The Royal Masonic Benevolent Institution Care Company

Scarbrough Court

Inspection report

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Date of inspection visit:
20 September 2017
21 September 2017

Date of publication:
08 March 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 20 and 21 September 2017. The inspection was unannounced on the first day and announced on day two.

Scarbrough Court is a purpose built care home registered to provide personal care with nursing for up to 58 people, including people who live with dementia. At the time of our visit, 56 people were using the service. The home is not far from the shops and amenities of Cramlington and was maintained and furnished to a high standard. People had their own spacious rooms with ensuite bathrooms and use of communal areas throughout the home, which included landscaped gardens and a roof top garden.

The service has a registered manager. 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.

People had not always received safe care. Staff were knowledgeable about how to keep people safe from harm. Risks to people's safety were assessed and plans were in place to manage and reduce risks. However, due to staff absence a shortfall of staff was created on one of the days of our inspection. This had placed people at risk. We saw that a person on Windsor (a residential unit that supported people who lived with dementia) had fallen on the floor. There were no staff available in the area, until we had alerted them; the person had not sustained an injury. The service had taken immediate action that ensured sufficient staff and had began the process of recruitment to cover any future staff shortfalls, such as annual leave and training. Additionally we found that at times Windsor was left with only one staff member due to staff breaks and meetings. We had discussed this with the registered manager who had taken immediate action to improve.

We have made a recommendation about the assessment of staff numbers and delegation of staff to meet people's individual needs within the environment they live.

People's needs were met by staff who were recruited safely using robust procedures. Staff had received the appropriate training, and had their skills monitored. People's medicines were managed safely by staff that had their competencies measured regularly. Health and safety assessments of the environment were completed that provided people with surroundings that were safe and comfortable.

People were supported to maintain their health and wellbeing. Advice was obtained from healthcare professionals when necessary. However, one person's blood pressure had elevated to a concerning level without being referred quickly to relevant health services. Staff had not sought immediate medical advice. This had placed the person at risk of further healthcare complications developing. We brought this to the attention of staff and immediate action was taken for the person to be reviewed by their GP. The registered manager proceeded to investigate why this had happened and also reviewed the daily processes used to monitor people's health.

People were supported by staff to have maximum choice and control of their lives in the least restrictive way possible. The policies and systems in the service supported this practice.

People were supported to eat a choice of freshly prepared meals and were complimentary of the meals provided. They were supported with special diets if required and when necessary their dietary intake was monitored.

Staff received an induction to their role and training to meet the assessed needs of people who use the service. Training updates were provided that included dementia awareness, equality, diversity, and personal care. Staff were supported in their job roles through one to one meetings, appraisals and team meetings.

The service was caring. Staff were kind, considerate and compassionate in the way they delivered support to people. They encouraged people to be as independent as they possibly could be. They addressed people in the way they liked and spoke respectfully to and about people.

The service was responsive. People's relatives and visitors were welcomed into the home and activities were designed to consider people's individual interests.

Peoples care plans were person centred and mostly detailed the information that staff needed to know to meet their individual needs. There were some omissions of detail to support people with their healthcare needs, which had not been identified through reviews of their care plans or quality monitoring processes. However, during our visit staff had commenced the process of adding the relevant information to the individual care plans.

People received person centred care that focussed on their individual needs and recognised their preferred routines. People and their relatives were comfortable to raise concerns and speak with the registered manager and staff team if they wished.

The service was well-led. There were systems in place to assess, monitor and analyse the service in order to make improvements. The registered manager had a proven record of having made improvements in people's best interest since becoming the manager at Scarbrough Court. The registered manager told us that they would review their quality monitoring processes to improve and ensure they were robust.

There was a high level of confidence in the registered manager amongst people, their relatives, staff and professionals. They were complementary of the registered manager who promoted an open, transparent and respectful culture within the home.

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 not always safe.

There were sufficient staff who had the relevant skills and experience to keep people safe. However, due to an incident that placed people at risk staff numbers were under review. This was to take into consideration staff absences and delegation of staff to promote a safe environment for people who use the services.

Staff knew how to protect people from abuse. People's families felt that their family members were safe living there. The provider had robust emergency plans in place which staff understood and could put into practice. Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were helped to see health professionals to make sure they kept as healthy as possible. However on one occasion a person's healthcare needs were not referred to an appropriate health professional as quickly as they should have. When identified by us this was managed effectively by the registered manager.

