The Gables Care Centre Limited

The Gables Nursing Home

Inspection report

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Silsden
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Tel: 01535655846

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The Gables Nursing Home is situated in the town of Silsden between Keighley and Skipton. It is registered to provide nursing and personal care for up to 46 people, some of whom may be living with dementia. The service is a mixture of old and new buildings where there have been improvements and extensions over time. Most bedrooms were for single occupancy but there were six that were for people to share. There were bedrooms, communal rooms, bathrooms and toilets on all three floors which were accessed via a passenger lift and stairs.

We undertook this unannounced inspection on the 21 September 2016. There were 43 people using the service at the time of the inspection, 35 who required nursing care and eight who required residential care. At the last inspection on 31 October 2013, the registered provider was compliant in the areas we assessed.

The service had a registered manager in post as required by a condition of registration. 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.

We have made the Caring domain outstanding. We have done this because we found the registered manager and staff team had developed very positive ways in ensuring people who used the service and their relatives felt cared for and supported, which had a positive impact on their wellbeing.

The end of life care people received was exceptional; everyone had an advanced care plan regarding the preferred place they wished to be cared for at the end of their life. A clinical nurse specialist in palliative care told us that people had been looked after to a high standard and staff had good knowledge of when end of life was approaching in order to rally the required support for the person and their relatives. They also said staff were very proactive in seeking the specialist nurse's advice when required and with actions resulting from weekly meetings. They said they did not need to attend meetings as often now because of the nurses management regarding people's end of life care.

We observed very positive staff interactions with people who used the service. Staff treated people with kindness, respect and dignity, offering encouragement and support when required.

Staff protected people from the risk of harm and abuse. There were policies, procedures and training to guide staff in how to safeguard people from abuse; they knew how to recognise signs of concern and how to report them. We found risk assessments were completed and kept under review. This helped to minimise risk and prevent accidents and incidents from occurring.

We found people were safe within the service. There were good recruitment systems in place and there were sufficient staff on duty to look after people and ensure their health and wellbeing.

Staff were aware of people's health care needs and how to recognise when their health was deteriorating. The support they provided helped to maintain people's health and wellbeing. Staff liaised with health professionals for advice and guidance when required. We found people received their medicines as prescribed. Staff managed medicines well by obtaining, storing, administering and recording them appropriately.

We found staff supported people to maintain their nutritional needs. They assisted people to make choices about their meals and to eat them safely when required. The menus provided were varied and offered choices and alternatives.

We found people were supported to make their own decisions as much as possible. For example staff offered people visual choices to aid decision making. When people were assessed as lacking the capacity to make their own choices, decisions were made in their best interest in line with mental capacity legislation. We made a recommendation that the registered provider seek advice regarding specific documentation tools to record best interest decisions.

People had assessments and care plans which guided staff in how to support them in line with their needs, wishes and preferences. We found people and their relatives were involved in assessments and developing care plans. Relatives told us their family members were cared for in an individual way; they were very happy with the service and had noticed there was a lot going on for people. There was a large range of activities for people to participate in and trips to local community venues were arranged.

Staff told us they received sufficient training to enable them to support people safely and to meet their assessed needs. Records confirmed this. We found staff received guidance, support, supervision and appraisal. This helped them to be confident when supporting people who used the service.

We found the service was well-managed. There was a quality monitoring system that ensured people's views were listened to via meetings, questionnaires and day to day discussions. Audits and checks were completed and any shortfalls were addressed. There was an ethos of learning to improve practice and the service provided to people. Staff told us there was an open culture where they felt able to raise issues with the registered manager.

There was a complaints policy and procedure on display and people told us they felt able to complain in the belief any concerns would be listened to and addressed.

We found the environment had been adjusted well to respond to people's individual needs. This included corridors with hand rails, the availability of moving and handling equipment, a passenger lift to the upper floor, signage to remind people of the location of toilets and light, airy communal rooms. The environment was safe and clean. Equipment used in the service was maintained and regular checks took place to identify any concerns.

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.

There was sufficient numbers of staff on duty day and night to ensure people's needs were met. Staff had been recruited thoroughly and checks were carried out to ensure they were suitable to work in a care service.

