HICA

Elm Tree Court - Care Home

Inspection report

344 Preston Road
Hull
Humberside
HU9 5HH

Tel: 01482788447
Website: www.hicagroup.co.uk

Date of inspection visit:
20 March 2018
21 March 2018

Date of publication:
25 April 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Elm Tree Court – Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elm Tree Court – Care Home provides accommodation and personal care to a maximum of 72 people including those people who may be living with dementia. The building is single storey and purpose built. It is divided into three separate bungalows that surround a courtyard. Each bungalow has its own communal areas, bedrooms and bathrooms.

At the last inspection in June 2017 the service did not meet all of the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection the service was rated 'Requires Improvement'. This was because the provider was in breach of three regulations, for which we made requirements and the service was in need of other improvements, for which we made recommendations. Breaches related to failure to work under the Mental Capacity Act 2005 legislation, inaccurately written care plans and ineffective auditing. Improvements were needed in staff deployment, using best interest decisions, maintaining medicine records and care for people living with dementia.

Following the last inspection we asked the provider to complete an action plan to show what they would do to improve the key questions is the service safe, is the service effective, is the service responsive and is the service well-led, to at least good? The provider sent us an action plan.

This comprehensive rated inspection of Elm Tree Court – Care Home took place on 20 and 21 March 2017 and was unannounced. We checked that the action plan had been followed. We rated the service as 'Good' because previous requirements and recommendations had been met. The rating is based on an aggregation of the ratings awarded for all 5 key questions.

The provider was required to have a registered manager in post. When we inspected there was a manager that had been in post since November 2017 and registered since January 2018. A registered manager is a person who has registered with the Care Quality Commission (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.

Staffing numbers were sufficient to meet people's needs and they were effectively deployed. People were protected from the risk of harm. Accidents and incidents were appropriately managed, risk assessed and mitigated. The management of medicines was safely carried out. Systems in place demonstrated there was a safe audit trail for handling drugs, which protected people from harm. The premises were safely maintained. Systems in place detected, monitored and reported any potential or actual safeguarding concerns, staff were trained in this area and understood their responsibilities in respect of managing them.

Infection control practices were safely and effectively followed and were underpinned by good infection control management policies and procedures. Recruitment policies and procedures were safe and carefully followed to ensure staff were 'suitable' to care for and support vulnerable people. When events went wrong the provider and staff learnt lessons so that mistakes were not repeated. These were documented and discussed as part of the process.

People's mental capacity was appropriately assessed and their rights were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Consent for all things to take place was respected so that staff always sought people's cooperation and agreement before completing any support tasks. Adequate nutrition and hydration ensured that people were supported to maintain good health and wellbeing. The meal time experience for everyone had been improved.

People's needs were assessed and staff were skilled and trained to carry out their roles. Qualified and competent staff were themselves regularly supervised and received annual appraisals of their personal performance. Staff respected the diversity that people presented and met their individual needs, for example, regarding health and social care. The premises were suitable for providing care to older people and measures had been taken when developing the service to include features which ensured the environment was appropriate for those people living with dementia. Facilities were being improved where needed.

People received compassionate care from kind staff that knew about people's needs and preferences. The management team set good examples to the staff team with regard to attitude and approach, which meant staff had good role models to follow. People were provided with the information they needed to stay in control of their lives and maintain their independence. Information sharing and communication was effective. People's diverse needs were understood and met and where necessary, advocacy services were accessed to ensure people's choices were respected. People's wellbeing, privacy and dignity were monitored and respected.

Person-centred care plans reflected people's needs and instructed staff on how best to meet these. They were regularly reviewed. People's preferences and views were respected. People had opportunities to engage in pastimes and activities that suited them and they enjoyed. They maintained good family connections and support networks with the help of staff if necessary. Their communication needs were assessed and met. An effective complaint procedure ensured complaints were appropriately investigated and without bias. End of life care was sensitively provided with regard to preferences, wishes and needs.