People were supported to eat a healthy diet that was nutritious and appetising. Their individual needs and preferences were met by staff who had received the training they needed to support people.

People had their freedom and rights respected. Staff acted within the law and protected people when they could not make a decision independently.

People lived in a comfortable environment that was furnished to a high standard.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity and promoted their

independence as much as possible.

People responded to staff in a positive manner and there was a relaxed and comfortable atmosphere in the home.

Is the service responsive?

Good

The service was responsive

Staff knew people well and responded to their individual needs. People's assessed needs were recorded in their care plans that provided information for staff to support people in the way they wished.

Activities within the home were provided for each individual. There was a system to manage complaints and people were given regular opportunities to raise concerns.

Is the service well-led?

Good

The service was well-led

People, their relatives and staff said the registered manager was open and approachable. They had confidence that they would be listened to and that action would be taken if they had a concern about the services provided.

The registered manager and provider had carried out formal audits to identify where improvements may be needed and acted on these.

Scarbrough Court

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 was a comprehensive inspection which took place on 20 and 21 September 2017. It was unannounced on the first day and announced on the second. The inspection was carried out by one inspector, a specialist advisor in nursing and an expert by experience on the first day. Specialist advisors are senior clinicians and professionals who assist us with inspections. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert who attended this inspection was experienced in caring for older people and people who live with dementia. One inspector completed the inspection on the second day.

Before the inspection we reviewed the information we held about the service, which included notifications they had sent us. Notifications are sent to the Care Quality Commission (CQC) to inform us of events relating to the service which they must inform us of by law. We looked at previous inspection reports of the service and contacted commissioners and health and social care professionals for feedback. We received feedback from two local authority social care professionals and two healthcare professionals.

We reviewed the Provider Information Return (PIR).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. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with nine people who live at the service and seven relatives. We also spoke with the registered manager, catering manager, facilities manager, business manager, in-house trainer, clinical lead nurse, two registered nurses, two senior care workers and six care workers.

We looked at records relating to the management of the service including eight people's care plans and associated care records. We looked at 10 staff files including staff training and recruitment records. We

reviewed quality audits relating to compliments, concerns and complaints, accidents and incidents, as well as a selection of documentation relating to the maintenance and safety of the premises.

Good

Is the service safe?

Our findings

People told us they felt safe living at Scarbrough Court. They felt confident that the management team and staff would listen to them if they were worried or had concerns about their safety. Comments from people included, "Oh yes I feel safe," and "There are hoists in my bedroom to get me out of bed or the chair safely." One person said, "Yes I do feel safe. I've got my own key, the doors outside are always locked and nobody can get in." Another said, "I feel safe because I know everybody here. I'd know if a stranger came in."

People's relatives also stated that they felt their family members were safe living at Scarborough Court. One person's relative said, "Mum has an alarmed pad that sits at the side of the bed at night. If she gets up in the night on her own, it goes off and staff come to support her."

People and their relatives told us that they thought staff had quality time to spend with them, and did not rush people. However, the residential area of the home had experienced a shortfall of care workers on the second day of our visit and an incident had taken place. As we entered Windsor unit we saw that a person had fallen to the floor. Three people who lived on the unit were attempting to support the person to stand. There were no staff to be seen in the area. On using the emergency call bell to alert staff, staff were on the scene within approximately two minutes. Appropriate action had been taken by staff to be satisfied the person had not sustained an injury and was well.

We established from speaking with staff that there was a shortfall of one care worker on the morning of the incident. Staffing levels were based on the minimum number of staff needed to safely meet people's needs. There were 17 people being supported in Windsor. Staffing levels were assessed as a minimum of three to safely meet their needs. There were no staff shortfalls identified on Windsor in the two weeks prior to our visit. The incident had taken place at approximately 11:30 am when a replacement member of staff had not been found.

In addition to Windsor having a shortfall of one staff at the time of the incident, a care worker had been delegated to have their break whilst the shift leader was attending a meeting. This had left Windsor with one care worker to support people and attend to various tasks. The delegation of staff was immediately reviewed by the clinical lead and the staff roster was reassessed to ensure sufficient staff cover for future shifts. This included scheduling agency staff where shortfalls were not covered by existing staff.

