Cedarfoss Homes Limited

Lake View Manor

Inspection report

29-30 Pearson Park
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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

Summary of findings

Overall summary

Lake View Manor is located in Pearson Park to the north of the city of Hull. The home is registered to provide personal care to 26 people. The home has 18 bedrooms arranged over three floors, eight of which are for shared occupancy. The upper floors are accessed by a passenger lift. Communal areas consist of a main lounge on the ground floor and a dining area that leads onto a conservatory. There is a selection of bathrooms and shower rooms in the service.

We undertook this unannounced inspection on the 19 and 20 January 2016. There were 22 people using the service at the time of the inspection. This is the first inspection since the provider registered with the Care Quality Commission (CQC) on 31 March 2015.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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 improvements were required in some areas of medicines management to ensure that recording was accurate and stock control was efficient. People received their medicines as required although there had been some occasions when staff could have contacted their GPs to seek advice.

There were policies and procedures to help guide staff in how to keep people safe from the risk of harm and abuse. Staff were knowledgeable about the different types of abuse and knew how to raise concerns. Although we found staff recorded when incidents occurred between people who used the service, the registered manager had not used the local authority safeguarding matrix tool which helped to gauge risk and the action required.

People had risk assessments in place which helped to guide staff in how to minimise the reoccurrence of incidents. However, we found two instances when risk assessments could have been improved. We found the environment was safe and clean; equipment used in the service was maintained.

We found staff were recruited safely and full employment checks were carried out before new staff started work. Staff received an induction and had access to training, supervision and support to help them to develop and feel confident when caring for people and carrying out their roles.

We found people's health care needs were met. They had access to a range of health professionals and staff were clear about how they monitored people's health in order to seek medical attention quickly. Comments from health professionals who visited the service were positive about the staff team.

People told us they liked the meals provided to them. The menus were varied and had choices and alternatives for each meal; we observed drinks and snacks were served between meals. People's weight was

monitored and referrals to dieticians made when required.

We observed the staff approach was caring and considerate. People's privacy and dignity was maintained and care plans were written in a way that reminded staff about this. Staff supported people to make their own choices and decisions. We found that when people had been assessed as not having the capacity to do this, the registered provider worked within the law.

People had assessments of their needs and plans of care were produced; these showed us people and their relatives had been involved in the process. We observed people received care that was person-centred. They were able to bring in items from home to make their bedrooms feel homely.

We found people participated in meaningful activities in the service and had access to local community facilities during trips out, especially in the warmer weather.

People knew how to make complaints and told us they had no concerns about raising issues with the staff team.

We found the culture of the organisation was open and focussed on improving the quality of life for people who used the service and also on developing staff. There was a quality assurance programme which consisted of seeking people's views and carrying out audits and observations of staff practice. This helped to identify shortfalls so actions could be taken to address them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were some issues with medicines management to improve which was mainly recording. However, there had been some instances when stock control had affected the timely administration of medicines.

Staff knew how to safeguard people from the risk of harm and abuse. Some minor incidents between people had not been assessed using the specific risk management tool provided by the local safeguarding team.

People said they felt safe in the service and risk assessments were completed in most areas. However, we found two instances when these had been overlooked and although risk had been acknowledged, assessments to reduce risk had not been completed.

Staff were recruited safely and deployed in sufficient numbers to meet people's current level of needs.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met. They had access to a range of health care professionals in the community when required. Menus were varied and provided people with a choice of meals and alternatives.

People were supported to make their own decisions about the care they received. When people were assessed as not having capacity to do this, the registered provider acted within the principles of the Mental Capacity Act 2005.

Staff had access to training, supervision and support which helped them to fulfil their development plans.

Is the service caring?

Good

The service was caring.

Staff were described as being kind and compassionate. We observed their approach was friendly and patient. People's privacy and dignity was maintained.

People were provided with information and explanations to help them make choices and they were involved in planning their care.

Personal information was held securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans to guide staff in how to best support them in line with their preferences and wishes. People received person-centred care.