The provider met the regulation on quality assurance systems and these were effective. Audits, satisfaction surveys, meetings, handovers and the provider's own internal quality monitoring tools ensured there was effective monitoring of service delivery. The system identified shortfalls in service delivery and was used to improve quality. The conditions of the provider's registration were met in respect of submitting notifications of specific events as required by law. The registered manager understood their responsibilities with regard to good governance, strove for continuous learning around best practice, updated their learning and practice at every opportunity and searched for innovative ways to deliver the service. The culture and the management style of the service were positive and empowering for people that used the service and staff that worked there. Good community links for people and their families were fostered. Experiences of transition between services were well managed, as partnership working was efficient. Recording systems protected people's privacy and confidentiality of information and records were securely held.

Further information is in the detailed findings below.

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.

Staffing numbers were sufficient to meet people's needs.

People were protected from the risk of harm. Staff were trained in this area and understood their responsibilities. Risks were managed and reduced.

The management of medicines was safely carried out and infection control practices were effectively followed.

Recruitment procedures were safe.

When events went wrong the provider and staff learnt lessons so that mistakes were not repeated.

Is the service effective?

Good

The service was effective.

People's mental capacity was appropriately assessed and their rights were protected. Interventions followed least restrictive practices and were safely planned, carried out and recorded.

Adequate nutrition and hydration ensured people's health and wellbeing. The meal time experience for everyone had been improved.

People's needs were assessed and staff were skilled and trained to carry out their roles. Health care needs were met.

Premises were maintained and facilities were being improved where needed.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff.

They were provided with the information they needed to stay in

control of their lives and maintain their independence. Information sharing and communication was effective.

People's diverse needs were understood and met and where necessary, advocacy services were accessed to ensure people's choices were respected.

People's wellbeing, privacy and dignity were monitored and respected.

Is the service responsive?

Good

The service was responsive.

Person-centred care plans reflected people's needs and instructed staff on how best to meet these. People's preferences and views were respected.

People engaged in pastimes and activities that suited them if they wished. They maintained good family connections.

An effective complaint procedure ensured complaints were appropriately investigated.

End of life care was sensitively provided.

Is the service well-led?

Good

The service was well led.

An effective quality assurance system identified shortfalls in service delivery and was used to improve quality.

The conditions of the provider's registration were met in respect of a registered manager and submitting notifications.

The culture and the management style of the service were positive. Good community links were fostered.

Experiences of transition between services were well managed, as partnership working was efficient.

Recording systems protected people's privacy and confidentiality of information and records were securely held.

Elm Tree Court - Care Home

Detailed findings

Background to this inspection

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

The inspection of Elm Tree Court – Care Home took place on 20 and 21 March 2018 and was unannounced. Four adult social care inspectors carried out the inspection. Information had been gathered before the inspection from notifications sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We received feedback from local authorities that contracted services with Elm Tree Court – Care Home and reviewed information from people who had contacted CQC to make their views known about the service. We used some information the provider sent us in the Provider Information Return, because although a new one had not been completed, the last one had been sent to us within the year. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people that used the service and four relatives or friends. We spoke with the registered manager, deputy manager, area manager, one team manager, two team leaders and two personal carers (staff) that worked at Elm Tree Court – Care Home. We looked at care files belonging to nine people that used the service and at recruitment files and training records for six staff. We viewed records and documentation relating to the running of the service, including those for quality assurance and monitoring, medication management and premises safety. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and some people's bedrooms.

Good

Is the service safe?

Our findings

People and their visitors told us they felt safe living at Elm Tree Court – Care Home, that risks were managed, sufficient staff supported them, their medicines were always on time and the place was clean and hygienic. People said, "It's nice here. The staff are always around when needed" and "I am safe here. I get my tablets when I need them." They also said, "I'm treated well. I like the place now the carpets have gone. That makes a difference", "Staff look after me and are kind" and "No one is treated unkindly. I know the staff and it's a clean place." Visitors said, "Absolutely my relative is safe. They are happy even though not been here long. Staff are available when I need to ask them anything", "My relative is settled and I visit every day so I know they are well cared for" and "I am so much more settled now knowing that [Name] is safe here and being well looked after."

