Chaptercare Limited

The Queens Residential Care Home

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?	Good

Summary of findings

Overall summary

The Queens is a residential care home. It provides personal care and accommodation for up to 46 older people and people who may be living with dementia. The service is a large detached building and accommodation is provided over two floors. The service is located in the seaside town of Withernsea, close to the town centre and the sea front. The registered provider is Chapter Care Limited.

We inspected this service on 22 June 2016. This inspection was unannounced. At the time of our inspection there were 31 people using this service.

The service was last inspected in August 2014 at which time it was compliant with all the regulations we assessed.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at The Queens.

People told us that they felt safe living at the service. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff understood their responsibilities in respect of protecting people from the risk of harm.

We checked medication systems and saw that medicines were stored, recorded and administered safely.

Staff received effective training and supervision to support them in their role. The registered provider and registered manager were taking additional steps towards further developing staff knowledge to improve staff knowledge in regards to dementia care.

People were supported to make decisions in line with relevant legislation.

People's nutritional needs had been assessed and people told us they were very happy with the food provided. We observed that people's individual food and drink requirements were met.

Staff were observed to be kind and caring. We observed that staff had developed meaningful caring relationships with the people they supported and people's privacy and dignity was respected.

We saw that there were systems in place to assess and record people's needs so that staff could provide personalised care and support. Care files were updated regularly and information shared so that staff were aware of changing needs.

Care staff and people who lived at the service told us that the service was well managed. People told us they would not hesitate to express concerns or make a complaint, and they were confident their concerns would be listened to and acted on. There was a process in place to manage complaints that were received by the service. In addition to this, there were systems in place to seek feedback from people who lived at the service, relatives and staff.

Quality audits were undertaken of the systems within the service to help make sure people's needs were safely met.

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.

Assessments were undertaken of risks to the people who used the service and the staff. Written plans were in place to manage these risks.

There was sufficient staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults procedures.

Is the service effective?

Good

The service was effective.

Consent to care and treatment was sought in line with relevant legislation and guidance on best practice.

People were supported to eat and drink enough and to access healthcare services where needed.

Training was provided to equip staff with the knowledge and skills needed to carry out their roles effectively.

Is the service caring?

Good

The service was caring.

People told us that their privacy and dignity was respected and we saw evidence of this on the day of the inspection.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the service and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as

possible, with support from staff.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and person centred care plans developed to guide staff in how best to support people using the service.

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager if they had any concerns.

Is the service well-led?

Good

The service was well led.

There was a manager in post who was registered with the Care Quality Commission (CQC), and people told us that the service was well managed.

There were sufficient opportunities for people who lived at the service and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that safe and effective care was being provided.

The Queens Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people.

Prior to our visit we looked at information we held about the service, which included notifications. Notifications give us information about how well the registered provider has managed incidents that affect the welfare of the people who use the service. The registered provider had completed a provider information return (PIR) for this inspection. 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. As part of the inspection process we contacted the local authority safeguarding adults and local authority quality monitoring teams to enquire about any recent involvement they had with the service. They told us they had no concerns about the service.

During the inspection we spoke with the registered manager, assistant manager and four staff. We also spoke with eight people who used the service, three relatives and one healthcare professional visiting the service. We spent time looking at records, which included the care records for three people who used the service, the recruitment, induction, training and supervision records for three members of staff and records relating to the management of the service. We observed interactions between staff and people using the service and observed lunch being served.

Good

Is the service safe?

Our findings

People using the service told us they felt safe living at The Queens, with comments including, "We have things to press, buzzers and someone is always there" and, "They [Staff] come to check on me every two hours." A relative of someone using the service said, "Without a doubt they [My relative] is safe."

We asked staff how they kept people safe and their comments included, "We use equipment such as hoists, stand aids, transfer belts, zimmer frames and slide sheets to help keep people safe. People are assessed and we have our competency checked."

Throughout our inspection we observed that people using the service were relaxed and at ease in their surroundings and responded positively and warmly to the staff supporting them. This showed us that people felt safe living at The Queens.

The registered provider had a safeguarding vulnerable adult's policy and procedure in place and staff received training which included safeguarding adults. We saw evidence of competency assessments that had been completed with staff to check their understanding and knowledge of the registered providers safeguarding policy.