There was a range of activities to ensure people participated in meaningful occupations. There was also access to trips out into the local community.

There was a complaints policy and procedure and people felt able to raise concerns.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and the registered provider welcomed suggestions from people who used the service, their relatives and staff. There was also an ethos of learning from mistakes and a focus on improving the quality of life for people.

There was structure to the organisation and levels of support. The registered provider was fully involved in overseeing the service.

There was a quality improvement programme which consisted of audits, observations of practice, meetings and questionnaires.

Lake View Manor

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 19 and 20 January 2016 and was unannounced and was carried out by one adult social care inspector and an expert-by-experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the ExE's area of expertise is dementia care and caring for older people.

Before the inspection, we asked the registered provider to complete 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 looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection, we spoke with the local safeguarding team and the local authority contracts and commissioning team regarding their views of the service. We also received information from three GPs, a district nurse and a dietician. There were no outstanding concerns from any of these people.

During the inspection we observed how staff interacted with people who used the service throughout both days and at mealtimes. We spoke with seven people who used the service and six relatives individually as well as a group of four relatives who were visiting one person. We spoke with the registered provider, the registered manager, two senior care staff, three care workers, a cook and a laundry assistant.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to them such as accidents and incidents and the medication administration records (MARs) for 15 people. 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 two staff

recruitment files, the training record, the staff rota, supervision logs, minutes of meetings with staff, relatives and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We looked around the service to make sure it was clean and tidy.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at Lake View Manor. They also said there was sufficient staff available and they didn't have to wait for care. Comments included, "This place gives me a sense of security, much more so than home", "You couldn't get anywhere better", "It's lovely, you couldn't knock it one bit" and "Very good, I couldn't fault it all." One person told us they felt safe from intrusion of other people into his bedroom and he was being cared for by people he liked. Another person told us that when they were moved in a hoist they felt very safe. Although the person said they didn't like being transferred in the hoist they said they knew it was necessary and the staff would make sure she was alright in it.

A visitor told us that her relative, who had a history of falls, was in a safer environment than at home as staff had made adjustments, such as assisting him with certain tasks, to make him safer. Another visitor said, "She's safer in here than the last place. They check on her constantly."

We found some improvements could be made in the management of medicines. On three occasions there had been a small delay, between one and three days, in administering pain relief patches, one of which was due to stock control. However, when we checked daily records of the care provided to the people, there had not been any impact on their levels of pain and both had settled days. There was also one occasion when staff had administered half of the dose of a medicine due to running out of stock until the medicine was delivered later that day. There was no record at the time that staff had discussed this with the person's GP. There was one issue of overstock of a specific medicine which led to a large amount being returned to the pharmacy and destroyed, which was an unnecessary waste.

Staff had received training in the safe handling of medicines and we found they had information about how people took their medicines. For example, each person had a laminated information sheet with a photograph of them and details about allergies, their GP and how they preferred to take their medicine. There was also a body map for people who received medication via patches so the application site could be rotated. However, there were some recording issues to improve on. For example, in previous months we saw people's medication administration records (MARs) had been signed when medicines were received into the service from the pharmacy but this had not been completed for January 2016. We found some gaps in recording on the MARs with no code to explain why. There were also gaps in the recording of topical products. It was difficult to audit if the medicine had been given or creams applied. There were no protocols for staff guidance when people were prescribed a variable dose of medicine or when they were given them 'when required'. In the controlled drugs book, staff had not recorded a nil stock entry when medicines had been returned to the pharmacy so it looked as though they were still in the service. These medication issues were discussed with the registered manager and registered provider and they told us they would be rectified immediately and further training for staff organised. We saw medicines were stored appropriately in secure cupboards and a fridge for those that required it.

