of staff around. My care plan is on-going, it's difficult because of the way I am now; they talk to me about it regularly", "I've been here two and a half years and I feel safe" and "It's very nice here; I can't fault it. Oh yes, I feel safe; I've got a key to lock my door."

Relatives said, "When they're here I feel safe. I can come any time day or night. It's their home; that's what they say", "They are so pleasant with them. I have never heard raised voices from staff", "It's very safe; staff are always calling in to my mum's room and this reassures her" and "Always clean and tidy and odours are well-controlled."

There were some mixed comments about staffing numbers, especially on the residential unit on the first floor, which were discussed with the registered manager during the inspection. Most people felt there were always sufficient staff on duty, whilst others felt certain times of the day such as mealtimes and when people were retiring required an additional member of staff. The members of staff we spoke with all said they were busy but they managed to get tasks completed and also had time to sit and chat with people on occasions. Following the inspection, the registered manager confirmed the registered provider had agreed funding for an additional member of staff to work an evening shift in the residential unit from 4pm to 10pm, seven days a week. This would assist meal provision at tea-time and supper, and provide additional supervision for people living with dementia who often spent a part of the evening walking about the unit.

Health professionals told us the service was busy with friendly professional staff; they reported there were no concerns with the delivery of care.

The registered provider had policies and procedures in place to guide staff in dealing with allegations of abuse or poor practice. Staff had completed safeguarding training and in discussions were clear about what constituted abuse, the signs and symptoms which may alert them to concerns and the action they would take to protect people. The registered manager had been open and transparent in raising issues with the local safeguarding team when required. The local safeguarding team told us they were investigating a care issue regarding one person and would let the registered manager and the Care Quality Commission know the outcome when completed. We saw there was a system in place to manage people's personal finances held within the service. Records were maintained and receipts obtained monies in and for purchases. This helped to safeguard people's finances when monies were held for safekeeping.

There were individual risk assessments for people who used the service. These included areas such as moving and handling, bed rails, falls, nutrition, skin integrity and specific health needs such as the risk of diabetic hypoglycaemic episodes or distressed behaviour. There were also risk assessments to ensure the environment was safe and checks on equipment such as wheelchairs, fire alarms, hot water outlets and

bedrails. Moving and handling equipment such as the lifts and hoists, and also gas and electrical appliances were serviced. The service had CCTV equipment installed for monitor the entrance, exterior of the building and car park. There was a business contingency plan which provided guidance on what to in case of emergencies such as floods or electrical failures.

We found medicines were managed well and people received them as prescribed. There had been some concerns regarding medicines management in previous months and errors had been made. However, these had been addressed and checking systems introduced which had significantly improved the administration of medicines. There was documentation held with the medication administration record (MARs) of who was prescribed antibiotics and for what reason so this could be monitored. The medicines files had dividers between each person to avoid mistakes; these contained relevant information such as a photograph of the person, how they preferred to take their medicine and whether they had any allergies. Medicines were ordered and stored appropriately in line with manufacturer's instructions and pharmaceutical guidelines, including those medicines which required stricter storage controls and those that required refrigeration. Staff who administered medicines had their competency assessed. There were some minor recording issues with ensuring clear guidance for medicines that had a variable dose to be administered when required. This was mentioned to the registered manager to address with staff who administered medicines.

We found that although staff were busy, there were sufficient numbers on duty to meet people's needs. There was a selection of staff at different grades on duty which included qualified nurses, senior care assistants and care assistants. There were also four people who used the service who had one to one care from a care assistant for various amounts of hours each day; these staff were additional to the usual staffing rota. There was a selection of ancillary staff such as catering, domestic, laundry, activity coordinators, an administrator and maintenance personnel which meant care staff could focus their attention on care tasks. The registered manager and deputy manager, who were both qualified nurses, were on duty Monday to Friday.

We found staff were recruited safely with full employment checks in place prior to them starting work at the service. These included an application form so gaps could be explored, references, an interview and a disclosure and barring service (DBS) check. This included a police check and assurance that the potential candidate had not been excluded from working with adults at risk. Qualified nurses had an additional check to ensure they were registered and there were no conditions on their registration to practice. These measures helped the registered provider make safer employment decisions.