At the last inspection the provider inefficiently deployed staff, which meant people's needs were not always met. They ineffectively managed low-level interventions for people living with dementia as these were not always legally sanctioned using the best interest process. The provider did not always ensure that medicines administered to people were signed for. We made three recommendations for these shortfalls at the last inspection.

At this inspection we found that staff teams were assigned to one of the three bungalows, which accommodated 24 people each. We also saw that since the last inspection staffing hours had increased by an extra 12 hours across the day on each bungalow, giving an extra 36 hours each day in the service. Two people were now receiving one-to-one support. All staff hours had changed from seven or eight hour shifts to 12 hours shifts, which condensed staffing hours worked and gave them a longer break when off duty. The team leaders' hours had changed from an 8am to a 7am start as well, which enabled them to see the night staff before they left work. The change in shift hours was a recent one, but we were told that so far everyone had found it agreeable. We were also told that staff were now logging on and off duty electronically.

We also found that best interest decisions were made to address the risks for those living with dementia when low-level interventions took place during personal care. For example, where people were reluctant to receive personal care, but it was decided they needed to receive it to maintain their health or avoid ill health, then best interest decisions had been reached and information was recorded in their care plans to show how the support should be given.

Risk assessments were in place to reduce people's risk of harm from, for example, falls, poor positioning, moving around the premises, inadequate nutritional intake and the use of bed safety rails. People had personal safety documentation for evacuating them individually from the building in an emergency or in case of fire and these were easily accessed.

Maintenance safety certificates were in place for utilities and equipment used in the service, and these were up-to-date. Contracts of maintenance were in place for ensuring the premises and equipment were regularly maintained. Audits were carried out to ensure fire safety and equipment safety measures were followed. All of this ensured the safety of people, staff and visitors.

We saw that the management of medicines was safe and improvements had been made with recording of accurate information on the medication administration records (MARs). MARs were completed by the team manager or team leader who signed on administration of all medicines and omission codes were properly used. We observed two team leaders on different bungalows administering medicines safely. The medical room was tidy and well organised and systems for following a robust audit trail were clearly defined. Medical room and medicine fridge temperatures were recorded to ensure medicines did not spoil. Medicines to be given 'as required' followed written protocols. Those subject to special administration regulations, controlled drugs, were given and signed for by a team leader and a member of the care team. Unused medicines were safely disposed of. Stocks were safely controlled and securely stored.

Systems and practices protected people from harm or abuse and robust risk management ensured people were safe. Staff demonstrated good understanding of safeguarding principles, procedures and responsibilities to report and refer safeguarding incidents. Staff told us about the training they had completed in this area and this was evidenced by their certificates.

Records showed that the number of safeguarding referrals over the last year, were consistent with any other service of this size. Discussion with the registered manager and staff and viewing some of the accounts of the action taken to manage safeguarding incidents evidenced that the provider protected people from harm and abuse and ensured any incidents were appropriately investigated. For example, when one person was without their liquid pain relieving medicine because it had been dropped and the bottle broken, an alternative temporary pain patch was obtained from the pharmacy after consultation with the person's doctor. Also when one person allegedly had a delay in receiving medical attention following an accident the investigation evidenced that the failure had been with recording practices and not the actual action taken to seek medical health care.

Recruitment practices were safe and ensured staff were suitable for their roles, which included seeking references and security checks before they started working. Staff files contained application forms, references, evidence of identity and interviews, correspondence and medical and equal opportunity questionnaires. The staffing complement was made up of staff from a varied age range, both genders and several cultures and backgrounds. Some staff had worked for several years at the service, while others were new within the last couple of years.

We found there were systems, processes and practices in place for maintaining safe infection control throughout the service. Housekeepers were employed to ensure the environment was clean and odour free. While on an early morning walk around the premises two bedrooms were found to have unpleasant odours, these had been eradicated later in the day. Cleaning schedules were maintained and seen to be effective. Staff were supplied with personal protective equipment; gloves, aprons and hand sanitising gel, so they could protect people and themselves form the risk of infection.

