Shelphen Resource Limited

Cottingham Hall

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Cottingham Hall is situated in the north of Hull and is close to local amenities. The home is registered to provide personal care and accommodation for up to 29 older people, including those living with dementia. There were 29 bedrooms all for single occupancy and are located on both floors. All bar two of the rooms have an en suite toilet. There is a large garden to the rear of the property and parking at the front.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We undertook this unannounced inspection on the 23 and 24 March 2016; there were 29 people using the service at the time of the inspection. At the last inspection on 12 June 2014, the registered provider was compliant in the areas we assessed.

We found the culture of the organisation meant people were able to express their views and were listened to. The new registered manager had re-started the quality monitoring programme which consisted of audits, questionnaires and meetings. This will need to be sustained over a period of time to ensure it is embedded in the organisation. The registered manager is to send us the next bi-monthly audit which is to be completed in April 2016.

We found staff were recruited safely and were deployed in sufficient numbers to meet people's needs. People told us they did not have to wait too long for assistance.

We found staff received appropriate training for their roles. They also received support and supervision from the registered manager and a senior manager.

We found staff knew how to keep people who used the service safe from the risk of harm and abuse. They completed safeguarding training, could recognise signs of abuse and knew how to ensure the correct agencies were informed. Risk assessments were completed which helped to guide staff in how to minimise potential risks associated with people's activities of daily living.

We found people's health needs were met. Staff ensured people had access to a range of health care professionals when required. We found people received their medicines as prescribed.

We saw people liked the meals provided to them. There was a healthy option at each meal and menus provided a variety of choices. We observed people were provided with drinks and snacks between meals.

We saw staff had developed good relationships with people who used the service and their relatives. We observed staff had a caring approach, listened to people and supported them in a kind and patient way.

Staff supported people to make their own choices and decisions and when they were assessed as lacking capacity for this, the registered provider acted within the principles of mental capacity legislation.

People had assessments and plans of care which provided staff with good information about how they preferred to be cared for. Staff had time to read care plans and passed on relevant information to each other in handovers.

There were activities provided to people for three hours each day during the week. Some people said they would like more activities; this was mentioned to the registered manager to check out with them.

We found there was a complaints procedure on display and people told us they felt able to complain knowing it would be sorted out for them. People were asked if they had any complaints in meetings which took place regularly.

We found the service was safe, warm, clean and tidy. Staff had appropriate cleaning materials and protective items such as gloves, aprons and hand sanitiser. Any equipment used was serviced to ensure it remained safe.

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.

Staff had policies and procedures to guide them in how to safeguard people from the risk of harm and abuse. Staff had completed safeguarding training and could recognise abuse and what to do to report it.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

Medicines were managed well and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's health care needs were met and they had access to a range of community healthcare professionals when required.

People liked the food prepared for them and their nutritional needs were met. Dietetic support and advice was sought when required.

People were supported to make their own choices and decisions. When people lacked capacity to do this, the registered provider used the Mental Capacity Act 2005 to guide decisions.

Staff had access to a range of training, supervision and support to enable them to feel confident when supporting people.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff demonstrated a caring approach.

People were provided with information about the service in written format and staff gave explanations to people prior to tasks being carried out. Menus could be in pictorial format to aid

people with memory impairment.

Confidentiality was maintained and personal records were stored securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs completed and care plans provided staff with guidance in how to support them in a person-centred way.

There were activities provided although some people told us they would like more to do.

There was a complaints procedure to guide staff in how to manage complaints. People who used the service felt able to make complaints in the belief they would be addressed.

Is the service well-led?

Requires Improvement

The service was well-led but we need to see it is sustained over time.

There was a quality monitoring system in place but this had only re-started in February 2016. Some audits and questionnaires had been completed but these need to be built on and continued in a structured way so that any shortfalls identified can be addressed quickly.

The culture of the organisation was open and staff and people who used the service felt able to express their views.

Cottingham Hall

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 23 and 24 March 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an Expert by Experience [ExE]. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE who accompanied us had experience of receiving care in residential care settings.