Staff had received training in how to safeguard people from the risk of harm and abuse. They knew what to do if they witnessed abuse or if someone disclosed concerns to them.

Medicines were managed well and people who used the service received them as prescribed.

The service was clean and tidy and there were good infection prevention and control practices.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met. People had access to a range of community health care professionals as required. The meals were varied and provided choices and alternatives to people.

People were supported to make their own decisions about the care they received. When they were assessed as not having capacity to do this, staff worked within mental capacity legislation. We made a recommendation that the registered provider seek advice regarding specific documentation tools to record best interest decisions.

Staff received training, supervision and support which provided them with the skills and confidence required to carry out their roles.

Is the service caring?

Outstanding ☆

The service was very caring.

Staff approach was observed to be extremely caring and compassionate. They respected people's privacy and dignity, spoke to people in a very patient way and comforted them when they were anxious. There were very positive comments from people who used the service and their relatives about the staff team's caring and compassionate approach.

The registered manager and staff team had developed ways to enhance support to relatives such as toy boxes for children and comfort packs for people visiting those residents in receipt of end of life care.

The support staff provided to people at the end of their life was exceptional. Staff had received training in palliative care and the service was accredited 'Commend' status when assessed for the Gold Standard Framework in end of life care.

Staff gave explanations to people prior to tasks being completed and ensured they had information available with which to make informed decisions.

Personal information about people was held securely.

Is the service responsive?

Good

The service was responsive.

People were provided with care that was person-centred and tailored to their individual needs. They had assessments and care plans which gave staff guidance in how to support people.

There was a wide range of activities provided to people that responded to their needs and interests. There was also access to community facilities which had impacted positively on people and improved the quality of their lives. This helped to ensure social inclusion and for people to feel part of society.

There was a complaints policy and procedure and people felt able to raise complaints or concerns in the knowledge they would be addressed.

Is the service well-led?

Good

The service was well-led.

The registered manager provided a good role model and a supportive environment for staff.

The culture of the organisation was open and supportive. People

were able to raise concerns and express their views.

There was a quality monitoring system which ensured audits were completed, action plans developed and learning took place.

The Gables Nursing 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 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 21 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection, the registered provider had been asked 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 checked the PIR and also checked our systems for any notifications that had been sent in, as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams about their views of the service. Following the inspection we received positive comments from three other health professionals.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with five people who used the service and six people who were visiting their relatives. We spoke with the registered manager, two members of staff who were office based, a nurse, three senior care workers, one of whom also completed an activity co-ordinator role, a new care worker, the cook, a domestic worker and a laundry assistant. We also spoke with a physiotherapist who provided treatment to people who used the service and advice to staff.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service, such as 16 medication administration records (MARs) and monitoring charts for food and fluid intake and weights. 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 three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

Comments from people who used the service included, "If you ring the bell they come in a reasonable time; they may be engaged with other people", "When you ring the bell you don't have long to wait", "Yes, definitely [staff speak to people in a nice way]", "The staff are alright and treat us kindly" and "Yes, I do feel safe here."

Visitors told us there were sufficient numbers of staff and they felt their relative was safe in the service. Comments from them included, "Her environment here is very safe and homely", "Yes my mum feels safe", "I think her medicines are managed very well", "They have never run out [of medicines]", "Excellent [management of medicines], they would never be left in pain", "There are plenty of staff checking them all the time" and "There always seems to be plenty of staff around and they are very chatty and approachable." Visitors also commented positively on the cleanliness of the service. They said, "The cleanliness of The Gables is spotless; one hundred per cent", "Very, very good" and "It's very clean and tidy and maintained well inside and outside."

A health professional told us, "I would say that I felt The Gables Nursing Home did offer a safe environment for their residents with sociable areas for them to relax/interact with other residents."

The service had procedures in place to guide staff in how to safeguard people from the risk of harm and abuse. We saw 'quick guide' procedures formulated by the local safeguarding team were displayed in the service, as a reminder to staff on the actions to take if they witnessed abuse or harm. Staff had received safeguarding training and demonstrated their knowledge of the different types of abuse, possible signs and symptoms of abuse and what action had to be taken if they became aware it had taken place. Staff monitored and recorded accidents such as falls and provided ways in which these could be reduced, such as installing sensor mats to alert staff when people at risk of falls got out of bed unassisted.