We saw that bathroom hoisting equipment, baths, showers and communal and bedroom en-suite toilets were clean and hygienic. The laundry had a clear direction of flow to handle dirty and soiled linen and clothes. Good hand hygiene reminders were posted in appropriate places. Kitchen staff wore protective uniforms, hats with nets and aprons as necessary. Staff serving meals from the hot locks in use also covered their daily uniform polo-shirts and wore netted hats.

Accidents, incidents and near misses were recorded and used to determine any improvements required with practice and monitoring of events. Mistakes made within the service were used to learn lessons from so that they were not repeated. Formal notifications were sent to us regarding all incidents, which meant the registered provider was meeting the requirements of their registration.

Good

Is the service effective?

Our findings

People and visitors we spoke with felt the staff at Elm Tree Court – Care Home understood people well and had the knowledge to care for them. They showed satisfaction with the food provided and the support they received with health care. People said, "The staff are good. They seem to know what they are doing. I really like the food", "We get really good food and there is always plenty" and "Staff know how to care for us. We see the doctor when we want to." Visitors told us, "My relative gets very nice food and never complains about it. I think it always looks very nice", "Food is lovely here, smells so good and I could eat it myself. I often manage to get seconds for [Name]" and "I have never heard [Name] complain about the food or anything really. Staff seem to be well trained to provide the care people need. I certainly have no concerns."

At the last inspection the provider was in breach of regulation 11 with regard to the Mental Capacity Act 2005 (MCA) and a lack of deprivation of liberty safeguards (DoLS) for low-level interventions used when some people living with dementia received personal care. We made a requirement for this.

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

At this inspection we checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We also discussed MCA and DoLS with the registered manager and staff and viewed documentation now in place to ensure the legislation was implemented. We found that staff had a better understanding of the implications of using interventions to provide personal care and documented their actions more clearly. Further considerations were made by staff regarding specific actions, for example, ways of hand holding and encouraging consent to receive care. MCA assessments were more prevalent and DoLS had been requested from the authorising body.

We found that best interest processes were followed, agreed and documented. However, on two occasions we saw that according to dated documents, the best interest process had been used in advance of an MCA assessment being carried out, which we discussed with the registered manager. They assured us that they would address this with team managers and team leaders who had responsibility to complete the MCA assessments and best interest documents. The best interest process and documenting decisions was further discussed with the registered manager and refinement of information was highlighted to ensure that absolute clarity was evident for staff when they needed to take action to provide care to people that were reluctant to receive it. For example, we saw that for one person who had good mobility it was decided that on occasion they would be bathed using the mobile bath hoist to ensure their hygiene was maintained and their health protected. We acknowledged that improvements had been made with implementing the MCA

and best interest decisions and that this was still a work-in-progress.

People consented to care and support from staff either by verbally agreeing to it when offered or cooperating through their body language and accepting support when staff offered their assistance. Some people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled on their behalf. The registered manager had also written to the families of people living with dementia to ask them if they had any lasting powers of attorney for their relatives in care and if they would provide some evidence of this. Regulation 11 was met.

At the last inspection we also made a recommendation that the provider looked to good practice guidelines regarding the meal time experience for people living with dementia, as it was observed to be hurried and chaotic.

At this inspection we observed lunch being served on two bungalows and found that the experience, while busy, was calm, relaxed, informal, supportive and organised. People's preferences were respected and we saw they made choices about where they sat or what they ate. Meal times were protected in that disruptions from visitors were not tolerated and all staff, including ancillary staff, were required to assist people. Meals were supplied via an outside catering company and delivered to Elm Tree Court – Care Home as part of a regular contract. Therefore specific meals to suit all cultures and religions could be supplied upon request. Food was served from heated trolleys and people were asked what they wanted from a choice of, or were actually shown the two options available.