There were policies and procedures to guide staff in safeguarding people from the risk of abuse and harm. In discussions, staff were able to describe what constitutes abuse, the different types of abuse, signs and

symptoms which may alert them and how to report concerns. The service had a risk matrix tool provided by the local safeguarding team. The registered manager told us they would speak with the local safeguarding team if there were any concerns about incidents which occurred in the service and use the tool to determine risk. We found some occasions when minor incidents between people who used the service had not been recorded on the risk matrix log. However, incident reports were maintained in other records which described the action taken by staff to support people. The registered manager told us they would use the log in future to record discussions with the local safeguarding team and any advice from them.

People had their individual needs assessed for any areas of risk. We saw these included falls, moving and handling, fragile skin, nutrition and smoking. Some people had behaviours that could challenge the service and other people at various times. One of the care files we looked at had good information about how to minimise the risk in this area but another person did not have a risk assessment in place. We saw the same person had spilled a cup of tea on their legs and although they were attended to straight away, this had not been fully addressed by looking at the risks of reoccurrence. These points were mentioned to the registered manager and registered provider to address. Each person had an evacuation plan which detailed the means of support they would need to exit the building in an emergency.

We found staff were recruited safely and full checks were completed as part of the recruitment process. These included gaps in employment, references and the receipt of disclosure and barring information to ensure potential staff had not been excluded from working with vulnerable people. There were records of an interview taking place to discuss their previous experience and to test out their knowledge and values.

We found there were sufficient staff on duty to meet the current needs of people who used the service. Rotas indicated there were three care staff and a senior on duty during the day. There were ancillary staff such as catering, domestic, laundry and maintenance which meant care staff could focus attention on care tasks with people. There were two staff on duty at night and an on call system when required. The registered provider told us they were monitoring the night staffing levels and would adjust them as needed. The registered manager was supernumerary to the staff rota and worked five days a week. The registered provider told us they also visited the service each day and took an active role in the running of it. We saw staff answered call bells promptly and people confirmed they did not have to wait long for attention from staff.

We found the environment was safe, warm, clean and fresh smelling throughout. One person who used the service told us their bedroom carpet was shampooed weekly. Equipment used in the service was maintained and any repairs carried out in a timely way. The registered provider told us there was a programme in place to install more electrical sockets in bedrooms and some communal areas that required them to prevent the overload of extension leads. There was an infection prevention and control policy and procedure and schedules with guidance on how cleaning tasks should be carried out, the frequency of them and whose responsibility they were. The laundry assistant told us they had received instruction on the temperatures for specific items including those which required a sluice wash. In the laundry, there were two driers and two commercial washing machines, one of which had a sluice function. After washing and drying, clean clothes were removed to a separate room for ironing and storing until delivered back to people. We saw there were plentiful supplies of personal, protective equipment such as gloves, aprons, paper towels and hand sanitiser. There were hand washing signs in communal bathrooms and toilets to remind staff, visitors and people who used the service of good hand hygiene technique.

Good

Is the service effective?

Our findings

People who used the service told us staff knew how to look after them and they were skilled. They said they saw health professionals when required. They said, "These lasses know what they're on about. I always listen to them. They know what's best." One person told us care staff went to hospital appointments with him. They said, "It's a great help because I can't always take in what's been said, or even remember it. It's good to have someone else there." People also told us they liked the meals provided. Comments included, "Top class food" and "Very good food."

Visitors told us they were informed if their relative was ill or if a GP had been called.

We found people's health care needs were met. There were records when people received visits from health care professionals such as GPs, district nurses, community psychiatric nurses, dieticians, opticians and chiropodists. People were supported to attend outpatient appointments as required and received treatment from emergency care practitioners following unplanned incidents and accidents. In discussions with staff, it was clear they had an understanding of the need to monitor people for signs of deterioration in their health. Staff described the signs and symptoms of chest and urinary tract infections and the action they would take. They were also knowledgeable about how to prevent pressure ulcers from occurring. GPs confirmed staff cared for people well, kept them informed and followed their instructions. Comments from them about the staff team included, "The staff are proactive and assist patients" and "The service is very good." A district nurse also commented positively on how staff met people's health care needs. They said staff were available to assist them when they visited and the service provided to people was a 'good standard'. They also said they were kept informed of changes in people's health.