The registered manager informed us that although there were no staff vacancies they were in the process of employing an additional three staff to allow flexibility to cover staff annual leave, sickness absence and training.

We recommend that the service consider current guidance or seeks advice from a reputable source on staff levels that includes consideration of staff delegation and staff absence to promote the safety of the people who use the service.

The nurses and care workers were supported by the registered manager, clinical lead, administrative staff,

activity coordinators, catering and housekeeping staff, a business manager, maintenance staff and a trainer. There were no staff vacancies. Shortfalls were mostly covered by staff working additional shifts and by agency staff where necessary. Throughout our visit, we observed staff were busy, without appearing overstretched or having to rush their duties.

People's medicine was administered safely. They told us that they received their medicine correctly and on time. Comments included, "Yes I get my tablets every morning when I need them" and "yes I get my medication on time". A person's relative told us how important it was for their family member to receive their medicine on time to alleviate pain, stating, "(name) always has his medication at the right time." During our visit, we observed several people receive their medicine and noted that staff were completing computerised records directly after the person received their medicine.

Registered nurses and senior care workers who gave people their medicine had their competencies assessed to promote safe practice. People's care plans included information about; side effects of medicines, how to give the medicine and how to position the person to enable them to swallow their medicine safely. Additionally, care plans described how people displayed pain. A recognised observational pain assessment tool was used in the care of people with dementia who may not be able to communicate that they were experiencing pain. PRN (as required medicines) procedures were in place in most of the care records we viewed. These assisted staff by providing clear guidance on when PRN medicines should be administered and of how often people required additional medicines such as pain relief. We noted that the procedure for one person's PRN medicine was not clear. For example, there was no process for one of their medicines and the procedure for another was not specific in relation to how the person presented with anxiety for the medicine to be given. Within another person's records, we did not see a PRN procedure for their prescribed pain relief medicine. The registered nurse addressed this immediately by updating the record. Peoples medicine administration records (MARs) showed no gaps or discrepancies. A MAR is a document showing the medicines a person has been prescribed and records when they have been administered. The MAR contained recent photographs of people to reduce the risk of medicines being given to the wrong person, and detailed if the person had any allergies.

People's safety was enhanced by detailed risk assessments relating to areas of care relevant to their individual needs. Examples included, equipment, moving and handling, mobility, falls, nutrition and hydration, continence and skin integrity. Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk and any action required to reduce risk.

People were supported by staff that had been recruited as safely as possible. Staff files contained completed application forms and relevant documentation to check identity, previous employment, confidence and character, together with criminal record checks.

Staff were able to provide a robust response in relation to their understanding of safeguarding. They referred to the organisation's whistleblowing policy and stated that if they were not listened to by the registered manager or within the organisation that they would report their concerns to the local safeguarding authority and/or Care Quality Commission. There was a whistleblowing policy readily available for staff to refer to within the home. All staff had received safeguarding training and refresher training was scheduled each year.

Requires Improvement

Is the service effective?

Our findings

People were supported to maintain their health and well-being. They told us they had access to local GPs and that GPs came into the home, along with regular visits from other healthcare professionals such as the dentist and optician. Their health and medical needs were clearly described in their care plans and records indicated medical advice had been sought promptly when people had become ill.

People's care plans had reflected the advice and guidance provided by external health and social care professionals. This ensured their individual needs were being met. For instance, assessments had been carried out to identify people who were at risk of developing pressure ulcers and preventative pressure relieving measures were in place. One person had a pressure ulcer, which had been sustained prior to admission to the care home. The treatment plan was clear, detailed and evidenced the progress, which was being made. Care plans evidenced access to the Tissue Viability Nurse to assess people's skin condition and provide specialist support on what was needed in terms of care and pressure relieving equipment, to minimise the risk.

However, one person diagnosed with high blood pressure had no risk assessment or specific care plan that detailed what the person's usual blood pressure levels were, or when to seek urgent help. We saw records of two blood pressure readings taken over a period of 13 days. These indicated that healthcare intervention was required. The information had been added to the person's progress notes and documented in the GPs notes for their attention when they next visited the service. No urgent advice had been sought from a health care professional. This had placed the person at risk of further healthcare complications developing. When we raised this immediate action was taken by the clinical lead who contacted the person's GP for review of the person's healthcare needs. The registered manager confirmed that their quality monitoring process would be reviewed to improve and to ensure staff were responsive when reporting changes of people's health care needs to health care professionals.