Those people that required specific diets, for example, diabetic, free from, vegetarian, Halal or Kosher, were known to staff and the cook and these meals were provided. Those people that required assistance with their meals were sensitively supported. Staff sought the advice of a Speech and Language Therapist (SALT) when needed and risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. While meal times were protected, family members who regularly visited across lunch time to assist their relative were enabled to do so. We observed at least two family members assisting their relative to eat and they later told us this was because they liked to know how well their relatives were eating.

People's care and support needs were appropriately assessed before admission and for a while afterwards so that an accurate picture of their needs could be acquired. The local authority 'My Life, My Way' document and consultations with family members were also used to determine people's wishes, preferences and needs.

The provider had systems in place to ensure staff received the training and learned the skills they required to carry out their roles. All of this was recorded electronically and used to review when training was required or needed to be updated. Certificates held in staff files of the courses they had completed corroborated the courses staff told us they had completed. The provider had a training team for certain skill areas and also used on-line courses or workbooks to deliver training.

Staff told us they completed the organisation's induction programme, received regular one-to-one supervision and took part in a staff appraisal scheme. Induction, supervision and appraisal were evidenced from documentation in staff files and via discussion with staff. Induction followed the guidelines and format of the Care Certificate, which is a set of standards that social care and health workers follow in their daily working life as recommended by Skills for Care, a national provider of accreditation in training.

Staff worked well with each other and other care and healthcare professionals. We saw evidence that

information sharing took place between the provider and other care providers in such as health correspondence, referrals for services and sharing of information from other care providers.

People and their family members were consulted about medical conditions and information was collated and reviewed with changes in people's conditions and shared in handovers or staff meetings. Documents evidenced that people saw their doctor, the district nurse, chiropodist, dentist or optician on request and when necessary. They contained guidance on how to manage people's health care and recorded the outcome of consultations as well as the when such assistance was given to them.

The registered manager had signed up for a joint health (the local Clinical Commissioning Group) and social care trial on monitoring and treating people's urinary tract infections. This involved setting up a rapid response system with a local doctor's surgery whereby any concerns with a person's condition or behaviour were emailed straight to the surgery, a doctor looked at the indications and the person's past history and quickly prescribed an anti-biotic. The study was looking at how this intervention reduced the number of falls and incidents among people living in residential care and nursing homes. The expected benefits were that people were treated more quickly, fell less often and experienced fewer altercations, which would also mean less use of hospital services.

The premises was a purpose-built care home and had a layout, signage and colour schemes that aided orientation for those people living with dementia. Corridors enabled free movement, bedrooms doors were identifiable and carpets, furniture fabrics and wallpapers were plain in the main, all of which helped to ensure people's confusion was kept to a minimum. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound and smell. The environment at Elm Tree Court – Care Home was suitable for its use.

Good

Is the service caring?

Our findings

People told us they thought staff were caring and supportive. They said, "She's nice [pointing to staff]", "I like the girls and [Name] is really nice" and "They [staff] are always there to help." Visitors told us that they found staff to be kind and compassionate. They said, "I have always found that staff are gentle with people. They are polite and courteous and show a lot of empathy" and "Staff have a good approach and always seem to know what works with people."

We saw that staff had a pleasant manner when they approached people and were gentle and quite, which helped to keep people calm. Staff knew people well, understood their needs and preferences and were kind when they offered support. Even when people's wishes were unknown staff treated them in a humanitarian way with compassion. Staff spent time with people so they could work out what they wanted and needed and emotionally supported people when they were anxious or upset.

We saw and heard people making their views known about meals, where they sat or when they got up to take a walk. People's choices were fully respected. For example, one person decided not to have lunch as they believed they had to travel a long way to get home, but agreed to eat a sandwich later. Another person got up to got to table for lunch and then changed their mind half way through. They too were given food later, which suited them. We heard people talking to staff about their families and past lifestyles and staff showed understanding and encouragement. Staff told us about their approach to people, for example, in the morning. They said sometimes people were disinclined to accept support to get up and dressed and so staff would leave people for a while and say they would come and see them later. If that approach still did not work then a different staff member would try and usually this worked. Sometimes people were more receptive after the presentation of a hot drink or snack first.