We found the environment was very clean and tidy. There were systems in place to prevent and control the spread of infection. These included staff training, cleaning schedules and protective equipment for staff to use, such as gloves, aprons and hand gel. There were also paper towels and wall mounted liquid hand soap in each en suite bedroom for staff to use following the delivery of personal care. There were hand wash signs above sinks in the sluices, and each communal bathroom and toilet to guide people on good hand hygiene techniques. We saw the two sluice rooms did not have any drying racks for commode pans; the registered manager ordered these on the day of inspection and told us maintenance personnel would fit them as soon as they arrived.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 found the application of MCA was inconsistent. Some people had restrictions in place such as bedrails, sensor mats and lap straps; however, their capacity to make these decisions had not been fully completed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option for people. One person declined speech and language therapy advice regarding the consistency of fluid that was assessed as safe for them to drink and records stated the person accepted the risk of aspiration this could cause. However, the person's capacity to make this decision had not been assessed and recorded.

There was also a lack of evidence that capacity and consent decisions for wound care monitoring photographs had taken place. Other people had assessments of capacity for decisions around the need for personal care but documentation was incomplete. One person lacked capacity but there was no best interest meeting regarding insulin therapy and blood sugar monitoring for their diabetes. The lack of full capacity assessments and records about best interest decisions meant it was difficult to audit if the actions taken were the least restrictive for the person or whether other options were considered. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided to them.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered provider was working within the principles of the MCA for some of the people who used the service. Applications for DoLS had been submitted to the local authority and were awaiting assessment. However, there were other people who we saw met the criteria for DoLS but application forms had not been completed. For example, one person received their medicines covertly and had anxious and distressed behaviour especially during personal care tasks requiring the use of holding techniques by staff, but did not have a DoLS in place. This meant some people may be deprived of their liberty unlawfully.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

People told us they were able to access health professionals in the community when required. They also said they liked the meals provided. Comments included, "They brought the doctor in this last time and he sent me into hospital. I've seen the optician; they come to check people's eyes", "If I ask for the doctor they get him the same day" and "They get the doctor if I need it. I've never had to go in hospital." Comments about meals included, "You get different foods on your plate and a good variety. I can have a cooked breakfast if I want", "If you don't like what's on the menu, they [staff] will get you something else" and "The foods good; I'd recommend it."

Visitors also told us they had observed the meals were very good and looked appetising. Comments from them included, "They get a choice with their puréed food and the soup is lovely; they eat well", "Mum is a good eater and loves the food; she has put weight on and thrived", "They especially like the home-made soup as there are plenty of vegetables", "The support for them at mealtimes is great", "The meals are nutritious with very good choices" and "When our relative had not been eating too well, they were provided with a supply of supplement drinks and food." One relative told us the pureed meals could look more appetising. We saw catering staff pureed each food ingredient separately to try to make it look more appealing and the registered manager told us they had been considering the use of food moulds to assist this.

Visitors told us staff contacted health professionals such as doctors and specialist nurses as needed and said they were kept informed about their relative's health care needs. Comments included, "They are quick to pick up on issues", "Their diabetes was out of control but now, with the staff liaising with the diabetic nurse, their confusion has stopped" and "She is bed-bound and has never had any pressure sores. In fact, the staff have healed pressure sores sustained in hospital." One person described how their relative's health had improved. They said, "The doctor's been in a few times and their health has improved massively in the last three months since they came out of hospital." Another visitor described how their relative's transfer from one service to another was 'seamless' and that their health condition has been more manageable since admission to Alexandra Court. They said, "The girls here are good with [Name] and they know how to deal with [Name].

People's care records evidenced they had access to a range of community healthcare professionals when required. Health professionals told us they were kept informed of issues and one told us, "We don't have too many problems. If we ask for something to be done, it gets done; there are not a lot of skin tears here" and "I've observed some good care practices." A GP told us they were happy with the delivery of care at the service. They said staff were organised and contacted them with concerns, and they followed directions and treatment well.