The care files for people who used the service included risk assessments, which helped to guide staff in how to support people to minimise risk whilst recognising their independence. The risk assessments included falls, moving and handling, nutrition, skin integrity, how to evacuate people in emergencies and the need for equipment such as bedrails and special chairs.

We checked the management of medicines and found people received them as prescribed. Medicines were obtained in a timely way, so that people did not run out of them and they were stored in line with manufacturer's instructions. Those medicines which required more secure storage were held appropriately and there was a designated fridge for those requiring cold storage.

We saw medicines were administered to people safely by qualified nurses. We observed a nurse administer medicines to a person and this was completed in a patient and professional way. Some people were prescribed medicines on a 'when required' basis to calm anxieties; we saw this type of medicine was only used when absolutely necessary. There were some minor recording issues which were mentioned to the registered manager to address with the nurses. Also the medication administration records were all coming

loose from the file they were held in, which meant they were at risk of falling out. The registered manager told us a new computerised medicines system was due to commence in October 2016 and all records would be held electronically. Staff were due to commence training in the new system in the next few days.

There was sufficient staff on duty to support people's assessed needs. Staff rotas indicated there were two nurses on duty during the day, one for each main floor. Occasionally the registered manager, who was also a qualified nurse, was rostered to complete a day shift. Between 7.30am and 4pm, in addition to the nurses, there were nine care staff and between 4 and 8pm there were seven care staff. At night, there was a nurse and three care staff on duty. There were two catering staff who assisted at mealtimes, a cook, two activity coordinators and domestic staff each day. Staff confirmed these figures in discussions with them. Staff told us they felt there was sufficient staff and they did not feel rushed when supporting people. They said, "There is no pressure on nights to get people up in the morning; care is over 24 hours" and "We have a good amount of staff."

The personnel files showed us potential staff were recruited safely. The registered manager looked at application forms for gaps in people's work history, obtained references, carried out disclosure and barring (DBS) checks and completed interviews. Checks on nurse registration were carried out and on whether staff from oversees had the right to remain and work in the UK. The recruitment process helped to ensure only suitable staff worked within the service.

We found the service was clean and tidy. Staff told us they had plenty of personal protective equipment such as gloves, aprons, arm covers and hand gel for good infection prevention and control. There were directions for laundry staff when laundering soiled linen and specific red bags to use that disintegrated at a certain temperature and which minimised hand contact. The service had a sluice room with a specific machine to wash commode pans and domestic staff confirmed they had sufficient cleaning equipment.

Equipment was maintained appropriately and serviced regularly. Maintenance personnel were on hand to complete repairs and to carry out checks such as the safety of hot water outlets, fire alarm tests, bedrails and wheelchairs. Fire extinguishers were held in tamper-proof cases which staff could access quickly when required. Staff had completed fire safety training and knew how to evacuate people. We saw some of the wheelchairs required cleaning and this was mentioned to the registered manager to address.

Good

Is the service effective?

Our findings

People who used the service told us staff looked after them well and made sure health professionals were contacted when required. They also commented positively on the meals provided to them and that they could make decisions and choices about the care they received. Comments included, "They [staff] do very well indeed and look after everybody", "They look after us well. I see the chiropodist and the hairdresser and the physio comes in two to three times a week; I'm walking a bit better now", "If I should ask, the doctor would come out", "The food? Yes, I like it", "Some days the meals are great; I like some meals better than others" and "The food is alright; I enjoy my meals and we get plenty to drink."

There were also positive comments from relatives about the effectiveness of the care delivered to people who used the service. Comments from relatives included, "Yes, if help is needed then the staff are always willing to help", "Healthcare is fine and they see the chiropodist, dentist or doctor when needed", "They are seen by the GP, optician, chiropodist and physio", "The care is wonderful. The diabetic specialist nurse calls and keeps in touch with nurses here. I am very confident about how they look after them", "I have been very involved in their care" and "They have a choice of meals and encouragement to eat."