The registered provider had not yet 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. However, we 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. There were no concerns expressed by these agencies. During the inspection we spoke with a health professional.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with nine people who used the service and two people who were visiting their relative. We spoke with the registered manager, a representative of the registered provider, the head of care, four care workers, the activity co-ordinator and a laundry assistant.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as medication administration records [MARs] for 21 people and monitoring charts for food, fluid, weights, pressure relief and bathing. 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

People told us they felt safe living in the service and there was sufficient staff to support them. Comments included, "Yes, I do feel safe. If I want something and don't feel right I use a buzzer and carers deal with what I ask them to do", "Yes, I think it's safe", "They look after you properly so you must be safe", "People are here all the time, which makes me feel safe", "I feel safe; it has that safe feeling, well secured, front door is on a code and fencing round the garden. Carers are there to make me feel safe", "It's easy to find a member of staff who comes and asks if you need anything. If there is anything they want to talk about in private, they take you away to talk", "Yes, there are [enough staff]. They come and talk to me and call me by my name; if there was anything private it would be in my room" and "Night staff don't have time to sit and talk; day staff do. They help you all they can if you have a query." Some people commented they thought staff were very busy and they would like to see more staff on duty.

People also told us they received their medicines on time. Comments included, "Staff come with the pills for me, I know all the tablets I take", "I manage them myself", "They come and give me my medicines; I don't know what they are for, they put them in my hand and I take them", "I take medicines for my heart and my breathing; the staff give them to me", "Yes, I know all the tablets I have. I have a morphine patch which gets changed every two days and that's really good as the tablets weren't working" and "Very good, the nurses come at the right time and make sure you have the right tablets at the right time not like at the hospital."

We found there were sufficient staff on duty throughout the day and at night. Staff rotas indicated there were four care workers and a senior care worker on duty each day and three care workers at night. The registered manager was supernumerary to the staffing rota and worked Monday to Friday. There was an activity co-ordinator for two hours each day and separate catering, domestic, laundry and maintenance workers which meant care staff could focus on caring tasks. Care staff spoken with confirmed the rotas and said they were busy but there were sufficient staff to support people safely. Comments included, "Everybody does their best; we are busy but we get through it", "Staffing levels are ok", "We have five staff on during the day and three at night; it's enough to manage safely" and "Out of hours, there is always someone to ring."

We found medicines were managed safely and people received them as prescribed. There was a system of ordering medicines which helped to prevent people running out of stock; there was no overstock in the medicines cupboard. We saw medicines were stored appropriately in a trolley and stock cupboards and although the medicines room was small, there was a hand wash sink for staff. There was a separate sink area outside of the medicines room to wash and dry the used medicine pots. Staff signed the medication administration records (MARs) when they administered medicines to people. There were some minor recording issues such as staff not always carrying forward stock amounts from the previous MAR, not always signing medicines in to the service and not clearly identifying who had made changes to medicine regimes when this occurred mid-cycle. There were some missing photographs of people which were used to aid identification when administering medicines to them. These points were mentioned to the registered manager to address with staff.

We observed staff administering medicines to people and this was completed in a professional way. People

were provided with a glass of water to take their medicines and the member of staff waited until they had taken their medicines before signing the MAR. The member of staff wore a tabard reminding people they were concentrating on administering medicines and they were not to be disturbed. We overheard staff asking a person if they needed specific medicines which were prescribed, 'when required'.

We found staff were recruited safely. The registered provider ensured that only suitable people were employed to work in the service. They did this by ensuring potential staff completed an application form to identify any gaps in employment, obtained references, carried out a disclosure and barring service (DBS) check and interviewed them. A DBS check was carried out to see if the person had been barred from working with vulnerable people in care settings.

Staff knew how to safeguard people from the risk of harm and abuse. There were policies and procedures to guide them and all staff had completed safeguarding training. In discussions, staff were clear about what constituted abuse and what the signs and symptoms were that would alert them to concerns. They knew how to report allegations of abuse and which agencies to contact for advice and guidance.