We found people's nutritional needs were met. There was a risk assessment tool used for some people to determine any concerns and they were weighed in accordance with the results; this had not been used for everyone though. The registered provider told us they would address this and ensure all people had been assessed using the tool. We saw each person had a care plan regarding their nutritional needs and the support they required. The menus showed there were two choices for the main meal served at lunchtime, one of which was a vegetarian option; there were alternatives of roast chicken breast or omelets each day. The lunchtime meal was three courses of soup, main and a dessert. We saw each table had staff serving from dishes on the table so people could choose the amount they wanted. People were given time to eat their meals at their own pace. We observed one person was still eating for a while after lunch had finished. They were sat at a table in an alcove with another person keeping them company. We observed drinks and snacks were served to people throughout the day; there were jugs of juice in communal areas.

The cook was aware of people's dietary information and how to prepare special diets such as fortified, diabetic and soft meals. They confirmed a dietician was involved when required and some people were prescribed food supplements. A dietician told us staff had been compliant with any nutritional plans they had put in place. They also said they had seen people had a choice of meals, snacks, puddings and drinks.

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. In discussions with staff, it was clear they had an understanding of MCA and the need for people to consent to care provided. Staff said, "We ask people", "We would gently try to persuade people and keep going back if they are not ready", "We try to explain it's in their best interest [if they decline care]", "If they refuse care then we have to report it to the senior; we can't force them. We'd speak to the manager and have a best interest meeting" and "There has been a best interest meeting for [service user's name]." Staff told us most people had capacity to agree to day to day care being carried out. The registered manager and registered provider were aware of those people who would need to have an assessment of their capacity for major decisions about their health and treatment.

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 example, the registered manager told us they had discussed one person's care needs with the local authority as they felt they met the criteria for DoLS. An assessment of capacity had been completed and an application made to the local authority supervisory body; the application was awaiting authorisation. There was a trigger tool used by the service to check whether people met the criteria for DoLS.

We saw staff had access to induction and ongoing training to enable them to feel confident when supporting people who used the service. The induction consisted of an orientation to the service, ways of working, values, and policies and procedures. In addition, staff were signed up to complete the care certificate induction standards, completed shifts with more experienced staff and had observations of their practice. We viewed specific modules of the care certificate some new staff had completed. New staff received four probationary reviews at intervals in the first six months of employment to track their progress. The registered provider told us there were plans to hold a block induction in the future at the company's headquarters.

There was training provided which was considered essential by the registered provider such as first aid, safeguarding, medicines management, moving and handling, food safety, infection prevention and control and fire safety. There was additional training such as end of life care, dementia care, equality and diversity, the Mental Capacity Act 2005 and DoLS. Staff confirmed they had received this training or were booked on courses. Some staff had also completed training in catheter care, diabetes and nutrition awareness. The registered provider and registered manager had developed a long term training plan from a training analysis exercise, discussions with staff, supervision sessions and observations of practice. Each member of staff had a training needs analysis form and a personal development plan. As part of their development staff were expected to complete a reflective practice journal and an evaluation sheet after any training has been completed.

Records showed staff received supervision and support; this was confirmed in discussions with staff. Comments from staff included, "We have good management support" and "The manager is helpful and their door is always open; you can ring the manager at home."

The environment had been adjusted to assist people living with dementia. For example, we saw doors to toilets had been painted a block colour to help people identify them; there was also a picture of a toilet on the doors. There were signs pointing to where the toilets were situated and where the dining room and sitting rooms were. There were grab rails in corridors, toilets and bathrooms and also toilets had raised seats. Carpeting through the hallways downstairs and the sitting room was one block colour which helped

to deter people with dementia from bending down to pick up what they sometimes see as objects, when carpets are patterned. The registered provider told us they would ensure the upstairs hallway carpet was similarly plain when it was replaced.

Good

Is the service caring?