Staff we spoke with described the signs and symptoms that may indicate someone was being abused and appropriately told us what action they would take if they had any concerns. One staff member told us, "I am doing my NVQ Level 3 which includes safeguarding. I have done training on Social Care TV (electronic learning) and the Care Certificate. I have no concerns on safeguarding, we recently had an issue around moving and handling and [Name of manager] alerted safeguarding straight away. Abuse could be neglect, verbal or physical, for example leaving someone who has wet themselves." National Vocational Qualifications (NVQs) are qualifications designed to equip learners with the skills and knowledge needed to care for others in a broad range of health or social care settings. These qualifications are now known as Quality Credit Frameworks (QCFs). The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care staff.

The safeguarding log at the service included the East Riding of Yorkshire Council (ERYC) Safeguarding Adult's Team risk tool for determining if a safeguarding referral needed to be made to them. Discussion with the local council's safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service. Checks of the safeguarding records held in the service showed that there had been two instances in the last year when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the Care Quality Commission (CQC) had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We reviewed three people's care files and saw that risks to people's safety were identified and risk assessments put in place to guide staff on how best to support that person to prevent avoidable harm. We

saw risk assessments in relation to people's mobility and the risk of falls, the use of bed rails, skin tissue viability, nutrition risk assessments to identify and manage the risk of malnutrition or dehydration and moving and handling. Risk assessments contained appropriate information and were updated regularly to reflect people's changing needs. For example we saw one person's mobility risk assessment had been updated in April 2016 and recorded, '[Name] now uses a zimmer frame since a fall this year.' Another person's tissue viability assessment showed a high score in the risk and we saw action had been taken which included a request for district nursing services and pressure relieving equipment and a profiling bed was in place. Staff we spoke with had a good understanding of people's needs and the support required to keep them safe and a visiting relative told us, "[Name] has to be changed all the time and the staff are dedicated and professional with them. They [Staff] move [Name] from side to side in the bed so gently."

One staff member told us, "We are supporting [Name] with end of life care (EOL) and we help keep their mouth moist with swabs and do positional changes every two hours." We looked at the persons care file and saw appropriate risk assessments were in place for the use of bedrails and a reclining chair. We also noted that the appropriate Deprivation of Liberty Safeguard (DoLS) authorisations were present for the use of this equipment. The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act (MCA) 2005. The MCA allows restraint and restrictions to be used - but only if they are in a person's best interests. We spoke to the persons relative who told us, "[Name] is in a proper bed, is immobile and has bedrails and bumpers to keep them safe. They [Staff] are wonderful."

We saw that any accidents or incidents involving people who lived at the service were recorded. These included information in relation to the type of accident, the person involved, the nature of any injuries and any follow up action taken. Accident and incident reports were collated and analysed annually to identify any patterns or trends. This system ensured that steps were taken in response to incidents to reduce the risk of reoccurrences

Checks of the building and equipment were carried out to minimise health and safety risks to people using the service and staff. We saw documentation and certificates which showed that relevant checks had been carried out on the electrical installation, gas services, portable electrical equipment and lifting equipment including hoists and the passenger lift. We saw that a fire risk assessment was in place and regular checks of the fire alarm system, fire extinguishers and emergency lighting were carried out to ensure that these were in safe working order. Records showed that fire drills were held to ensure that staff knew how to respond in the event of an emergency and we saw 25 staff had completed fire drill and fire sledge training in May 2016. Fire evacuation sledges are used to move immobile people if there is a fire alarm or other emergency. A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of a fire. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire forced the closure of the service. This showed us that contingencies were in place to keep people safe in the event of an emergency.

We checked the recruitment records for three members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that

only people who were considered safe to work with vulnerable adults had been employed at The Queens.

We asked people who used the service if they felt there were enough staff, comments included, "On nights we could do with more but we get through," and "There are a lot of people around." Relatives we spoke with said "There are enough staff and they are consistent" and, "Yes they do have enough and these girls [Staff] work hard."

The registered manager told us that they used a dependency calculation tool to determine whether people had low, medium or high needs. The allocated hours for each person dependent on their level of need were then added together and divided by the seven days of the week to determine the required staff numbers. On the day of the inspection we observed that there were sufficient numbers of staff on duty to enable people's needs to be met. We noted that call bells were answered promptly and that people did not have to wait for attention. The registered manager told us that the standard staffing levels were four care workers and one senior care worker during the day, reducing to two care workers and one senior care worker in the evening and throughout the night. In addition to this the registered provider employed a cook, maintenance staff, bed makers, laundry assistants, a housekeeper and an activities worker who worked 32 hours each week. We checked the staff rotas and saw that these staffing levels were being consistently maintained. The registered manager and assistant manager were supernumerary and the team leader was supernumerary to the staff duty rota. Supernumerary is in excess of the normal or required number. This meant that care staff were able to concentrate on supporting people who lived at the service.