A person in one of the bungalows expressed their views to us about the environmental changes they had observed and said they found that the lounge looked a whole lot better now the carpet had been replaced with wood effect flooring. Another person, with insight into their condition, expressed that they did not really like being in Elm Tree Court – Care Home, as although it was close to where family lived it had not turned out to be what they wanted. They told us they had expressed this freely to staff and the management team and that everything was being done to help them improve their perception of the service. Their visiting family member felt the service was the right place and told us that they had been extremely satisfied with the care the person received. They said staff were kind, understanding and inclusive.

We were told at the time of our inspection that people with diverse needs were adequately provided for. While no one presented any obvious differences, staff were aware of people's religious and cultural needs, knew who required support with any physical disability due to age and was aware on a need to know basis about people's sexual orientation. Staff confirmed with us in discussions that they had completed equality and diversity training and were aware of some people's particular diverse needs, which they told us were never judged, but respected and accommodated. They told us that people were given the same opportunities in the service to receive the support they required and were treated as individuals with particular needs to be met according to their individual wishes, choices and inclinations.

We saw that people were treated and supported according to their specific needs, which incorporated consideration of their age, disability, gender, race, religion and belief. Those that followed a religion were enabled to do so by accessing services in the community or in-house with visiting religious ministers of various faiths. For example, a Catholic priest visited those that required Holy Communion. People using wheelchairs to mobilise were included in all of the activities that ambulant people undertook and every effort was made to ensure they had equal opportunity to join in with physical exercises and trips out. Everyone's views and those of their family members were taken into consideration, especially with regard to their personal preferences for daily living by listening to what they had to say and enabling them to make choices.

Because people at Elm Tree Court – Care Home were living with various stages of dementia their communication needs were diverse and some also had physical conditions that impaired hearing and sight. These were assessed as part of the initial assessment of needs. Communication aids or methods, such as hearing aids, loop systems and presenting visual choices with meals and clothing were used to help people make decisions. Most people verbalised their daily needs with which staff had become familiar, but some resorted to physical demonstrations. Staff relied on information from family members where people could not express needs.

The registered manager was aware of the Accessible Information Standard (AIS) and the standard's assessment process. The AIS aims to ensure that those with a disability receive accessible health and social care information. People received information in large print, via loop systems and other languages where necessary and as the need presented itself.

Staff carefully monitored people's general well-being, knew what might upset their mental or physical health and ensured these situations were avoided, where possible. The ethos within the service was that if people's needs were met, choices respected, they received stimulation, were occupied, ate well and felt cared for then well-being would be experienced. Identified changes in well-being were managed with medical, psychological and family support and changes to people's care.

While everyone living at Elm Tree Court – Care Home had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them.

People's privacy, dignity and independence were respected. Staff described how they achieved this when offering and providing support and gave examples of their actions to ensure people felt comfortable receiving personal care. We observed staff maintaining discretion when assisting people: one staff member asked a person permission to wipe their clothes when they spilled food, so as to maintain their dignity. Staff explained that people's choices about their appearance were fully respected, for example, where men wished to grow a beard this was encouraged. Certain clothing was suggested to maintain the dignity of females who were hoisted.

Good

Is the service responsive?

Our findings

People and particularly their family members told us they felt their needs were being appropriately met. They said staff were responsive to people's needs for daily living, health and social care. They said, "I have all that I need really", "Staff are available when you need them to help" and "I get all the support I need." Family members said, "The staff are really good. They are always close by and any questions I have about [Name's] care are answered. Staff will do anything for the people here and always try to maintain calm and keep people satisfied" and "I have no worries at all about [Name] being cared for. I do like to come and make sure they eat well, are clean and comfortable, but I have never had cause to complain that they weren't." Family members had information in the form of a service user guide that told them what to expect from the service and how to complain should there be a need.

At the last inspection the provider failed to ensure people's care plans accurately recorded their wishes and preferences regarding daily routines, which meant they were at risk of receiving the wrong support. This was a breach of regulation 9 with regard to person-centred care for which we made a requirement.