Our findings

Every person we spoke with was very positive about living in the service and complimentary about staff; all said staff knocked on doors prior to entering their bedroom. Comments included, "They would do anything for you; nothing is too much trouble", "They know who I am. I feel like this is my home", "The staff are lovely, all of them. They're kind and compassionate", "If there's anything the matter I can confide in them. I trust them absolutely," "Never too busy to talk to you", "Nothing but praise for them [staff]." A visitor said, "They always make sure the doors are closed when they are changing him." Another visitor described how staff made sure her relative was covered during a bed bath. Another relative confirmed they could visit at any time, they were kept informed of issues and they were offered refreshments when they arrived.

We observed staff were attentive to people and had a good approach during interactions with them. Staff spoke to people in a caring and calm tone of voice and manner. They made eye contact and got to the same level as people. We saw staff had developed a rapport and good relationships with people. Staff knew people's names and those of their relatives. Equally some people who used the service called the staff by their first name. We saw a member of staff sitting with a person who was anxious and a little distressed; they spent time focused on them until they were settled. A GP told us he had observed staff had a gentle approach with people. A dietician told us they had observed staff had a good rapport with people. A district nurse confirmed staff treated people with respect and dignity. They said people's privacy was maintained when staff supported the nurse during treatment.

We observed people were treated with dignity and their privacy was maintained. People looked well dressed with their hair brushed, nails clean and men had been shaved. We observed staff discreetly asking people if they needed to use the toilet. Some people had shared bedrooms; we saw there was a privacy screen for use between the beds. One person had requested a privacy screen around the sink in their bedroom for use during personal care and this had been provided for them. We saw all walking aids and wheelchairs had people's names clearly visible on them to ensure they were only used for them. In discussions with staff, they were clear about how they maintained privacy, dignity, choice and independence. They said, "We encourage people and give them choice to wash themselves; we help them if we are needed", "When we deliver personal care we keep doors and curtains closed and keep people covered with a towel", "Give people choice about clothes, perfume, toiletries and how they want their hair", Knock on doors before entering" and "Have discussions in private and keep care files locked up."

We saw care plans had been written in such a way as to prompt staff to respect people's privacy and dignity. For example, we saw written in one care plan that the person could be incontinent of urine but could become embarrassed by this. It was written that staff had to discreetly say the person had spilt something on their trousers and could they assist them to change them.

Staff received observations of their practice called 'dignity and respectful care' which was discussed with them in supervision to help them make improvements and to feedback good practice. We observed staff provided information and explanations to people during interactions and care tasks. For example, whilst assisting a resident with a walking frame, a member of staff gave instructions and encouragement in a

gentle manner. Other staff were observed assisting people to move around the service in a safe manner.

We saw people's bedrooms were personalised and they had been encouraged to bring in items to make their environment homely.

There was other information on display throughout the service. The day's menu for all meals was displayed on a white board in the dining room. We saw there were pictures of breakfast foods to assist people with dementia in making choices. The registered manager told us they were expanding on this to have pictures for all the meals. There was an activity board which detailed those activities planned for the week and an activity newsletter for the month of January 2016. Staff provided information every two months in 'Lake View News', which detailed planned activities for the next month and how last months were received. There were also details about fund raising, changes to the environment, new staff and people admitted to the service, progress with developing policies and procedures, staff training and reminders about how to make a complaint. There were pictorial signs for toilets and colorful arrows pointing towards them and other communal rooms. There were hand wash signs over communal sinks to provide information and prompts about good hand hygiene. There was a complaints procedure on display in the entrance. There were details of the staff team including their photographs on display. The food safety certificate on display showed the rating which had been awarded to the service by the local authority. This was rated as five, the highest score that could be achieved.