Staff provided support where necessary to help people using the service take their prescribed medicine. The registered provider had a medication policy and procedure in place and staff administering medication had received training to support them to do this safely.

One person who used the service told us, "I understand why I take my medicines and have had this explained to me" and a visiting relative told us, "They [Staff] sort all [Names] medication out and they have fully explained it to me."

We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, stored, recorded, administered and returned when not used. We looked at medicines and medication administration records (MARs) and we spoke with the registered manager and a member of staff about the safe management of medicines, including creams and nutritional supplements within the service.

We observed that medicines were stored safely and securely, including controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We also saw that CDs were audited each week to ensure no recording or administration errors had been made.

The temperature of the medication fridge and room were checked and recorded each day to ensure medication that needed to be kept cool was stored at the correct temperature. The packaging of medication that was stored in boxes or bottles was dated when the medication started to be used, to ensure it was not used for longer than the recommended period of time.

We found that MARs were clear, complete and accurate and there was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in a 'bio dose' system; this is a monitored dosage system where

tablets are stored in separate compartments for administration at a set time of day. The system was colour coded to identify the time of day the tablets needed to be administered and the same colour coding was used on MARs; this reduced the risk of errors occurring.

Good

Is the service effective?

Our findings

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 MCA 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 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 provider information return (PIR) we received told us, 'The provisions of the Mental Capacity Act 2005 are followed. Where a service user lacks the capacity to make a particular decision, the decision is made using the Best Interest Checklist, Best Interest Decision Form, and Best Interest Meeting where appropriate.'

We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. At the time of this inspection records showed that nine people who used the service had a DoLS authorisation in place around restricting their freedom of movement, the use of bedrails and the covert administration of medication. We found that each person had a risk assessment in their care files to identify the expiry date of the DoLS and a monthly review sheet recorded if the DoLS was due to expire in the next 28 days. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS and approximately 50% of the staff team had completed training in the MCA. One staff member told us, "Yes I have done MCA training. I have seen a DVD and read booklets. Someone might be able to choose what it is they want on one occasion and then not another. We would support them as well as advocates and family members."

We reviewed care files and saw that people using the service had signed to show that they consented to the care and support provided. Where there were concerns about people's capacity to make an informed decision, we saw that a mental capacity assessment had been completed. Two people's care files included information about a person who acted as Power of Attorney (POA) for their family member. For example, one person's care plan recorded, 'I could manage my own finances independently. However, I have chosen to get help and therefore appointed [Name of solicitor] to assist me.' A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. One person's relative told us, "I am [Names] POA and they [Staff] have always involved me and bent over backwards." This showed us that staff were working within the principles of the mental capacity act and that consent to care and treatment was sought in line with legislation and guidance on best practice.

People we spoke with felt the staff at The Queens understood them well and had the knowledge to care for them. Comments included, "They [Staff] have a good approach and I couldn't fault them." A relative told us, "I have just been saying to the girls [Staff], that I know how long people have worked here as I can tell. They

are all dedicated and skilful" and a visiting healthcare professional told us, "They are well organised and knowledgeable. They take instruction on board and are good at assessing people. They are well trained and provide good care."

During our inspection and throughout our conversations with the registered manager, we found that the registered provider was making some steps towards developing staff knowledge with regards to dementia care. On the day of our inspection we spoke with the activities co-ordinator who told us they had completed dementia, reminiscence and therapeutic therapy training. They told us they focussed their time when working with people who may be living with dementia on activities such as themed washing days and holidays to aid reminiscence with people. They told us when people had been on trips out they did 'Do you remember when' sessions to talk about their outings and that people enjoyed repetitive activities using bricks and art. We saw the service had a dolls house which people enjoyed using and each lounge area had a name which corresponded to the location of the service. There was a pictorial season, day, and date and weather board, a reminiscence board with picture cards on it and pictures of the staff team with their names to aid people's memory. This showed us that the registered provider was taking steps to aid communication and improve social opportunities for people living with dementia.