People's nutritional needs were met. The menus, set over a nine week period, provided people with a varied and balanced diet suitable for their nutritional needs; there was a list of alternatives if people did not want either of the two main choices at each meal. The chef prepared a selection of specialist diets such as sugar-free and textured meals; they received information about people's dietary needs following their admission to the service. There was a dining area attached to the lounges on each floor; there were two lounge/dining areas on the first floor one in each of the residential and nursing units. People could choose where to eat their meals and some chose to remain in their bedrooms. There was a small satellite kitchen near each dining area so staff could make people drinks and snacks whenever they wanted them.

We observed staff supported people to eat their meals in a patient and sensitive way. During both meals, we saw people were provided with alternatives quickly when they informed staff they did not want the main choices; staff went through a list of options for one person until they arrived at a suitable one for them. Some people had equipment to help them eat and drink independently such as plate guards and spouted beakers. Staff monitored people's weight and made referrals to dieticians, speech and language therapists and specialist nurses if they had concerns.

We saw from records and from discussions with staff, that they had access to induction, training, formal supervision meetings, appraisal and on-going day to day support. There was a range of courses, including clinical training for nurses, which enabled staff to gain knowledge, experience and confidence when supporting people who used the service. Staff confirmed the training was essential to their roles and appropriate for their development needs. They said, "The company trainer comes and they are really good

and interesting. They go through things really well and the training helps us to care for people properly."

Relatives of people who used the service said, "The staff are totally aware of their needs", "The staff seem to have the right capabilities for the job", "They seem well-trained" and "Each level know their duties well"

The design of the premises was suitable for people's needs. Corridors were wide and had hand rails on both side and there was a range of moving and handling equipment to support varying degrees of need. These included a passenger lift and one large enough for stretchers, hoists, stand aids, assisted bathrooms and shower rooms, grab rails in toilets and wheelchairs. The garden and patio area were accessible to people in wheelchairs. There were signs throughout the service to help people locate toilets. We saw some bedroom doors were missing people's names and more could be done to increase the 'dementia friendly' approach of the service. This was mentioned to the registered manager.

Good

Is the service caring?

Our findings

People who used the service told us staff looked after them well and treated them with dignity and respect. They said their privacy was maintained. Comments from people included, "I like it here and they look after me well. My family come every day; they can just come in anytime", "The staff are lovely. On the whole they are caring and if you want something, they'll try and do it for you. I have a cleaner with a heart of gold", "I have no difficulties with bank staff and these two here [activity coordinators] are marvellous" and "I can talk to the staff about anything".

Relatives told us staff had a caring approach and kept them informed; several relatives described being part of a 'family' at Alexandra Court. Comments included, "The staff are wonderful", "It's a nice atmosphere and she is very happy here", "Most carers seem genuine and thoughtful", "Their [staff] actions are kind and appropriate to her condition" and "They are patient and calm with dad. Other relatives said, "I'm involved in everything", "The girls recognise everyone as an individual and that you have to try different things with different people" and "He's as contented as he can be. They help him with bathing at least once a week and they keep him covered. There's curtains around the bath and the door is shut; it's just good practice." One relative said, "We have never come across one member of staff who isn't anything but kind and caring towards mum. They have worked miracles pulling her from the depths of despair to a content person with a new family around her." They went on to describe how staff delivered care in ways that promoted privacy and dignity.

Health professionals had positive comments about the staff team and said, "The staff are always friendly and care about the residents", "I have observed good care practices" and "Yes, I'm happy with the care delivery at the home."

We observed staff were patient, attentive to people and had a caring approach. For example, we observed staff sat and chatted to people and offered drinks and biscuits throughout the day. We saw a member of staff responded quickly when one person said they were a bit cold. They asked if they wanted their shawl, went to the person's bedroom to get it then helped them put it around their shoulders. We saw one person was quite sleepy throughout the day and staff used a gentle approach to try and wake them to engage them so they would accept a drink and snacks. One person sneezed and staff acknowledged this by saying, "God bless you." We saw staff were also attentive to visitors who stopped for a chat with them and asked questions about their relatives care and wellbeing. On one occasion staff went and checked records to provide specific information to a visitor.