The registered provider and registered manager were aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. People's care files were kept in a lockable cupboard outside the main office, where they were accessible to staff but held securely. District nurses also kept their nursing records there. Medication administration records were secured with the medicines trolley. The registered provider confirmed the computers held personal data and were password protected to aid security; The registered provider was registered with the Information Commissioners Office, which was required when records were held electronically. Staff records were held securely in lockable cupboards in the main office.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs and provided them with care that was person-centred. They said they were able to get up and go to bed anytime they wanted. They told us there were activities to participate in and they were able to access community facilities. People also said they would feel comfortable making a complaint and they would be listened to.

Visitors told us their relatives received care that was specific for their needs and they all confirmed they were able to have input into care plans. For example, one visitor told us their relative preferred not to have staff or their daughter to bathe them, instead they requested their sisters for this support; it was arranged the person's sisters would come and assist her each week. The visitor said, "She's very shy and this is what she wants. It makes her feel better." Another visitor told us her relative like to watch darts and had stayed up until 5am watching it on television. A third visitor said, "I look at it [care plan] to see mum's needs. I am going to do that monthly to keep an eye on her." A forth visitor told us that when their relative first arrived, they would get up in the middle of the night and get dressed. They said, staff would make him a cup of tea and toast and then sit with him until he decided to go back to bed. A fifth visitor told us their relative was resting in bed today as she hadn't been very well.

We saw people had assessments of their needs, which included identifying any areas of risk. The assessment process included a document called 'This is me' which provided information on the person's history, their medical conditions, what elements of care they could manage themselves and what activities they liked to participate in. Assessments included people's dexterity and what support they needed when participating in activities.

Care plans were produced from the information and provided staff with guidance on how to care for people in line with their needs and preferences. In one person's care plan for managing their behaviour, which could be challenging for the staff at times, there were scripts for them to respond to situations. For example, it was written the person preferred to sit in front of their sink and get washed. It said staff were to fill the sink and say, "There you go, do you want to start and get washed." It was written the person responded well to this. In discussions with staff, it was clear they knew people's needs well and were familiar with their likes and dislikes. They said they had time to read care plans and seniors in charge of shifts received information in handovers. Seniors then passed on information to care staff. We were told this could potentially lead to care staff not always having full information. The registered provider and registered manager told us they would rectify this and ensure all oncoming staff attended handovers.

There was evidence the person's family had been involved in planning and providing care. In people's nutritional care plans there was information about their likes and dislikes, how they took their tea and coffee, what food preferences they had, whether finger foods should be provided, where they preferred to eat their meals and what size plate was required. We saw one care plan to manage a person's incontinence gave a description to staff of the support they needed to provide and the type of aids they required. The same person had a plan which detailed how they expressed pain and how this was to be managed. Another person had a care plan to support them to be safe when smoking cigarettes. The registered provider and

registered manager told us the care plans were under constant review as they wanted to make them even more individualized to include all the important details relevant to each person.

We saw people had a range of activities to participate in. These included, 'baking and making', reminiscence, board games, hand massages, armchair exercises, 'name that tune', arts and crafts, bingo, ball games, sing-a-longs with entertainers and life story work. There were rummage boxes in some people's bedrooms and in the main sitting room. These contained items for people to pick up and use and we saw one person took comfort from doll therapy. We observed staff playing cards and dominoes with groups of people and on a one to one basis. One person who was living with dementia was still able to knit very well and was encouraged to maintain this skill. Another person had a tangle of wool that they were sorting out. Staff told us that without this, the person would sit picking at their clothes and this provided them with a meaningful activity.

We saw there were also visits to local facilities with money raised from fund-raising activities. These included shops, parks, pubs for meals out, the Street Life Museum, The Deep, [a large aquarium and information centre] and annual events such as Hull Fair. Several people told us they attended church on Sundays. There were photographs on the walls of people participating in activities and outings and these showed people took pleasure from them.

The registered provider told us people who used the service had been consulted about what to spend money on from funds raised during a summer fayre; they had decided on a tropical fish tank, which had been installed in the main sitting room.