The care files showed us people had access to a range of community health care professionals when required. These included GPs, district nurses, specialist nurses, speech and language therapists, a physiotherapist, opticians, dentists and chiropodists. We saw people were supported to attend out patient's appointments when required. Staff recorded when visits from health care professionals took place and when advice was given or treatment changed. Health care professionals told us, "They keep in touch with me around any changes with individuals needs so we can provide the best care and support around their continence needs", "I have always found the service to be very efficient and referred [people] timely when they required expertise within the field of tissue viability. The staff were always helpful and friendly and gave a good history of their residents when questioned; I have always been happy with the level of care observed" and "Staff have been very welcoming and eager to learn. Information regarding clinical care was observed on the walls within the treatment room, along with orderly policies and procedure folders/clinical guidance."

People had their nutritional needs met. The lunchtime and evening meals were provided from an external company. However, the cook added to these meals by making specific items such a desserts and custard, Yorkshire puddings and stuffing, sandwiches, soups, mushy peas, salads and garlic bread. The registered manager told us the people who used the service liked to have these items prepared freshly by the cook. We observed the dining room was set out with individual tables and chairs and was light and airy. Mealtimes were a pleasant and social experience for people. We observed some people chose to eat their meals in their bedroom or in easy chairs rather than in the dining room and this was respected. We saw, when required, staff supported people to eat their meals in a sensitive way and at a pace suitable for them. People were asked if they had sufficient to eat and we saw there were drinks and snacks served between meals.

The care files indicated people had nutritional screening to establish if there were any concerns or risks about their food and fluid intake. Care plans were formulated to guide staff in how to meet people's

nutritional needs. These included any special dietary needs, preferences about dining with others or alone, the drinks they preferred, how often they needed to be weighed and the level of support required from staff. We saw staff monitored people's food and fluid intake and their weight and raised concerns with the person's GP when required. The cook told us they received information about people's dietary needs, likes and dislikes from care and nursing staff. They also confirmed those people on a pureed diet had their meals set in moulds to represent the different types of food and to make it look more appetising for them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

A member of staff had designated responsibility for monitoring DoLS applications and contacting the local authorities for updates. The information was readily available on a spread sheet and identified which person had a DoLS authorised and which person had an application pending assessment and authorisation. We saw there were 15 people with DoLS in place and 22 further applications awaiting processing by the local authority. The registered manager and designated DoLS member of staff were knowledgeable about the criteria and application process for DoLS. Care plans identified when DoLS were place but the reasons for the DoLS and restrictions were not clearly identified; some of the information was spread throughout the care plan and it would be clearer if the restrictions that had led to the DoLS were all included in one aspect of the care plan. We spoke to the registered manager and designated member of staff about this and they told us they would address it. Best interest meetings had been held to discuss decisions that were required when people lacked capacity. These were recorded on review documentation, but the information lacked clarity about the decision being considered. We recommend the registered provider seek advice regarding specific documentation tools to record best interest decisions.

We found consent was sought in accordance with MCA and its principles were followed where people lacked capacity to give consent. Staff had a good understanding of the need to seek consent prior to care tasks. In discussions they described how they sought consent and the action they took if, on occasions, people declined care. They said, "We ask people and speak to families about how they like things done", "We look for body language, encourage people and we can always walk away [if people decline care] and ask another staff to assist; some residents have favourite staff" and "We don't use restraint here."

The training records indicated staff had access to a range of training relevant to their roles. This included training which was considered essential and also that which was specific to the needs of people who used the service, such as end of life care, wound care and catheterisation. Staff had completed training in health conditions, such as dementia, epilepsy, strokes, diabetes and Parkinson's disease. Staff confirmed they received training and supervision and were supported with their development. Comments included, "We have plenty of training" and "We have supervision a couple of times a year but we can go to the nurses or the manager at any time." A health professional said, "They always seemed to have sufficient staff that were capable and competent of delivering safe and effective care."