During lunch and the evening meal, we observed staff asked people what choices they wanted, sat next to them to encourage people to eat their meals and on occasions assisted them to eat in a discreet way. Staff offered people the choice of clothes protectors which some people used. We noted these were white plastic aprons but a box of cloth protectors was seen in one of the linen rooms; we asked the registered manager to check out with staff why these were not used. We observed a patient, kind and caring approach by members of staff during lunch and the evening meal.

In discussions with staff, it was clear they had a good understanding of how to promote privacy, dignity, independence and choice. They said, "We help people to choose their clothes and how they want their care", "We try and let residents do what they can for themselves, don't swoop in and take over. Some people need a lot of help but can still wash themselves if we give them the flannel and give them time", "We close curtains and put a towel over people to cover them during personal care" and "Always make sure people are covered during hoisting and use full slings; they are supported in an upright position though which helps."

We saw people were provided with information about the service via newsletters, notice boards, meetings and a 'service user guide'. There were leaflets and brochures in the entrance and a reception which was staffed during usual working hours.

The registered manager confirmed it was possible for people to remain at Alexandra Court for end of life care. We checked the records of a person who had been admitted for end of life care, and who had recently died, to see what care had been recorded as provided to them. A care plan had been updated regarding pain management. Family were involved in the decision about the person's preferred place for end of life care and were at the service when the person died. The daily notes referred to pain management, personal care and liaison with health professionals for advice. There was evidence the person received appropriate end of life care in accordance with their wishes and those of their relatives. One visitor whose relative had recently died said, "I was happy with all the care and kindness my mum was shown here; it was the best decision I made [relative having lived at Alexandra Court]."

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office or the registered manager's office. People's reviews were held in their bedroom or a quiet area. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The registered provider was also registered with the information commissioner's office, a requirement when computerised records were held. Staff records were also held securely in the administrator's office.

Requires Improvement

Is the service responsive?

Our findings

We found some concerns in the assessment and care planning processes within the service. Each person who used the service had an assessment, risk assessments and a care plan, however, there were areas of need which had been identified but lacked a care plan to guide staff in how to support the person. For example, one person had a specific health condition and had been prescribed medicines for this by their GP. Their health need was not included in a care plan and there was little evidence of how this was monitored and when staff should report concerns. Two people's wound care documentation lacked clear information about the actual wound care plan and evaluation to monitor that healing took place; the records were more about when dressings were changed and what products were used. One person had a risk assessment but their needs had changed following an incident; the risk assessment had not been updated until several days after the incident.

Some care plans had detailed information about how to support the person in a person-centred way but this was not consistent throughout all the care plans we looked at. Some care plans did not have sufficient information, some had not been updated when the person's needs had changed and some information was spread throughout several planned areas rather than one specific plan. For example, one person had behaviours which caused them distress and anxiety but the care plan was brief in how this was to be managed in a person-centred way. Another person's nutritional intake regime and care of their stomach feeding tube had recently been changed by a dietician, but their care plan reflected the old regime. One person was at risk of pressure damage and prevention methods were detailed in care plans for mobility, skin care and sleep. However, there was a concern these plans missed specific elements and did not detail all the care required. For example, in discussions, care staff said they supported the person's leg on a pillow to elevate their heel but this was not detailed in the plan.

Not ensuring people's needs were properly assessed and failing to ensure care was thoroughly planned to ensure those needs were met was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us staff listened to them and responded when they raised concerns. They staff responded as quickly as possible when they used the nurse call. They also said there was a range of activities to participate in. Comments included, "My family can come in anytime. My family come every day", "If I buzz my buzzer, they're here immediately", "In the middle of the night you only have to press the buzzer and they're there", "I can talk to the staff about anything" and "On odd times I go to the church service; there are catholic and protestant services. They have a coffee morning and bocce [game similar to boules]. We have our own choir and we go and sing at the church for them. There's a lady here who won 'Hulls got talent'".