We saw the complaints procedure and this highlighted people's right to complain and the registered provider's duty of candour to let people know when things go wrong and what they have done to put it right. The procedure indicated timescales for acknowledgement and investigation and provided information on how to escalate a complaint should people remain unsatisfied with an outcome. The procedure gave guidance for staff in how to manage complaints and concerns. The complaints procedure and the forms used to raise issues were displayed near the front door. There was also a suggestions box and slips for people to complete.

Good

Is the service well-led?

Our findings

People told us they felt listened to and suggestions were acted upon. They said they felt happy to raise any problems with the registered manager. Comments included, "You just mention something and it's done", "The manager is very good; she listens to you. There's no problem with raising anything with her" and "The manager and staff are brilliant. She can have anything she wants changing done."

We spoke with the registered provider about the values and culture of the organisation. They told us their focus was on improving the quality of life for people who used the service, on supporting and developing staff and on providing an open culture where knowledge is shared and lessons are learnt. We saw these values were working in practice. The registered manager told us they felt supported by the registered provider and in the short space of time they had been in post they said their knowledge had improved, as they had been involved in each step of the development of the service. In discussions, staff told us there had been lots of changes since the new provider took over the running of the service and they felt supported within their roles. Comments included, "It has changed for the better", "There is good management support. We all work together and they are doing a lot of improvements; there are also more social activities now", "They [management] are stricter with paperwork and there is more to do with the residents; they don't mind if we sit and chat to people", "The second cleaner has made a big difference" and "It is a good service."

There was a business plan which included initiating new policies and procedures for each area of the service. The Quality Assurance Improvement Programme (QUIP) included audits, questionnaires and meetings to enable people who used the service, their relatives and staff to express their views about how it is managed. There was information about the QUIP in the registered manager's office. This was an annual plan and a log for the next six months was on display. The plan included when meetings were to take place, when observations of practice were due, when policies and procedures had been checked for their effectiveness and when audits had been completed. We saw the registered provider or other senior managers visited the service and completed reports about their findings. We looked at the report dated 9 November 2015 and saw this included a full environmental check, an audit of each person's bedroom and observations of staff practice. The senior manager had identified areas that required action and a plan had been produced to rectify shortfalls.

The QUIP file included audits which had been completed by staff internally. These included documentation, activities, first aid equipment, care plans, work force development, accidents and incidents, and infection prevention and control. Where shortfalls were identified there was an action plan with timescales to address them. We saw meetings had taken place for staff, people who used the service and their relatives. Some people told us they felt they didn't need to attend the meetings because they were very happy to raise any suggestions or concerns directly with the registered manager. Relatives confirmed they had the opportunity to attend meetings where general items were discussed. Surveys had been sent out to people. For example, people who used the service completed them in April and November 2015, relatives in July and August 2015, staff in October 2015 and health and social care professionals in April 2015. People spoken with told us they had filled in questionnaires. One person said, "We probably do it twice a year." However, there were no minutes of the meetings or results of audits and questionnaires on display. This was mentioned to the

registered manager to address.

There was evidence of learning from incidents. For example, security had been heightened with bars placed on a window and improved lighting following an attempted break-in to the registered manager's office. Accidents and incidents were monitored each month to identify the type of injury, possible causes and the area in which it happened to prevent reoccurrence. We mentioned to the registered manager that there was a longer wait than expected when we rang the doorbell; this was resolved by renewing the battery straight away.

We found the registered provider and registered manager were aware of their responsibility to inform agencies such as the local authority, commissioners and the Care Quality Commission (CQC) of incidents which affected the wellbeing of people who used the service. On the whole this had been completed in a timely manner. We found two instances when this had been overlooked and there was a delay in reporting to the CQC. The registered manager told us all notifications would be sent in straight away in future.

We saw good relationships had been built up with health and social care professionals. There were positive comments from GPs, district nurses, dieticians and the local safeguarding team about the service. A district nurse told us their nursing team and the staff in the service worked well together.

We saw the service had been awarded a 'Healthy Options' certificate from the local authority. This meant an audit of the food provided to people had found there was a choice of meals which enabled people to eat a healthy diet if they chose to.