The environment was suitable for people's needs and there was some signage, for example, indicating where toilets were located. Additional pictorial signage for the sitting rooms, dining rooms and bedrooms

would help to make the service more dementia-friendly. One health professional commented there was a need for pictorial menus to assist people with their choice of meals. This was mentioned to the registered manager to address. There was additional seating in corridors for people to stop and sit if required. Baths had hoists to assist people to get in and out.

Outstanding ☆

Is the service caring?

Our findings

There were very positive comments from people who used the service, their relatives and visiting professionals about the staff team and their approach. Comments from people who used the service included,"They don't make decisions for me; I can have a lie in if I want and I watch television in bed at night", "All the staff are really nice and kind", "They are good; they knock on the door and wait for us to say come in" and "They [staff] are all very nice to me."

Visitors told us, "The care is wonderful and the staff here are very caring and kind, from the cleaners to all staff to management", "This nursing home is wonderful", "All the staff we have met are very caring", "She is always smartly dressed and appearance has been important to her", "Staff are all kind and helpful", "I am satisfied with all the care", "If I am worried at all, they [staff] talk to me", "They could not be better; they are so kind to my husband" and "If help is needed, then the staff are always willing to help." One visitor described how staff provided emotional and practical support to them, such as giving them food and items to freshen up with when they accompanied their relative to hospital and had a long wait before they were settled on a ward.

Comments from health and social care professionals included, "It's a welcoming care home and in my experience, staff are very passionate about the care they provide",
"Staff appeared to be conscientious and caring" and "The staff are very good and friendly; they know the residents and their families well. It's still run by a family and this makes a difference. The care staff have been here a long time and because they live in the community, they have known some of the residents since they [staff] were children."

The way staff recorded daily care interventions and care plan guidance demonstrated care and compassion. For example, staff had written, "At times becomes upset and cries. At these times reassurance of a compassionate carer is invaluable", "For his afternoon rest, the door can be left open then he can see staff around and will not feel isolated", "[Persons name] needs at times almost constant reassurance from carers to maintain mental and emotional stability. Carers to be patient and compassionate and spend one to one time talking to her" and "When his family visit, they can supervise [person's name] but reassure them that they can call for help at any time." The daily notes recorded that when people woke in the night, they were offered refreshments and pain relief if required.

We saw staff supported people who used the service to celebrate birthdays and special anniversaries and also supported them to go out on activities with their relatives. The registered manager told us they had bought cards, flowers and a small gift on behalf of people who used the service for their partners. They said this had been appreciated by relatives. People who used the service were each given a gift at Christmas and the registered manager told us this was individualised to their likes and dislikes rather than generic items. Staff had developed a 'memory tree' for use at Christmas for all the people who used the service. Residents and visitors were supported to hang a special memory or message on the tree regarding someone close to them.

The registered manager told us they had organised a canal boat trip for one person who used the service and his wife. This had been particularly difficult to arrange because of the person's dementia care needs. However, the trip was successful and the person's wife was so happy they were able to spend the time together as the person died a few days later.

Staff had recorded how people communicated their needs when they had difficulty expressing themselves. One person's care plan stated, "Carers need to make eye contact with [person's name] and speak clearly and simply ensuring she understands what is going to happen." Staff spoke about watching for body language and facial expressions. They said, "Staff should assess his mood when giving cares and watch for facial signs of discomfort or displeasure." We observed very positive interactions between staff, the people who used the service and their relatives. For example, staff were heard describing what was on offer for lunch, they checked out if people had received sufficient to eat, they offered choices of meals and fluids, they described actions when transferring someone from a chair to a wheelchair and they were seen getting down to people's level so they could make eye contact. They offered comfort when people were upset and reassurance at other times. Staff knew people's preferred names and it was clear they had developed good relationships with relatives. We saw staff tried to include people. For example, one person's care file stated, "When you are delegated to giving them one to one [support], help them to socialise by sitting near others and including them in conversation." We saw this happened in practice.

Staff were very clear about how they promoted choice, privacy and dignity. They said, "People have a choice about where they want to sit", "We show people visual choices, for example trousers or a skirt", "We had a residents meeting to taste the 'Appetito' meals", "They can have alcohol with their meals anytime but one afternoon a week we have a 'happy hour' and take drinks round; we're going to set up a bar in the dining room", "We know which people prefer a female carer", "One person doesn't want to be disturbed at night and that's respected" and "We knock on doors, make sure doors are closed, keep people covered, ask them if it's ok to wash them and involve them."