There were risk assessments completed for each person to support them in their activities of daily living and to guide staff in how to minimize risk. These included falls, mobility, fragile skin, nutrition, choking when eating, self-administration of medicines and the use of equipment such as bedrails. Staff monitored the risk assessments to ensure they remained up to date. We saw risk assessments had been updated and risk scores increased following one person's fall. Any red marks or injuries as a result of a fall were documented on a body map and a 'falls screening tool' completed within 24hours following a fall to see if any further action was required. This was completed by a care worker and overseen by the head of care. We saw people did not have an individual personal emergency evacuation plan (PEEP) and instead there was generalized information about how to evacuate people from the building. This was mentioned to the registered manager to address.

The service was clean and tidy and equipment was maintained appropriately. There was sufficient personal, protective equipment for staff such as gloves, aprons and hand sanitizer. The laundry was fitted with commercial washing and drying appliances. Checks were carried out on fire safety equipment, hot water outlets, the nurse call system, first aid boxes, moving and assisting items such as hoist and the lift, and gas and electric appliances.

Good

Is the service effective?

Our findings

People who used the service told us they liked the meals provided to them. Comments included, "Staff talk about meals; there are the two sorts of diet. One is the healthy option, so that is better for me. Dinner and tea times are ok; if I go out the meals are flexible", "I eat all the good things I should eat, I finish when I'm full", "I have a choice of cereals", "It's good food, I can't grumble about the meals", "There's a bowl of fruit on the table and I can help myself. I like most food; if there was something I didn't like they would change it", "The meals are really quite good. I have a choice and they find things I like. The meals are the right size for me. I have chosen fruit I like from the bowl" and "There are two cooks and one makes the most fabulous pies. Today we get a choice of brunch or salmon salad. This evening there's a choice of sandwiches or quiche, homemade soup and in the evening they bring hot drinks, toast and biscuits."

A visitor told us their relative had put on weight since coming to live at the service.

People told us they were able to see their GP or other health professionals when required. Comments included, "A podiatrist comes to sort out my feet and a dietician has now finished with me", "I still have my own GP and if I wanted or needed a visit he would come. They are going to try and get me some physiotherapy to help me walk better, but it hasn't happened yet", "Someone comes to cut my toenails. They came about a month ago; I pay for that" and "No-one has checked on my teeth since I have been here." This was mentioned to the registered manager to check out.

We saw people's health needs were met. Care records highlighted people saw a range of health and social care professionals when required. These included GPs, community nurses, dieticians, speech and language therapists, emergency care practitioners, physiotherapists, the falls team, dentists, social workers, opticians and chiropodists. Staff supported people to attend outpatient appointments. A health professional spoken with on the day of inspection told us, "It's a good standard of care here with not many pressure area issues. Any problems are dealt with straight away and they are proactive in contacting the GP" and "They follow guidance; one person has a sore but it won't heal fully which is down to their frailty and age."

In discussions with staff, they were clear about the signs and symptoms that would alert them to a person's deteriorating health. They described how they would prevent pressure ulcers from appearing and the actions they would take and who they would contact to ensure people's health care needs were met in a timely way.

We saw people's nutritional needs were met. People's likes and dislikes were recorded in their care files and catering staff were made aware of them. We saw one person's nutritional care plan reminded staff the person ate their meals in bed. The plan directed staff to seating position information and monitoring the person for choking and aspiration during assistance with eating their meals. Staff used a screening tool that looked at people's weight, height and body mass index to identify if there were any concerns to speak to a dietician about. Staff weighed people in line with their risk score. We saw the dietician had been involved with some people and had prescribed food supplements. Those people who required a close eye on them had monitoring charts and staff recorded what food and fluids they were offered and how much they had

eaten. The menus went in eight-week cycles and were varied. They provided a choice and alternatives at each meal. The alternative to the main meal at lunchtime was a healthy option.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw an assessment of capacity and a best interest meeting had taken place to discuss the need for one person to be nursed in bed due to their fear of using a hoist to move and assist them. The assessment and best interest meeting documentation reflected the person lacked capacity for the decision in question, what was the least restrictive option for the person to minimise their distress, who was involved in the decision-making and what the final decision was. We saw relevant people were involved in decision-making on the person's behalf. We saw some people had bedrails insitu and there was a possibility they did not have capacity to consent to them. This was discussed with the registered manager to complete capacity assessments and best interest meetings and to record the decisions.