At this inspection we found that people's care plans were in the organisation's standard format, though these were systematically being reviewed and updated. Those we looked at contained person-centred information that reflected needs and stated, for example, the times that people liked to rise or go to bed, the equipment to use should they have a fall and the interventions to use to avoid risk. Care plans had action plans and information for staff on how best to meet needs, contained personal risk assessment forms to show how risks to people were reduced, for example, with pressure relief, falls, nutrition and activities that people engaged in. Care plans were more reflective of needs and along with risk assessments were reviewed monthly or as people's needs changed. Regulation 9 was met.

Staff were receptive to people's individual preferences for rising, going to bed, what they wore, where and what they ate and whether or not they engaged in activities or conversations with others. One person who was immobile and received care in bed was comfortable and protected from risks. Monitoring charts showed when positional changes had occurred, creams were applied and how much food and fluid was taken.

People were supported to engage in activities, pastimes and occupation, because plenty of activities and events were offered, which meant they were able to find satisfaction and purpose. One person regularly collected plates and cutlery after people had eaten their meal. Another liked to walk around their bungalow tidying up. We saw some people walking together and discussing what they found on route. Several people received visitors and engaged in tidying cupboards in their bedrooms, taking coffee together or generally passing time talking about days gone by. We saw that corridors on each bungalow contained numerous photographs of film and television celebrities, or had themed displays on the walls, which stimulated conversation. Each bungalow had its own kitchen serving area where people accessed a drink and a snack at any time, which was also seen as engaging in occupation. People ate fruit and crisps and could have a drink on request.

We were told that a connection had been established with the local professional Super League rugby club Hull Kingston Rovers, in the immediate vicinity and this was backed up by a promotional photograph that had been taken for use by the team and the service. Plans had been made to have the club cheer leaders come to the home to demonstrate their dance moves and hold exercise classes for people living in the service and for some of them to receive complimentary tickets to games. This was an excellent connection for people at the service to build relationships within the local community. All activity and occupation helped people to feel their lives were busy and purposeful, which aided their overall wellbeing.

The provider had a complaint policy and procedure in place. Records held on complaints showed that they were handled within timescales. The service had appropriately addressed complaints and complainants had been given written details of explanations and solutions following investigation. Complaints were mainly to do with lost items of clothing. A complaint log showed how issues had been analysed to avoid repetition and there were strategies put in place to ensure problems were resolved. The registered manager had made a decision on taking up the post to relocate their office to a room close to the main entrance of the service so that family members had instant access to them. This meant they could see the registered manager on entering or leaving the building to discuss any niggles or concerns, which were easily voiced and quickly addressed.

Staff discussed the complaint procedure with us and demonstrated their understanding of how complaints helped them to improve the care they provided. They said they liked to sort complaints out quickly if they could, but referred any that could not be resolved straight away to the team leaders. Family members told us they knew how to complain and had discussed issues in the past, but that recently they had no cause to. Compliments were recorded in the form of letters and cards sent to the service and these had been numerous over the last year. They included satisfaction with, for example, the care people received after leaving hospital and setting up Skype for a person to see their family in Canada as well as many 'thank you' comments for caring for people.

We looked at how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans. People's wishes following illness and when faced with end of life decisions were obtained through discussion with them and their family members. Some people had 'do not attempt cardiopulmonary resuscitation' documents in place to protect them from any unnecessary and unpleasant treatment when the end of life stage was reached. Those people without these documents were assured their right to life would be protected and respected by the health and social care services they might need to access and use. Staff related to us how they approached end of life care and demonstrated that they saw it as a special time for reverence (respect or devotion).

Staff were sensitive to people's needs and those of their relatives at this time of their life. Records showed that people received regular monitoring and support checks, which were recorded on monitoring charts for nutritional intake and output, pressure relief and application of topical creams and lotions. People and their relatives were treated respectfully, with compassion and dignity.

Good

Is the service well-led?