People benefited from being cared for by staff who had received training and had, or were developing the necessary skills through further training and experience for the job role. New staff received an initial induction to the service, which included training sessions in areas such as moving and handling, infection control and fire safety. After this, they spent time shadowing experienced staff in order to meet and get to know the people they would be supporting. The provider had implemented an induction that complied with the care certificate. All new staff are required to complete the care certificate, which is a set of 15 standards that health and social care workers adhere to in their daily working life. Staff said they had received training and were provided with development opportunities, which was evident from training records we viewed.

People were complimentary about the food, stating, "The food's lovely. Just like I used to get at home" and "There's always a lot to eat". A person's relative told us that they had lunch with their family member, stating, "I wanted to be with him. The food was lovely and we just had a nominal amount to pay for it."

People were provided with adequate amounts of nutritious food and supported to drink enough fluids to keep them healthy. A recognised nutritional screening tool was completed to assess individual risk of

malnutrition and dehydration. This helped identify the level of risk and appropriate preventative measures. Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day and included portion sizes. Fluid charts were fully completed in respect of the information asked. However, these records were being updated at the time of our visit to specify the amount of fluid recommended for each person based on their weight and or personal health needs. We observed that each unit had a kitchen with tea, coffee and juice available for people and their relatives who could also make toast if they wanted. In all the communal areas there were chilled 'hydration juices' available, and all bedrooms had jugs of fresh water on hand. People were offered drinks and snacks throughout the day and could choose where to eat their meals. For example, there was a formal dining area on the ground floor that most people used, whereas on Windsor people normally preferred to have their meal on the unit around familiar surroundings.

People who displayed behaviours that could cause distress to themselves and or others were provided with support that was personalised and specific to their needs. Triggers for anxiety or agitation were documented so staff could recognise them and offer intervention before the person became increasingly anxious and or distressed. Staff were directed to offer support to resolve the problem by offering the person time, using verbal and non-verbal cues to communicate and to show they were listening to the person. The service made appropriate referrals to other professionals to enable them to provide positive behaviour support for people with these specific needs.

People's rights were upheld by the management team who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can 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 DoLS. The service had made appropriate DoLS applications. People were encouraged to make as many decisions and choices as they could. Best interests meetings were held and the content recorded, as necessary. Care plans included detail of the day-to-day decisions people were able to make and how staff should assist them to make them. During the inspection staff asked people's permission before undertaking any personal care or other tasks. For example, what activity they would like to do.

Scarbrough Court was purpose built to meet people's needs. People said, "Yes, it's very good furniture, and it's well maintained" and "This room has a hoist tracking system and I get hoisted into and out of bed. It's very good". Wide corridors and doors allowed wheelchair access, and assisted bathrooms with specialist baths enabled people to receive personal care in comfort. People had their own bedroom and ensuite bathroom and had easy access to call points should they require assistance. The nursing floor had track hoists in each room and enabled people to be supported in comfort and safety. The unit referred to as Windsor had been adapted to meet the needs of people who live with dementia. This enabled them to distinguish between rooms and gave various points of interest to refer to and reminisce. A rooftop garden and courtyard gardens provided pleasant surroundings with seating for people to enjoy. Overall, the home was furnished to a high standard.

Good

Is the service caring?

Our findings

People were provided with care by caring and committed staff. One person said, "The girls are very nice here. They are a good bunch of staff, and you can tell they are happy working here because of their attitude towards us all". Another person said, "The girls know me well and know how I like things done".

When we asked people if their dignity was respected one person stated, "When I'm having a shower, I need help and they always act respectfully towards me. They know I'm embarrassed at times, but they're very good". Equally, we asked if they were actively involved in making decisions about the care and support they received. They told us they were. One person gave a good example of how people can change the way their support was delivered. The person stated, "I have done my own tablets for 30 years. I don't know why they had to give them to me and so I asked to see the manager and we had a good chat about it. She made sure she thought I would take control of my medication safely and I now have boxes of tablets in the drawer (safe medicine cupboard in the person's room). I take them when I need to and I'm happier about that."