In discussions, staff were clear about how they ensured people consented to care and support. They said, "We talk to people and explain things, try different approaches and come back later with a cup of tea", "If there was a mental capacity issue we would ask what would they have been like before and what would be in their best interest", "We ask people and encourage them" and "We were concerned we weren't meeting one person's needs so we called the GP and district nurse and had a best interest meeting; they went to a nursing home."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered provider had acted appropriately and one person had been assessed as lacking capacity and met the criteria for DoLS. The local authority, as the supervising body, had organised and completed assessments for DoLS and had informed the registered manager that the DoLS would be authorised; the registered manager told us they were awaiting the formal paperwork to authorise this. The registered manager told us they were currently completing DoLS application paperwork for one other person who used the service as they felt they met the criteria. They were also in the process of assessing and discussing the possibility of three other people meeting the criteria for DoLS. We found the registered manager had a good understanding of DoLS.

Staff confirmed they had access to training, supervision and support. Records showed staff completed training considered essential by the registered provider. This included dementia awareness, safeguarding, infection prevention and control, health and safety, food hygiene, fire safety, first aid, moving and handling and medication. There was other training arranged such as end of life care, equality and diversity, challenging behaviour, catheter and stoma care and mental health awareness. New staff were enrolled on the 'Care Certificate' which would provide them with a nationally recognised qualification in care and assess their competence; other staff had already completed the equivalent to this at level 2 and 3.

Staff confirmed they received formal supervision meetings with their line manager and were able to discuss issues with the registered manager on a day to day basis. Comments included, "The manager is approachable and available; there is always someone to ring out of hours", "My last supervision was a few weeks ago", "Yes, I've had an appraisal", "We are always asked about training in supervision" and "Management has been better recently; more things have been put into place and it's been positive."

Good

Is the service caring?

Our findings

People spoken with told us staff were caring and respected their privacy. They said their visitors were welcomed at any time. They told us they were able to bring in small items to personalise their bedrooms. Comments included, "It's very nice; I've got a good family that comes and visits. I have my own room and staff knock before they come in; they give me privacy but I like staff to be around. I bought in some photos, clothes and a few trinkets, not a lot", "My sister chose this home for me, she visited before and decided I would like it. I was living at home, but I couldn't look after myself and I kept falling", "They knock on the door before they come in" and "My family isn't involved in my care plan. I have my own voice; I can speak for myself."

People told us they were able to make decisions and choices about aspects of their lives. They said, "They ask me what I want to do. I go to bed at 1am, any time after midnight. I get up when I want; sometimes they bring me tea and toast and then I get up after it", "Yes, I don't think I can get any more control than what I have got here", "Yes, I might buzz for help and they ask me what I want them to do", "I get up any time I like and go to bed when I choose", "They make my bed and help me to get dressed. I won't have a bath; I get a strip wash twice a day and always have clean clothes", "Yes, they always ask permission before they do anything for me" and "I decide for myself such as medication; they ask me if I want something doing. They have a folder that they keep downstairs and keep the paper work up to date."

We overheard two people who used the service talking to each other at lunchtime. One said to their companion, "They look after you well don't they" to which the other person replied, "They do."

We observed positive interactions between staff and people who used the service. For example, when staff were talking to people they got close enough to speak in a quiet tone, they used encouraging words and gave them time to respond. We heard staff call people by their first name; we confirmed with people they were happy for staff to use their first name. We observed staff stop and speak to people to ask if they wanted a cup of tea or to check if they needed anything. We observed staff support people to walk about the service and accompanied them using encouraging words when they used a walking aid. We observed staff provide explanations before tasks such as assisting them into a wheelchair or to rise from a chair. We observed staff support people to enjoy the company of other people who used the service. For example, they asked two people if they would like to sit together and positioned chairs so they could sit and talk and watch television together. We saw call bells were answered promptly.