The registered provider had an induction and training programme to support staff to gain the skills and knowledge needed to provide effective care and support. We saw that new staff completed the 'Care Certificate' (a nationally recognised set of standards) as part of a 12 week induction and staff also completed three weeks of nights, evening and day shifts at the service to familiarise themselves with the environment and the people living there. This was confirmed by the staff who we spoke with.

The training covered topics including safeguarding, infection control, moving and handling, fire prevention, medication and equality and diversity. In addition to this we saw staff completed training in pressure care, death and dying, MCA/DoLS, challenging behaviour, first aid awareness, person centred care and dementia care. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed.

Staff told us they received regular supervision in line with the registered provider's policy and there was evidence of this in their staff files. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. They confirmed with us that they met with a line-manager to discuss issues within their roles and concerns about individual people they cared for. One staff member told us, "We have supervision every six months and can raise any concerns or issues we have. We can get things out in the open and discuss our workload."

We saw that communication within the service was good between the management team, the staff and people that used the service. Communication methods included daily diary logs, handover sheets, communication books, telephone conversations, meetings, notices and face-to-face discussions. On an individual basis communication was always face-to-face as well as in people's individual records, for example, their keyworker monthly reviews and their personal health visit records.

Care files we looked at contained information about people's health needs and medical history. One person using the service told us "If you want a GP you just ask them [Staff] and they ring them" and a relative told us, "[Relative] needs are seen to as quickly as possible. The staff are very prompt if they need a GP." Staff maintained a 'GP and professionals visit record' providing an overview of visits to or from health or social professionals. These records showed us that people were supported to access healthcare service if needed.

People had their nutritional needs met by the service because people had been consulted about their likes

and dislikes, allergies and medical diets and all of this was clearly recorded in their files. The service sought the advice of a Speech And Language Therapist (SALT) or a dietician when needed. There were nutritional risk assessments in place, for example, for those people that had a poor diet. We saw one person's assessment recorded they had poor nutrition and needed supplements and support to eat. These needs were clearly recorded in their files so that staff knew about them and were able to meet them.

Three people who we spoke with told us the food was very good and that the cook came round to them in a morning to ask them what they would like from the menu. We were given access to the kitchen paperwork which included preference sheets for each day that recorded the person's choice of options from two meals at lunch and tea time. We observed the lunchtime meal and saw that the food was hot when served. Staff encouraged people to eat and when they required assistance; this was done on a one to one basis and was unhurried. Some people had adapted cups that helped them to drink independently. There was music playing and staff chatted to people and they chatted to each other; this made the mealtime a social experience. We saw people were provided with drinks frequently throughout the day and people told us they were able to access snacks and drinks whenever they wanted them. This supported the dietary needs of people living in the service and helped them to remain hydrated.

Good

Is the service caring?

Our findings

People who lived at the service told us that they felt staff really cared about them. A relative told us that they observed staff with people who lived at the service and said, "They [Staff] never rush people" and, "They [Staff] are always cheerful and friendly." Another relative told us staff were, "Wonderful" and they, "Built up a bond with the person." They told us their family member had received, "100% excellent service. When you need help they [Staff] give it to you and I am so grateful." Staff told us that they felt their colleagues really cared for people. One staff member told us, "Yes, we are helping to improve people's quality of life by spending the time and listening to people. We never rush anyone."

We noted several thank you cards at the service which had been received from people's relatives with positive comments that included, "Thank you for making a hard time in my life more bearable. My [Name] is very comfortable and you are taking good care of them. I couldn't ask for anywhere better. You all do an amazing job and I can't thank you enough."

A visiting relative gave us an example of the positive care provided to their family member. They told us, "They [Staff] have taken away all of the stress from me. It's the little things like they [Staff] even got an inflatable neck cushion and rested [Relative] head and neck on whilst washing their hair to make it more comfortable" and a healthcare professional told us, "They [Staff] are people focussed and are good advocates. They will tell you if they think a person would like something or not. They [Staff] have a really good rapport with people."

During our inspection we spent time observing interactions in communal areas including at lunchtime. We observed a number of positive interactions where staff and people using the service engaged in meaningful conversations. We saw a number of examples where people using the service responded positively and warmly to staff showing us that they had developed positive caring relationships with the staff supporting them.