We saw people were provided with information and explanations in order for them to make informed decisions, for example, there were menus in the dining rooms. There were notice boards with information about activities, social clubs to attend, dates the hairdresser would be visiting, staff photographs and who was on duty, how to make a complaint, food hygiene certificates and service user guides describing what was available at The Gables. A member of staff supported one person, who did not have any relatives, and who had difficulty leaving the service, to order clothes on-line.

The registered manager provided a 'comfort box' with tissues, wipes, towel, flannel, soap and puzzles to relatives when the person they were visiting was at the end of their life; this offered practical support for relatives during a difficult time. The registered manager told us it had been well-received by relatives and said it had been a genuine help to them. There was also a toy box for young children to use when they visited people, which helped to keep them entertained.

The service has been accredited with the 'Gold Standard Framework' (GSF) for their approach to end of life care. This meant staff had completed the GSF training programme over nine months, embedded this into the care service for at least six months and then underwent rigorous accreditation. The accreditation meant they were assessed against 20 standards of best practice and assessors used a specific tool to review the care people had received at the end of their life, to ensure the processes were integrated into everyday practice. The service had been awarded 'Commend' in the Gold Standard Framework. GSF information states, "To attain Commend status a home must show innovative and established good practice in at least six of the 20 standards". Staff had received training facilitated by the local hospice and we saw minutes of weekly meetings for people who used the service held with a multidisciplinary team and relatives.

Staff told us the GSF helped them to ensure people were supported to plan their care in order for them to stay in their preferred place at the end of their life. An audit completed by the registered manager indicated that out of the 17 people who had died within the specific audit timeframe, all 17 had died in The Gables, in line with their preferred place. All 17 people had anticipatory medicines in place and all had good symptom control. A Clinical Nurse Specialist (CNS) for palliative care stated, "All the patients I have seen over the past few years have been looked after to a high standard. The staff have recognised when a patient is in the last year of life and then when they are approaching the last few days of life, ensuring all anticipatory medicines are available when needed" and "The staff are very proactive in referring to myself if they feel they need my support." They went on to say, "They are very proactive with GSF and hold weekly GSF meetings in which they discuss current coding of patients, patients approaching end of life, recent deaths and any critical incidents that have occurred." The CNS stated they no longer had to attend the meetings as the staff at The Gables were so proactive.

The registered manager and staff 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 in an office, where they were accessible to staff but held securely. Medication administration records were secured in the nurses offices with the medicines trolleys. The registered manager confirmed the computers held personal data and were password protected to aid security. The registered manager provided evidence they had registered with the Information Commissioners Office, which was a requirement when people's personal details were held electronically. Staff records were held securely in lockable cupboards in the main office.

Good

Is the service responsive?

Our findings

People who used the service told us staff looked after them well and responded to their needs. They said they had the opportunity to participate in activities. One visitor spoken with told us they would like more information about the activities their relative had participated in. This was mentioned to the registered manager to address.

We saw people who used the service had assessments of their needs and risk assessments completed to ensure staff had information available to formulate care plans. The care plans described people's likes and dislikes, and preferences for how they wished care to be provided. For example, one person's care plan described how they preferred their bedroom door left open during the day so they were aware of activity in the service. Each person had an advanced care plan regarding end of life care and their preferred place to receive this.

The assessments and care plans demonstrated relatives had been involved in providing information and they included names of important people, the relationships they had with the person and the impact the loss or change in relationships could have on them. We found the care plans were written with the person at the centre of the provision of care. This helped to guide staff in how to deliver person-centred care. For example, we saw one person's care plan described how staff were to ensure they had toiletries to hand and to stand back and let them self-care, but to, "Observe to make sure she is thorough" and "Help [person's name] to select her own clothes for the day then lay them out on the bed for her. She can then be left to dress in her own time."

