HICA

Elm Tree Court - Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Elm Tree Court provides accommodation and personal care to a maximum of 72 people all of whom are living with dementia. The building is single storey and purpose built. It is divided into three separate communities that surround an inner courtyard. Each community has its own communal areas, bedrooms, bathrooms and a courtyard with plants and seating.

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 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 10 and 11 May 2016. At the time of the inspection there were a total of 72 people living in Elm Tree Court. At the last inspection on 16 January 2014, the registered provider was compliant with all areas assessed.

We found there was inconsistency regarding the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered provider and registered manager had not always followed best practice regarding assessing people's capacity and discussing and recording decisions made in their best interests. We found there were people who met the criteria for DoLS but applications to deprive them of their liberty lawfully had not been made to the local authority. You can see what action we have asked the registered provider to take at the back of the full version of the report.

We found there was a quality monitoring system which consisted of audits, surveys and meetings and practice had been changed as a result of suggestions by people. However, the registered provider and registered manager had a responsibility to ensure any member of staff who worked in the service was able to fulfil their role and tasks. All permanent staff received training, support and supervision but there was limited audit regarding the skills of agency staff employed for one to one support tasks with people. We have made a recommendation about this in the well-led section.

We found people who used the service were protected from the risk of harm and abuse. Staff had received safeguarding training and knew what to do if they witnessed abuse or if it was disclosed to them. People had risk assessments which helped to analyse any risk of harm, for example with moving and handling and falls and how it could be minimised. We found staff knew what to do in cases of emergencies and each person who used the service had a personal evacuation plan.

We found staff were recruited safely with all employment checks carried out prior to new staff starting work. New staff received a full induction and shadowed more experienced staff until it was felt they were competent to work alone with people. We found there were sufficient care staff on duty to meet people's current needs; there were ancillary staff for tasks such as activities, laundry, catering, domestic work,

maintenance and administration so care staff could concentrate on looking after people.

We observed staff had a patient and caring approach. There were positive comments from relatives about the staff team. People who used the service and their relatives were provided with information on notice boards, in meetings and in newsletters. Staff treated people with respect and maintained confidentiality. Personal records were stored securely.

We found people received their medicines as prescribed and had access to a range of health care professionals in the community, when required to meet their health needs.

People enjoyed the meals provided to them. The menus enabled people to have choice and special diets when required. People's weight, their nutritional intake and their ability to eat and drink safely was monitored and referrals to dieticians and speech and language therapists took place when required for treatment and advice.

We found people had assessments of their needs and care plans which gave staff information about how to care for people in a person-centred way as they preferred.

We found there were activities for people to participate in. These were provided in small and large groups and on a one to one basis. The activities helped to stimulate and include people and prevent them from being isolated.

The registered provider had a complaints procedure on display. Relatives told us they would feel able to complain and any concerns would be looked into and addressed.

We found the service was clean and tidy. Staff had cleaning schedules and equipment used within the service was maintained so it remained safe to use. The environment had been adjusted to meet the needs of people living with dementia.

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

Staff received safeguarding training and knew what to do to keep people safe from the risk of harm and abuse. People had risk assessments to help guide staff in how to minimise risk.

People received their medicines as prescribed.

The service was clean and tidy and equipment used was safe and well-maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was inconsistently applied. This meant some people who may meet the criteria for DoLS had not been assessed and could be detained unlawfully. The principles of MCA regarding restrictions placed on people had not been followed for each person they applied to.

People liked the meals provided and their nutritional needs were met.

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

Staff had access to training, supervision and appraisal which provided them with the skills, knowledge, support and confidence they required to care for people.

Is the service caring?

Good

The service was caring.

Staff were observed speaking to people in a kind and patient way and treated them with dignity. Staff respected people's right to

privacy.

People were provided with information and explanations so they could make choices and decisions about aspects of their lives.

Confidentiality was maintained and personal information stored securely.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and had assessments of their needs and care plans to provide information to guide staff when caring for them.

People had access to a range of activities to help prevent social isolation and to ensure they were included and remained as active as possible.

There was a complaints process and people and their relatives felt able to tell management of any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The culture of the organisation was open and transparent and there were systems in place to raise concerns and ensure senior management had oversight of them.

There was a quality monitoring system which consisted of audits, surveys and meetings. Action plans were developed to address shortfalls. However, issues regarding checks on agency staff working within Elm Tree Court had not been identified in audits. We have made a recommendation about this.

Elm Tree Court - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 10 and 11 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors for the first day and one adult care inspector for the second day.

The registered provider had completed a Provider Information Return (PIR) prior to the 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. 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 safeguarding and contracts and commissioning teams. We also spoke with two continuing health care professionals about their views of the service.

During the inspection, we used the Short Observational Framework for Inspection (SOFI) in each of the communities. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with three people who used the service and four of their relatives. We spoke with the registered manager and deputy manager, six care workers, an agency worker and an activity coordinator. We also spoke with a visiting health professional.

We looked at six 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 38 medication administration records (MARs), visits from health and social care professionals, accidents and incident records. 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 also checked how people's personal allowance was managed.