We reviewed two care files of people using the service and saw these contained person centred information about that person that enabled staff to get to know the people they were supporting. This included information about people's likes, dislikes and interests. For example, one person care file recorded, 'I like to wear a lot of jewellery which include three watches.' This helped people to be supported with their individual preferences.

Staff told us that they supported people to be independent in their day to day lives. Comments included, "I always ask the person before I do anything," "I ask people if they want to wash themselves and if they can't I would always explain to the person what I am going to do" and, "People can eat and drink independently and [Name] and [Name] go out on their own."

During the inspection we saw that staff were patient with people and took time to explain things to them clearly and in a way that they could understand. This varied from person to person to take account of their level of understanding. We observed that staff spoke in an appropriate manner and tone to people using the

service and in this way treated people using the service with respect. Relatives told us that they were happy with the level of communication between themselves and the service. One relative said, "I am always involved."

Relatives told us that they had observed staff respect people's privacy and dignity. One relative said that when their family member was being supported with personal care there was, "No gossip and it is always very professional." They added, "Curtains are always drawn and door closed and the staff always wear gloves." We observed during the inspection that staff knocked before entering people's rooms to maintain their privacy.

We saw that people had care plans in place that recorded their wishes for care at the end of their life. Some people had 'Do Not Attempt Resuscitation' (DNAR) records in place and those we saw had been completed appropriately. We saw the service had a love heart on the back of each person's bedroom door. This helped to identify people who had an active DNAR in place. One staff member told us, "I have done end of life care training and this helps to make sure the persons wishes are met giving them privacy and dignity" and a healthcare professional told us, "They [Staff] are very good with palliative care. Paperwork is always completed when we ask and if I ask for people to receive mouth care this is done and kept up." A relative told us, "There is one of those hearts on the back of [Relative] door."

There was a noticeboard in the hallway for people and their visitors/relatives with information such as four different advocacy services, fire procedures, the service newsletter, the local safeguarding team contacts, visitors survey evaluation results, upcoming events and a coffee morning for people in the local area to attend. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Good

Is the service responsive?

Our findings

We saw that people's needs were assessed before they moved into The Queens and this information was recorded in their care file for staff to access. Care files contained information about the support people required as well as information about people's preferences regarding how those needs should be met. People's care files contained assessments, risk assessments and individual care plans in place for care needs which included mobility, sight, hearing, communication, dietary needs, mouth care, foot care, continence, medication and personal care.

The care files we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care files included a life story document which recorded the person's life story so far, their routines and any medical diagnoses.

We saw each of the person's individual care needs and the outcome were appropriately reviewed and updated to ensure a person's current needs were known and met and had been signed by a member of staff and the person concerned (when they were able to do so) or their representative. One member of staff told us care files, "Are updated regularly. For example, [Name] care plan was updated after an accident and they were using a wheelchair and doing exercises provided by the physiotherapist." Another staff member told us, "We key work two or three people each and change their care plans when anything changes." A keyworkers role is to take a social interest in the person in conjunction with the management and take part in care file development with the individual.

We saw staff completed daily logs and a communication book to record important information about peoples changing needs or significant events such as DNARs, hospital admissions, positional changes and nutritional and hydration needs. This ensured that information was effectively shared so that staff could provide responsive care to meet people's needs.

There was an activities coordinator working at the service over four days each week. We saw the activity board which displayed the activities on offer for the week of this inspection. This showed that a wide variety of activities were offered including games, bingo, gentleman's pub afternoon, cinema afternoon, flexercise and voting in the EU referendum. We spoke with the activities co-ordinator who told us they provided a range of individual and group activities that included seven trips out each year. They went on to tell us that they had recently started a coffee morning on the first Wednesday of every month which was available for all people and care staff to attend. We saw this was advertised on the East Riding of Yorkshire Council (ERYC) website. We saw the planning for 2016 trips included The Deep, Bridlington, Doncaster safari park, East park and Christmas shopping.

The service had a dedicated activities/resource room which had an abundance of materials for arts and crafts, games, books and computer equipment. The activities co-ordinator told us that two people who lived at the service had their own e-mail accounts and used 'Skype' to talk to and send photographs to their family members. One person we spoke to told us the activities co-ordinator "Did everything with them." We observed people going out to the local pub for lunch on the day of the inspection and one staff member told

us, "People do sit and be fit, baking, arts and crafts, dominoes and go on mystery trips. Later on this year people are going to Doncaster safari park. [Activity co-ordinator] does one to one activity with people that are cared for in bed." We saw activities were evaluated to determine if people had enjoyed them and if not how they could be improved.