People's relatives also told us that the whole staff team were extremely caring and helpful towards them and towards their family members who lived in the home.

Throughout the inspection we observed staff being extremely kind, caring warm and considerate towards people and their visiting relatives and towards each other. During the times when people were offered drinks and snacks the mood was light hearted and jovial. Lunchtime was similarly happy and caring as staff promoted people's independence, whilst providing those who needed it with support and encouragement to eat their meals.

People received compassionate end of life care. Staff were provided with training on end of life care and further training was scheduled for those staff who have not received the training. An end of life guide was available in the foyer area of the home for people and their relatives and or carers'. This provided information on the final stages of life, and choosing where you would like to be looked after. People's records included end of life care plans. This meant information was available to inform staff of the person's wishes at that important time and to ensure the person's final wishes were respected. People were able to choose to have 'do not attempt cardio-pulmonary resuscitation forms' (DNACPR), in place. DNACPR's had been signed by the appropriate health care professional.

Staff had received dignity and values training and demonstrated throughout our inspection their commitment to ensuring people were treated with the utmost respect at all times. People's records were kept in an office that was locked when no staff were present. The staff team understood the importance of confidentiality to respect the information they had about people in their care.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service. This information was used to create a care plan for each person that was held electronically. People and or their relatives were able to see a printed copy for the purpose of review.

People were able to view the home before they made a decision to live there. A person's relatives told us that the registered manager and another member of staff visited their family member at their previous residence to discuss the proposed move to Scarbrough Court. They confirmed that a care plan had been agreed before their family member moved to the home and that they were fully involved in the decision making process about what care would be provided.

People's records contained a pre-admission assessment to assess their needs before they moved into the home. This ensured that staff could meet their needs and that the home had the necessary equipment that ensured the person's safety and comfort. Following the initial assessment, care plans were developed for people's daily needs such as mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Their care records contained a 'This is Me' document, which included details about the person's preferences, interests, people who were significant to them, cultural and spiritual care and previous lifestyle. This provided important information about the person's personal history that enabled staff to better respond to the person's needs and enhance their enjoyment of life. The information also supported the provision of activities, which met people's needs.

People's care plans contained person-centered information on their care and support needs. Person-centered planning helped people to plan their life and focused on what was important to them. For example, one person's care plan stated, "I have no mobility apart from my left arm, please make sure everything is in my reach on my bed table. I can then feed myself; I don't have any memory problems and I'm able to talk to you and guide you for my needs". Communication care plans were also in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with the person. This approach meant staff provided responsive care and recognised that people who lived with dementia and or with communication needs could still be engaged in decision-making and interaction.

Staff were able to give us a detailed account of people's needs and the support they required. Care plans were reviewed to ensure people's needs were met and relevant changes were added. Staff told us that people and their relatives had been involved in care planning on a minimum of a six monthly basis. This meant that people were consulted about their care, and thus the quality and continuity of care was maintained. For one person we saw frequent discussions with their relative regarding the person's care. For another person who had recently been admitted to the home we saw that a number of documents had been given to family members to complete such as 'This is Me.'

There was a system in place for people when they had to transfer between services, for example if they had

to go into hospital or be moved to another service. These documents were available on the electronic care management system. They detailed information about the person, their needs and preferences and accompanied the person, which meant they would receive consistent, planned care and support if they had to move to a different service.

There were some omissions within people's records that were not identified through exchange of information meetings, and or quality monitoring processes. These had included information about monitoring a person with diabetes to ensure their blood sugar readings were stable and of what action to take if they were too low or too high. For another person supported with percutaneous endoscopic gastrostomy feeding had no guidance on when to seek urgent help. For example, when coughing and or vomiting during or after their meal. Staff reassured us that they would arrange for additional details to be included in the individuals'' care plans.

People's changing needs were communicated to care workers by a number of methods. For example, daily records were kept for each person and provided information about the care and support they received and registered nurses gave a verbal handover at each shift. Daily meetings between the heads of department and regular unit meetings and registered nurses meeting had taken place.