Our findings

People and especially their family members told us they felt the service had a homely, family orientated atmosphere, which was helped by the care model used: that of having three bungalows of 24 people. People said, "It is lovely here" and "I find the place is small and cosy." Family members said, "The home is friendly, homely and comfortable" and "It is always clean, comfortable and well run. I am always made to feel welcome when I visit." Staff we spoke with said the culture of the service was, "Friendly, lively and accommodating." Staff expressed that they enjoyed coming to work as they supported people that were full of character and interesting.

At the last inspection the provider had failed to ensure that quality assurance systems, particularly audits were effective, because they had not identified issues we found with staff deployment, low level interventions, medicines and care plans. This was a breach of regulation 17 with regard to effective monitoring of the service, for which we made a requirement.

At this inspection we found that there was an organisational quality assurance system in place that involved bi-monthly checks carried out on all areas of service delivery to determine whether or not the service was meeting organisational requirements in line with registration regulations. The service had been assessed as operating at a 96% performance rate in March 2018, which had been a significant improvement to previous months. We were told that this system, which assessed the service on any one particular day, was being reviewed and would soon include an assessment of performance across a whole month so as to give a more representative picture of the on-going service delivery and performance.

The registered manager also completed regular audits on various functions of service delivery to identify shortfalls experienced by people in their daily care. Audits included checks made, for example, on kitchen efficiency, building and premises maintenance, equipment used, infection control and prevention and management of medicines. There was audit evidence to show that shortfalls had been identified, actions planned for and improvements made. Both systems had been used effectively to identify shortfalls, take action to address them and drive improvements in the service.

The quality assurance system also included sending out satisfaction surveys to people that used the service, relatives and health care professionals. The last satisfaction survey issued in December 2017 to people that used the service and their family members identified a need for improvements with the gardens and an increase in staffing numbers. The registered manager had taken these on board; staffing numbers had already increased and plans were in place to make gardens more suitable and accessible so they would be ready for use in summer 2018. General written comments from family members were positive and included, 'Carers are amazing' and 'Staff are caring and polite.' Staff questionnaires were also completed by new staff to the service to ensure equal opportunities legislation was being followed when recruiting new workers.

Staff meetings were used to discuss service achievements, concerns, plans and changes and relatives' meetings were held to seek their views of the care and support that people received. Shift handovers were held, which ensured people's individual needs were discussed and monitored and changes implemented.

Regulation 17 was met.

The provider was required to have a registered manager in post and on the day of the inspection the manager had been registered for just two months, but had been in post for nearly five months. The registered manager and provider maintained a 'duty of candour', which is the responsibility to be honest and to apologise for any mistake made under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Notifications of events were sent to the Care Quality Commission (CQC) and so the service fulfilled its registration responsibilities.

The management styles of the registered manager and deputy manager were open, inclusive and empowering. Staff were complimentary about the managers and team leaders and said, "I am confident I can go to the manager any time and speak up about anything" and "The manager and deputy are always available and they run the place extremely well." Staff told us they were friendly with each other at work and got on very well. One staff member said, "I am proud to work at Elm Tree. It is a good place to live and work." The staff knew about the visions and values of the organisation and spoke about the SHINE initiative underpinning the provider's philosophy, which is a strategy for making a difference to people's lives through activity, interest, achievement and maximising potential for service users and staff.

Staff encouraged people to maintain links with the local community, where possible, through religious bodies, schools and by visiting local shops, stores and cafes. Visitors were made welcome and encouraged to treat the service as their relatives' home, where they could stay with them as long as they wished.

The registered manager strove for continuous learning around best practice and met with other care home managers in the organisation, updated their learning and practice at any opportunity and worked towards improving the service by searching for innovative ways of service delivery and the means of sustaining them.

The registered manager and staff ensured good partnerships were forged with other agencies and organisations by keeping in contact with them, sharing information and listening to and acting on advice when it was offered. This was evidenced in care plan documentation which showed that care, support and treatment provided to people was based on shared information and took into consideration the requirements made by visiting health care professionals. People were seen and treated as individuals with differing needs and preferences and responsibility for their care and support was shared with other professionals when appropriate.