Relatives spoke of their knowledge of care plans, staff being responsive to people's needs and the type of activities available. Comments included, "For safety reasons he gets a bed bath. His care plan is on-going to support his changing needs" and "I can come any time day or night and phone any time to check on him; I'm involved with everything." Other comments were, "When she first came in, the first social event was a cinema

evening. The room was full and the girls dressed up as usherettes with torches and everything like the old days; it was fantastic", "There are lots of opportunities to join in like chair games and outings" and "The activity girls have helped her become interested in music and to play the keyboard. They include her in raffles and coffee mornings."

We attended a residents meeting held at the service on the afternoon of the inspection; this was attended by 10 people who used the service and six of their relatives. The monthly meeting was facilitated by the two activity coordinators. We observed people were able to raise issues of concern and make suggestions about the activity programme. We saw staff responded to comments made by attendees and provided relevant information on action that had been taken from previous meetings.

We saw there was a range of activities to participate in. These included in-house activities such as visiting singers, musicians and dance entertainers, birthday celebrations, movement to music, quizzes, bingo, film nights, table games, activity games such as bocce and curling, choir practice, reminiscence, sing along, craft work and nail care. There were one to one chats and 'read the newspapers' with activity coordinators. There were trips to community facilities such as local museums, a community café and a visit to a college to meet students. There were themed activities to celebrate annual events such as Halloween, Easter and Christmas celebrations. There was a large notice board in the entrance with photograph of people who used the service taking part in activities throughout the year. There was also a monthly magazine detailing what the activity schedule was and a shop trolley for people to make small purchases. One person who used the service told us how much they had enjoyed an Elvis impersonator. Staff said, "We try to get three singers a month; they [people who used the service] vote for who they want." An activity coordinator told us the staff and people who used the service raised £150 singing in the church choir and sent it to a children's charity. This helped people to be part of their community.

There were records when people participated in activities but this did not include all the people who used the service. A significant number of people had limited information about their ability to participate and their actual participation in activities. This was mentioned to the registered manager to address with activity coordinators.

The registered provider had a complaints policy and procedure, of copy of which was displayed in the service. This detailed who to refer complaints to and timescales for acknowledgement and completion. Relatives said they felt able to raise concerns if required and staff knew how to manage them. Comments from relatives included, "I have raised concerns in the past and they have been put right straight away" and "Concerns and complaints can be raised but I have no reason to raise any." One person felt they did not always have sufficient time when they wanted to talk or raise issues with management and said they felt 'hurried along'. This was mentioned to the registered manager to address.

Requires Improvement

Is the service well-led?

Our findings

We found the quality monitoring system had not been fully embedded into practice yet. There were concerns in recording which meant documents were not always up to date and accurate. Some audits, for example care files, had not captured shortfalls to be addressed and when shortfalls were identified, these had not been addressed in a timely way. We saw a 'Thematic Impact Audit' on catering and nutrition had taken place in February 2017 by the registered provider's quality manager. This had highlighted a shortfall in monitoring charts for food and fluids and also with nutritional care plans for specific people. During the inspection, we found several people's monitoring charts had gaps, so it was difficult to audit if care had been delivered or food and fluid consumed; there was no effective system in place to ensure monitoring charts were checked throughout the day to enable senior staff to see if they were on track for completion.

Staff maintained a log of who was prescribed antibiotics for infections such as urinary tract infections, however, there were no records to see if the figures related to issues such as hygiene or reduced fluid intake.

We found the care plans had gaps and were not consistently updated when people's needs changed. Staff did not always have clear guidance to assist them when supporting people which meant important care could be missed. Although care plans were audited, these issues had not been identified; the care file audits assessed the presence of documents and not the quality of them. The registered manager showed us a new care plan audit tool which could be much more effective in guiding the auditor in what to look for when assessing the documents.