Overall records showed audits of care documentation were carried out three monthly. These had highlighted deficits in nursing and care staff making regular timely entries. For example, updating risk assessments and documenting follow-up directions and interventions after GP and or health care professional visits. Details of the actions to be taken and the date they were to be completed by were thereafter documented and transferred to the electronic care record.

People said that they would approach the registered manager if they needed to make a complaint and felt confident that their complaint would be acted upon. Those who had had cause for complaint said their complaint was dealt with quickly and effectively and the problem did not arise again. The service had received 24 compliments in the last 12 months. They also received four complaints that had not identified any trends. These were investigated and resolved.

There were two part time activity coordinators. However, they were both on annual leave during our visit and so we did not have opportunity to speak with them. We asked people about links to the local community. Comments included, "We go all over the place in a minibus". People spoke highly of the two activity coordinators and said that they were enthusiastic about activities. One of the people we spoke with had a printed sheet of the week's activities that included music and movement, balloon tennis, group sensory morning, craft workshop, bingo, charity car wash, film show and armchair yoga. We observed that there was a sensory room which had recently been developed with calming lights and was decorated as a 'sweet shop' that people could help themselves to. This room also doubled up as a cinema.

Good

Is the service well-led?

Our findings

At the time of this inspection, the service had a registered manager who was present throughout the first day of our visit. The documented values of Scarbrough Court were, personal, respectful, professional, learning supportive and kind. We observed all of these values throughout our visit, which had included an open and honest culture.

People and their relatives spoke extremely highly of the staff and the management team. When asked if they felt staff were happy working here one person said, "Yes I think they are happy here, their attitude tells me they are happy." Another said, Staff are good to each other and their attitude is good." People also stated, "I do think the home is well managed. The manager talks to us all, from time to time." There were many good examples of good practice that we observed, some which we have outlined throughout this report. For example, complaints had been dealt with effectively, where the registered manager and staff had taken time to listen to people's concerns and of how involved people and their families were in the care they received.

Health and social care professionals who responded to our request for information were confident that the registered manager and staff would act in people's best interest and had no concerns about the services provided at Scarbrough Court.

Staff received the support they needed to meet people's needs that included a robust training programme that met their development needs and was being actively reviewed and improved at the time of our visit by the homes training manager. Staff received supervisions and appraisals of their work that contributed to them feeling valued and to an open and transparent culture within the home. Staff comments included, "I love it here, it's different every day and we are provided with lots of training." And, "Yes I do feel supported here. Honestly (name of clinical lead) is brilliant; she has supported all of us." Comments about the registered manager included, "She is always there, to be fair you can go to her with anything and just rant, and she listens."

There were areas of the service that needed to be improved by more robust quality monitoring possesses. We discussed these in-depth with the registered manager. These included improved day-to-day quality monitoring of the staff roster and delegation of staff to be equipped for any possible occurrence. The registered manager had commented on an incident that had taken place due to a shortfall of a care worker and delegation of the staff team. Adding that they would, "follow up on the incident and investigate further, to see what learning outcomes could be achieved."

Other areas identified for improvement were closer monitoring of individuals' procedures for PRN (as and when required) medicines and that people's records had all of the information required to monitor and report any healthcare concerns. At the time of our visit, the clinical nurse had started to address these areas. Further development identified included improved quality monitoring of people's health care records. This was to be assured that staff had all the information they needed to act in a timely manner when reporting peoples changing needs to healthcare professionals. The registered manager confirmed that their quality monitoring processes were being reviewed to improve the exchange of information between staff, and

information kept within people's records. This was to be confident that information within people's records supported their health and wellbeing. In addition, the registered manager confirmed improvements were in progress to monitor care staff numbers and delegation of staff to promote people's safety.

Overall, there was a system of audits and checks to monitor the quality of the service. These comprised of internal and external audits by various senior staff and representatives within the provider organisation and out with. Audits covered all areas of the service, which included unannounced night checks of care practice that asked various questions such as, "Are call bells being left ringing unnecessarily?" Additionally health and safety audits comprised of infection control, accident, incidents, near miss statistics, fire safety and fire risk assessments. Monthly and weekly audit checklists were completed of the grounds and overall environment. These included checks of hazardous substances and clinical waste and of action taken to promote people's safety. We saw that overall where audits had identified any areas of concern actions were taken to improve.