All of the people we spoke with told us they knew how to raise issues or concerns and they felt that staff and the registered manager would listen to them. One person told us, "If I want anything I would just go to [Manager]. When I was here on respite I was worried about managing if I went back home and I told [Manager] and they sorted everything out for me." A relative told us, "There is a sign on the back of [Names] door that tells you what to do if you have any concerns."

The registered provider had a complaints policy and procedure in place. Records showed that there had been one complaint in the last 12 months. We reviewed documents relating to these complaints and saw that they had been appropriately investigated where necessary and a response provided to address the concerns raised. This showed us that the registered manager was responsive to concerns and acted appropriately to resolve issues

The registered provider completed annual surveys which involved sending quality assurance questionnaires to people using the service, staff and relatives. We saw questionnaires from the surveys conducted in February and March 2016. Relatives surveys comments included, "Staff are friendly, ready to listen and supportive," "The dining room is airy and excellent" and, "Peoples personal care is excellent and noticeable." We saw comments from the surveys sent to staff included, "Main lounge could be decorated and need a four slice toaster." We saw the surveys had been evaluated and the main lounge decoration was included as part of the registered provider's refurbishment plan and a new toaster had been purchased. This showed us that the service listened to people's views.

We saw that residents and relatives meetings were held to share information, gather feedback and discuss improvements. We saw the minutes for a residents meetings held in May 2016. We saw that the refurbishment plan, laundry and menus ideas were discussed. We noted comments included, "[Name] said they are very happy living at the service and all staff are lovely," "[Name] is very happy. Reported their tap and this was fixed" and, "I am happy with the laundry service and the food."

Good

Is the service well-led?

Our findings

We sent the registered provider a 'provider information return' (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned within the given timescales. The information within the PIR told us about changes in the service and improvements being made.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection. The registered manager told us that they received good information from within the organisation, and that this helped them to keep up to date with any changes in legislation and with good practice guidance.

We asked for a variety of records and documentation throughout our inspection and found that these were stored securely, but readily available on request.

When we reviewed people's files we saw evidence of how the management and staff worked with other professionals to help make sure people's needs were met. This included collaboration at best interest and decision making meetings, and we also saw that district nurses visited the service regularly.

The registered manager was on duty and along with the assistant manager; they supported us during the inspection and they were knowledgeable about all aspects of the service and able to answer our questions in detail. We found through our discussions during this inspection that management knew about their registration requirements under their registration with the CQC and were able to discuss notifications. The Health and Social Care Act 2008 (HSCA) requires providers to notify CQC of certain incidents and events.

All of the people we spoke with, without exception told us they thought the service was well run and spoke highly of the registered manager and felt they could approach them with anything. One person told us, "They [Staff] communicate with me personally." Relatives told us they felt the service was well-led and they felt comfortable talking to the manager about anything good or problematic. One relative told us, "I think the management is good. [Manager] used to work here so knows the service and the new owners seem to be good."

We asked staff if they thought the service was well-led; feedback included, "Everyone gets on with the managers and you can talk to them about anything and they will always keep things confidential." When we asked staff about the culture of the service they told us, "I think it has improved and everyone gets along," "I enjoy it, it's friendly," "I love working here" and, "We get a bonus at Christmas and they [Managers] bought us all a bottle of wine and some chocolates." This showed us the staff team felt valued and supported.

We saw the minutes of staff meetings and management meetings in which there were discussions in relation to safeguarding, moving and handling, complaints and if staff felt they could approach the managers for support. Staff told us that they felt they were listened to. One staff member said, "We have full staff meetings every six months and the managers discuss shifts, daily routines and any issues we have. They [Managers]

have an open door policy and they would sort anything out straight away."

We could see that the registered manager completed regular audits which covered areas of the service such as health and safety, fire, bedrails, water temperatures, medications, DNARs, and care plans. We saw the registered provider had a development plan in place for 2016 which included yearly checks and evaluations of accidents and incidents, infection control, complaints, equipment, staffing, training and satisfaction questionnaires. For example, we saw that advanced first aid training was required for staff and this had been highlighted in the development plan for completion in 2016. This meant the current systems in place would identify any shortfalls in practice and help to identify where improvements to service delivery may be required.