We saw people received care that was person-centred. For example, one person, on occasions, slept in a recliner chair as they declined to go to bed. Staff were aware of this and ensured the person received additional checks through the night. Another person was mainly nursed in bed, but let staff know when they wanted to sit out in a chair. The daily notes evidenced the person's changing needs and approach to end of life. Staff had documented care, such as pressure relief, continence care, attempts at fluid intake and hydration, regular checks, visits by family and GP, and a good day when the person managed to sit out in the garden, enjoy a cigarette, two glasses of wine and good portions of their meal.

We saw there was a range of equipment used to help people be independent and also to aid staff to respond to their changing needs. For example, some people had sensor mats to alert staff when they got out of bed unaided and were at risk of falls. This enabled staff to respond quickly and help to reduce the risk of falls. There was a range of pressure relieving mattresses and cushions to assist people at risk of developing sore areas. There was moving and handling equipment such as slide sheets, hoists, wheelchairs and walking aids.

Daily care notes evidenced staff responded to people's changing needs. For example, staff had recorded in people's care notes when they had responded to their increased pain levels, what action they took and how this had impacted positively on people to relieve pain. Staff had recorded their response when sore areas on people's skin was noticed and the action taken such as the provision of heel protectors to relieve pressure.

Health professionals told us staff responded appropriately to people's needs. For example, comments from them included, "I can confirm that from a tissue viability aspect, all residents were clean and dry at the time of assessments and nutritional screening and clinical notes relating to skin integrity and wound care were accurate and valid" and "All notes that were requested were always available, including oral intake charts and re-positioning charts and residents had appropriate pressure relieving equipment."

We saw there was a range of activities for people to participate in and two activity co-ordinators were employed specifically to organise them and provide assistance. These included reminiscence and complementary therapies, spa sessions, poetry readings, games such as bingo, cards, dominoes and board games, 'music for health', quizzes, arts and crafts, chair exercises, indoor bowls, coffee mornings, church services, horticulture and flower arranging. Staff told us they had 'Fruity Fridays' which consisted of preparing and tasting different fruits and cheese tasting afternoons. There were visits from the Zoo Lab, which involved animals brought into the service for people to see and touch. Staff told us they had an annual 'bake off' with staff and relatives making cakes and these being judged by people; the monies were collected for a local charity.

We saw people were encouraged to take part in community events. Some of the people who used the service belonged to a local singing group. There were visiting entertainers and trips out to local community facilities. These had included Bolton Abbey, Tropical World in Leeds, The Deep in Hull, pubs, a local petting farm and canal boat rides, which consisted of a full day out. The activity co-ordinator told us that so far 10 people had enjoyed the canal trip this year. The service had guinea pigs in hutches in the garden and also well stocked fish in two ponds. There were bird feeding areas so people could enjoy the wildlife in the garden.

There was a complaints procedure on display in the service and this was provided to people in a 'service user guide'. The policy and procedure described timescales for acknowledgement, investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. People who used the service and their relatives told us they would feel able to raise concerns in the belief they would be addressed.

Good

Is the service well-led?

Our findings

We found people who used the service and their relatives knew the registered manager's name. They could raise concerns with the registered manager and they felt they would be listened to. People knew the service was a family-run business.

A commissioner of the service stated, "Overall a lovely home. It's family-run and they are very proactive and listen to feedback. All the service users spoke highly about it. The manager does monthly audits and highlights 'the good', 'the bad' and 'the ugly' so practice can be improved."

We spoke with the registered manager, a qualified nurse who is also the main director of the company. They described the culture of the organisation as open and willing to learn to improve practice. The registered provider's mission statement focussed on the importance of delivering a quality service, respecting people's individual rights and developing the staff team. There was a set of core values staff were expected to adhere to which included, privacy, dignity, independence, choice, inclusion and empowering people. We saw these values were adhered to in practice. The registered provider had achieved 'Gold status' in the Investors in People award. This is a nationally recognised award for businesses and organisations who want to improve the level of service they provide by focussing on developing the skills of their staff. They had also achieved 'Commend' status in the Gold Standard Framework (GSF) for end of life care provided to people who used the service.

The registered manager was aware of their responsibilities regarding notifying the Care Quality Commission and other agencies of incidents that affected the welfare of people who used the service. We received notifications in a timely way.