We observed a member of staff support a person in a very caring way which relieved their anxieties, reassured them and helped them to settle. The conversation was conducted in calm tones, with the member of staff on a level with the person and making eye contact. They spoke to them about their daughter and when they would be visiting, that their daughter knew where the person was and they lived nearby so they could see them more often. They provided explanations about meal times, got the person a cup of tea and answered questions patiently, repeating them until they were happy.

One person told us they had wanted to go to a funeral of another person who had used the service but there

had not been any staff available to take them. We checked this out with the registered manager who told us the person's funeral was held many miles away near to their family so instead the staff and people who used the service held their own memorial service at Cottingham Hall. They talked about the person, played music, bought their favourite flowers and wrote messages on balloons which they then let go in the garden.

We observed staff support one person to return to their easy chair using a walking frame following lunch and helped them to carry their soft toy dog. This was a precious item for the person, which brought them comfort and reassurance; staff recognised this and treated the person and the soft toy with respect. The staff used reassuring words to the person, "Shall I hold him [the soft toy] for you" and "I've got your bag don't worry."

Staff were attentive before meal times asking people what they would like for lunch and during meals. For example, at lunch we observed a member of staff had noticed a person had used a spoon for the main course so they quickly supplied another for their dessert before they had to ask for one. Staff supported people to cut up their food into bite size pieces when required and they poured juice for them. Staff provided a choice of dessert for people following the main meal and there was a selection of juices to drink. We saw one person left their main meal and staff asked if they wanted sandwiches instead. They did and these were promptly organised for them which they enjoyed. They offered people serviettes and clothes protectors when required. People were offered a choice of where they wanted to sit to eat their lunch; some people chose to eat at dining tables whilst others chose to remain in easy chairs in the sitting room area or in their bedrooms.

We saw one person was sitting side ways to a television and kept having to move their head to watch it. This could possibly cause a strain to their neck and we mentioned this to the registered manager to see if the person would like to reposition their chair. We also noted that staff did not always ask people if they wanted a second helping at lunch. This could be because staff knew people's needs but it was recognized they should be asking and checking this out. The registered manager told us they would speak with staff about this.

We saw staff treating people with respect and maintaining their privacy and dignity. People were smartly dressed in clean clothes, their finger nails were clean and hair was brushed. Men had been supported to shave. Staff were observed knocking on doors prior to entering bedrooms. We saw care plans reminded staff to promote privacy and dignity during personal care tasks. In discussions staff described how they maintained privacy, dignity and independence. They said, "The district nurse and doctor always see people in their bedrooms", "You can't take people's independence away; you can pass them the flannel and see if they can wash themselves. Six to seven people manage to get themselves washed and dressed in the mornings", "Encourage people to do as much as they can for themselves and offer choices of clothes, tea and coffee for example" and "Knock on doors and wait for them to say come in."

We found people were provided with information about the service. There was a service user guide in each of the bedrooms which detailed the services and facilities on offer in the home. The meals provided for the day were written on a notice board in the main sitting room area. This detailed the main lunch time meal, a healthy option alternative and what was available for the evening meal. We noted pictorial signs could be used for menus to assist with choices; this was mentioned to the registered manager to address. There were details on a notice board about an Easter party and 'residents meetings'.

Good

Is the service responsive?

Our findings

People told us care was provided which met their individual needs. Comments included, "They sorted me out a fridge to keep my fruit in", "I can't think of anything being done any better. They have changed my food over to a very good diet and they weigh me. I don't know if I have lost any weight" and "There's a bell that I can ring; one is pinned to my sheet or pillow if I am laid down." One person told us staff had to be very careful with them as they had fragile skin.

We saw people had assessments of their needs prior to admission into the service. The assessment form had been reformatted since the last inspection. It included areas such as decision-making ability, health needs, medication, personal care and dressing, how continence was managed, mobility and any history of falls, communication, sleep routine, diet and weight, social interests and hobbies and decisions about end of life care. The assessment information was used to help the registered manager and staff decide if a person's needs could be met fully and whether any additional support or equipment was required. The registered manager told us they also completed a body map when someone was initially admitted and before they went into hospital in case relevant information was required at a later date. A separate body map was also used as an on-going record of any injuries or bruises sustained following falls or knocks whilst in the service. As well as assessment information, there was a document completed called, 'About me – My story'. This provided information about the person's life history. There was also a personal profile which detailed preferences. We looked at one person's personal profile in detail and saw this was worded in a person-centred and careful way. For example, it started by saying, "Hello and let me tell you a little about myself". It provided information about what name the person preferred to be called by, how they mobilised, how many baths they liked to have each week, what type of razor they used for shaving and the help they needed when they missed areas. Also included was food likes and dislikes, preferred times for rising and retiring and the fact they liked to have Horlicks at night.