Although complaints were managed and resolved, we found some minor concerns and niggles had not been logged. This meant there was no audit trail which would help with learning from issues to prevent a reoccurrence. Accidents were logged and the forms were signed off as seen by the registered manager, however, there was little evidence that analysis took place to look for patterns and trends so that practice could be changed to prevent reoccurrence. The registered manager told us this was completed verbally but not documented.

Environmental checks were carried out but these did not identify improvements were needed to make the residential unit more 'dementia friendly'. The registered manager had been without a deputy manager for several months which had led to a lack of oversight in some areas and not all planned checks being carried out.

Not having a robust quality monitoring system which consistently identified shortfalls in records and other areas was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls in quality monitoring, mainly in relation to records, there were some areas where audits had significantly improved the service, for example with medicines management. There had been several medicines errors in previous months but robust audits had identified shortfalls and action had been taken to improve how medicines were managed. There had been a reduced food safety score from

Environmental Health in December 2016, but a recent follow up visit had reinstated the score of 5, which is the highest score. Senior managers completed visits to carry out quality monitoring audits, the findings of which were added to an on-going 'home development plan'. We looked at the visit completed in March 2017 and saw this was comprehensive and had identified areas to be improved such as replacement of carpets in specific areas and quotes were underway for this. There had also been areas of care planning and catering practices identified as having shortfalls; the senior manager prepared an action plan with timescales for completion and the registered manager told us these would be monitored at the next visit. There were effective cleaning schedules and environmental checks to look for maintenance issues.

The registered manager completed weekly 'operational reports' for business purposes which indicated occupancy levels, the use of agency staff, staff vacancies, training statistics and any HR issues.

People who used the service knew who the registered manager was and where their office was located. They confirmed they had been asked their views about the service.

Relatives said, "I can talk to [Registered manager's name] about anything; I can ring them anytime they are really supportive of me too", "Yes, I've had questionnaires before. I know the manager by face; I know all the staff by face but not all their names", "It's well-led, brilliant; it's made a big difference to my life", "This is as good as it gets", "She is readily available to talk to and has an open-door policy" and "[Registered manager's name] is approachable. She pops around and says hello sometimes. She'll even put a uniform on and get stuck in." The person went to say how the registered manager was supporting them to sort out some funding issues.

A health professional said, "The manager is very approachable; it's a professional and well-run home."

We spoke with the registered manager about the culture and values of the organisation. They described the organisational structure which consisted of tiers of management support. They said they were very well supported and felt they could raise issues of concern knowing the response would be timely. The registered provider's statement of purpose referred to people who used the service as being 'at the forefront of our philosophy of care' and described the importance of core values such as dignity, privacy, independence, choice and fulfilment; we saw these values were carried through into practice. Staff were given a handbook which described the standards they were expected to work within. Staff told us they were supported by the registered manager and their views were listened to. Comments from staff included, "The manager is fantastic; really supportive and sorts out problems", "I really enjoy working here; we have a good team of staff", "The manager is fabulous; very helpful and deals with things. I think the service is very organised and well-run; we all get on" and "The manager is very nice and supportive. She comes around the units and you can go and talk to her to her." Staff told us communication worked well within the service.

There were meetings and questionnaires for people who used the service and their relatives. Records of the meetings referred to issues raised at them and also outcomes from the month's previous meeting. This showed us people were able to make suggestions and these were listened to. For example, the minutes from the April 2017 meeting reported on staff having new name badges, music being played in corridors and new flooring and carpet in some areas. The results of questionnaires were on display in the service.

The registered manager was aware of their registration responsibilities and always notified the Care Quality Commission, and other agencies, of incidents which affected the safety and welfare of people who used the service. This helped us to monitor incidents and request further information when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people's care plans included full information about how their needs were to be met in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity. Also they had not consulted with the local authority when there was the possibility some people met the criteria for a deprivation of liberty safeguard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured adequate systems were in place to monitor and improve the quality of the service delivered to people. Also to ensure there were contemporaneous and accurate records relating to people.