Staff were provided with a handbook which detailed their expectations as an employee and also what they could expect from their employer. In discussions with staff, they described a supportive and open environment. Comments included, "Management support is fab; you can go to them at any time", "Very approachable and helpful" and "It's a great family-run home." All staff were very emphatic that they would have a relative of their own admitted to the service. When asked to describe what the atmosphere in the service was like, they said, "Friendly, homely and happy." We saw staff were supported in their development. For example, nurses had supportive meetings to prepare for re-validation of their practice and registration requirements. All senior care staff had completed a national qualification in care at level three and most care workers had gained level two or three. Staff confirmed they had reactive and themed supervisions in order to talk about issues. We saw there were computer stations for staff to use when electronically recording the daily care provided.

There was a quality monitoring system in place which included audits and checks. Audits included how people experienced end of life care, unplanned hospital admissions, medicines, training needs and people's skin condition. Documentation was also audited. For example, nurses checked fluid monitoring charts several times a day to ensure people were on track to have the correct amount of fluids and if not, this was discussed with care staff and addressed. Applications for Deprivation of Liberty Safeguards (DoLS) were

checked and at intervals an update in progress was requested from the local authority. Care plans were checked to ensure information was included. There was a quarterly report which collated information on risks associated with nutritional intake, infections and incidents such as falls. The registered manager and staff team looked at trends and themes in the report so that action could be taken to prevent reoccurrence. For example, each person who used the service with a specific nutritional risk score was discussed and the action taken to address risk was recorded. We saw action plans were produced when shortfalls were identified in audits and checks. The registered manager told us they had completed root cause analysis in the past regarding a specific issue. This had resulted in improvements in hand hygiene and a reduction in cross infection.

Maintenance staff completed safety checks in areas such as hot water outlet temperatures, condition of furniture in bedrooms, bedrails, window restrictors, light bulbs and call bells. The form for each person's bedroom identified if there were any issues or repairs needed and whether these had been addressed.

The registered manager sought the views of people who used the service, their relatives and staff. The annual 'resident's survey' had been completed in May 2016. This asked people their views on catering, furnishings, cleanliness, personal and medical attention, care and support, complaints, staff, activities and whether sufficient information was provided to people. We saw people were asked to state their favourite meal, give suggestions for new dishes on the menu and how the service could improve. We saw there were very positive comments in the surveys from people who used the service and their relatives. We saw a copy of a letter which was sent to people with the results of the survey. This thanked people for their participation and described the actions taken or planned to address suggestions that were made. The registered manager had developed a bereavement questionnaire to help them assess end of life care from the relative's perspective. Reviews of people's care were held with relatives and issues discussed and recorded. We found staff kept relatives informed of issues affecting people who used the service.

In discussion with the registered manager, it was clear they knew the people who used the service very well. They spent time talking to people and their relatives and completed shifts as a nurse periodically or when required. This gave people the opportunity to talk to the registered manager and also gave the registered manager the opportunity to assess staff practice.

There were staff meetings held in order for staff to make suggestions. This was confirmed in discussions with staff. Each Monday discussions were held to ensure the correct amount of staffing was in place and to anticipate any possible changes. The registered manager described the use of 'huddle meetings' which were short daily meetings with staff to discuss any concerns that may need attention. There were senior staff meetings and weekly GSF meetings where each person who used the service was discussed and any concerns highlighted. These communication methods with people who used the service, their relatives and staff helped to ensure all were able to express their views and make suggestions about the way the service was managed.

We found the registered manager and staff had developed ways of working with other agencies. They used communication and referral systems to include multi-disciplinary support for people who used the service. They took part in training sessions facilitated by external agencies such as a local hospice. They held meetings to discuss end of life care for people who used the service. They had a telemedicine system with Airedale Hospital in order to reduce the number of hospital admissions. The telemedicine system is a two-way secure video link between the service and a clinician, in the first instance a senior nurse, which can then be escalated to a doctor as required. A television screen is taken to the person requiring clinical oversight and enables discussion of symptoms and advice or treatment prescribed for them without hospital admission or a consultation in person. Working together with other agencies helped people who used the

service to receive care and support they required in a timely way.