Risk assessments were completed and we saw the information from all assessments was used to formulate care plans to guide staff in the best ways to support people. The care plans covered all areas of people's needs. The care plans were person-centred although we found some minor details could be enhanced in some of the care plans we looked at. For example, one person's care plan to manage their continence was detailed whilst another persons could have had more information about the type of continence aid and barrier cream they were prescribed and a prompt to remind staff on personal hygiene following any episode of incontinence. This was mentioned to the registered manager to address. They told us staff completed these tasks automatically but realised any new staff would need clearer instructions. We saw person-centred care was delivered by staff. For example, some people had small plates to eat their main meal at lunchtime as a large meal would over face them. One person described the system they had for contacting staff for assistance when they went out unescorted. Some people had plate guards when eating their meals to help them manage more effectively. The registered manager told us one person preferred to spend part of the night in a chair and staff had difficulty getting them to go to bed. They liked to have snacks throughout the night and sometimes had two breakfasts as they often forgot they had eaten the first. Staff accommodated this. Some people required closer monitoring to prevent pressure ulcers from occurring or getting worse, to manage their behaviour, to prevent choking during eating and drinking, to keep a check on nutritional and

fluid intake and to observe for weight loss. Specific charts were completed to ensure staff carried out these monitoring tasks. These were checked by the head of care to ensure they were completed correctly.

We saw one person was struggling to manage their meal with a fork and their fingers; this was mentioned to the registered manager to check out and see if a spoon would be preferred. One person told us staff put too much sugar into their cup of tea. Again this was mentioned to the registered manager to address with staff to make sure the correct size cup was used or to see if the person would prefer to have a sugar bowl and help themselves to it.

We saw each person had a 'patient passport' which gave information about their needs. The patient passports were held on file and used to accompany people when they had hospital admissions. These provided relevant information to medical and nursing staff.

People said there were activities for them to participate it but some felt they would like more to do. Comments included, "I go out with my husband", "I go to hairdresser once a week and I go by wheelchair taxis", "I went out to go shopping with my family", "In summer we used to sit out in the garden; it's not happening so much now, probably people are not wanting to go", "There's skittles, bingo, quoits and giant dominoes", "They do bingo and I played cards yesterday", "It's Easter on Sunday and we have made some hats to wear", "A church group comes and sits and talks once a month", "At Christmas, families came and we had a meal. I like music and they have it on most of the time", "People come in, young ladies, and play games. I join in with something that has a result, "St. John's Newland bring me communion", "Church people come on Saturday, clappy, happy church, and they're lovely people. School children came and sang carols and St Cuthbert's came and sang carols", "They have sitting down exercises", "They are trying to talk to people to ask what we want to do but people don't always want to do things. I would love more things to happen" and "Could do with more activities. I don't like losing my independence. I would love to go out and not be here. Everyone doesn't want to do the same thing. I would love to go to the shops." An activity coordinator was employed for three hours each day during the week. Records showed staff supported people to participate in a range of activities such as skittles, bingo, quizzes, games, craft work, hand massages, reminiscence and gardening. One person told us they had enjoyed attending a pantomime. One person told us they would like to do baking again; this was mentioned to the registered manager.

The registered manager told us there were plans to set up Skype to enable people who used the service to keep in touch with family who lived away.

We saw adaptations had been made to the environment to accommodate people and to help them get around. There were grab rails in corridors, bathrooms and toilets. There were raised toilet seats or frames to sit on that could be positioned over the toilet. There was an assisted bath and a walk in shower room. There was a large garden with patio and grassed areas for people to use. Windows and patio doors were large so people had good views of the garden. There were lots of bird feeders to attract wildlife. The service had an intercom system which had portable call stations which could be taken with the person when they moved out of their bedroom. There was pictorial signage to guide people to where the toilets, the dining room and garden were located. There were also other means of making the environment more dementia friendly which were discussed with the registered manager for use when refurbishment and redecoration was next planned.

The service had a policy and procedure to guide staff in managing complaints. The complaints procedure was on display in the service and included in the service user guide which was held in each person's bedroom. The procedure gave timescales for resolution and to which agencies people could escalate the complaint if they remained unsatisfied with the internal investigation. People spoken with confirmed they

would feel able to complain in the belief it would be addressed. They said, "The head of the home is open to discussion and problems. There's nothing major, I can't think of anything at the moment", "If I want to change something, I talk to a carer and they take it to the head carer, or I can talk to the manager." One person told us staff listened to them and sorted out a query about their medicines. Another told us they were listened to when they made a complaint about a new member of staff who was unsure about how to care for them. One person told us the evening meal had been served too early so they brought this up with staff in a meeting. We observed that this had been listened to and the evening meal was served later.

Requires Improvement

Is the service well-led?

Our findings

Three people told us they were unsure who the registered manager was. We mentioned this to the registered manager so they could remind people who they could raise concerns with and to make sure everyone knew who they were.

We spoke with the registered manager about the culture of the organisation. The registered manager told us they felt supported by the registered provider and could raise issues with them. Meetings took place between the registered manager and the registered provider's representative. The last one was 25 February 2016 and we saw the meetings provided direction and guidance for the registered manager on areas of practice and which systems to audit. Staff spoken with told us they found the registered manager and registered provider approachable and would listen to concerns. Staff were provided with an 'employee handbook'. This detailed their job description, relevant policies and procedures and general expectations regarding caring for people who used the service, dress code and behavior. The handbook reminded staff that the aim of the service was to ensure all people who lived there enjoyed a 'full and constructive life'.

The service had a 'statement of purpose' and a 'service user guide'. These documents detailed aims and objectives. These focused on providing 'quality care', 'a clean, comfortable and safe environment', 'service users to be treated with respect and sensitivity to their individual needs' and 'empowering service users'. We found these aims and objectives were met in practice.

We found there were systems in place to enable people to express their views. For example, meetings took place for people who used the service. The minutes of the meetings for people who used the service showed us topics such as staff changes, activities, menus and other issues were discussed. We saw people were listened to and their suggestions acted upon. For example, people commented that the evening meal was too early at 4.30pm so staff now provide the meal at a later time; we saw this happened in practice on the day of the inspection. Some people had commented that their walking aid often went missing or got mixed up with other people's; we saw these had all been labelled with the owners names to prevent them being used by other people. Some people had requested staff have name badges; these had been ordered. There were staff meetings which enabled them to make suggestions.

The service had a quality audit system although we saw this had been re-started in February 2016 after an absence of several months. The new registered manager had completed a check on several areas such as accidents, supervision meetings, care plans, appraisals, activities, training, cleaning schedules and health and safety. The information was collated and a small action plan developed to address identified shortfalls. The registered manager told us they would be completing these checks every two months in future. The registered manager told us they had completed an environmental audit but there was no record of this. This said any issues found were written in the maintenance book so they could be addressed and signed when completed. There was no redecoration/refurbishment plan.

The registered manager had completed questionnaires in February 2016; these included five for people who used the service, four for relatives, five for staff and two for health professionals. This was only a small

sample of the views of people who used the service and other stakeholders. We did see that some issues identified by people had been added to an action plan.

It was difficult for us to assess compliance with quality monitoring as this would need to be sustained over a period of time. We recommend the registered manager continues to monitor the quality of service provided to people and further develops it to ensure there is a structured annual audit system where shortfalls can be identified quickly and addressed.

We found the registered manager was aware of their responsibilities in notifying agencies of incidents which affected the safety and wellbeing of people who used the service.

We saw the service had received a 'score on the door' of five, which is the highest achievable score for food safety management awarded by the local authority. The service had also achieved a 'Healthy Option' award for their menus as these provided a healthy alternative to the main meal.