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. We completed a tour of the environment.

Good

Is the service safe?

Our findings

The three people we spoke with said they were looked after well. Comments included, "Yes, I do feel safe here", "We are well looked after; it's a very clean place", "I'm not rushed" and "It's spotlessly clean here."

The four visitors we spoke with told us they thought their relatives were safe at the service and there was sufficient staff to look after them. Comments included, "I think they keep him safe; they are aware of where he is and if there are any dangers like other residents who might hurt him", "The doors are locked and they can't get out unless the staff are with them", "They keep an eye on her and make sure she's safe, there is always someone with her", "There are plenty of staff around to watch them. My wife gets one to one all the time so she's ok" and "There seems to be enough staff, sometimes they're a bit pushed when someone is playing up but they never lose their temper or shout."

We found staff knew how to keep people safe from the risk of harm and abuse. There were policies and procedures to guide staff and they confirmed they had received safeguarding training; they were able to describe the different types of abuse and how these would show in someone who may be the victim of abuse. Comments included, "They would be withdrawn and quiet", "You would maybe see bruising and marks" and "There would be unexplained injuries in unusual places like tops of arms and legs." Staff were able to describe the registered provider's procedure for reporting any abuse and said they would report issues to the registered manager or senior care worker on duty. Comments included, "I would report it to [registered manager's name]", "I would go to my senior if there was anything wrong" and "I know I can report any abuse to other agencies, like social services or the Care Quality Commission (CQC)." Staff were confident appropriate action would be taken if they did report abuse. They said, "Yes, they would do the right thing and pass it on" and "I have every confidence it would be dealt with in the right way." We found safeguarding procedures were followed in practice; staff had alerted the registered manager to a recent incident of concern and they in turn immediately contacted the safeguarding team so they could make a decision about investigation.

There was a system to manage people's personal allowance when this was deposited in the service for safe keeping. Receipts were obtained for monies in and out and checks on the balance made three times a week. The system helped to safeguard people's monies from misuse.

We saw people had assessments of any areas which could pose a risk to them. These included moving and handling, falls, skin integrity, bedrails, nutrition and behaviours that could be challenging to others. Each person had a personal emergency evacuation plan. The risk assessments were kept under review and helped guide staff in minimising risk and managing difficult situations.

We observed there was a staff presence in communal areas to observe people all the time. They were quick to respond to any situation which might become a risk to people and encouraged people to other areas if they were becoming anxious or disruptive. Staff spoke to people calmly and knew what the person liked to do and used this as a distraction.

There were robust recruitment processes in place prior to people starting work in the service. These included the completion of application forms to identify gaps in employment, obtaining references and proof of identity, a disclosure and barring (DBS) check and an interview. The recruitment process checked that people had not been barred from working with vulnerable adults and helped to ensure only appropriate staff worked within the service.

We found there were sufficient staff employed within the service to meet people's needs. Each of the three communities, Sycamore, Willow and Hawthorne had team leaders or senior care workers allocated to manage the shift and care workers. The deputy manager and registered manager were supernumerary to the care rota but would complete care tasks as required. The service had a complement of activity coordinators, domestic, laundry, catering, administration and maintenance staff. There was an on call system for support to staff out of usual working hours and the use of agency staff when required. Some people required one to one staff support; this task was mainly completed by agency staff although the registered manager told us they were recruiting staff for this support to aid consistency. Staff told us they thought there were enough of them on duty. They said, "The staffing levels are fine, sometimes it gets a bit hectic" and "I think the staffing levels are ok, we could always do with more but we manage quite well with what we have." We observed staff were busy but were able to spend time with people, talking and looking at books with them.

We looked at people's medication administration records (MARs) and found they received their medicines as prescribed. Medicines were stored appropriately and recorded when received into the service or carried forward from the previous month, when administered to people and when returned to the pharmacy. There were some protocols missing which would provide additional guidance to staff when administering medicines on an 'as required' basis. There were also some minor recording issues, for example not consistently identifying the dose administered when it was variable, not signing and dating changes on the MARs mid-cycle; both these points were mentioned to the registered manager to address with staff who administered medicines. There was a system in place for ensuring people had the correct medicines when they were discharged from hospital. Staff told us when a person was admitted to hospital, they sent a form to the supplying pharmacy and on the person's discharge, the pharmacist would check the medicines the person was discharged with and complete a review if required. The hospital pharmacist also rings up as part of their audit process to check if the person was discharged with the correct medicines.

We found the service was clean and tidy. There were hand wash signs above sinks in communal toilets and bathrooms to provide guidance on good hand hygiene technique. Personal protective equipment such as hand sanitiser, soap, paper towels, gloves and aprons were available. There were clinical waste bins for soiled items. The laundry was equipped with sluice washing machines and the system used to transport soiled laundry through the service was appropriate. Staff had completed training in infection prevention and control and water sampling took place to rule out the presence of a legionella. There were cleaning schedules for domestic staff.

We found equipment used in the service was checked and maintained to ensure it was safe to use. These included gas and electrical appliances and fire fighting equipment such as extinguishers, emergency lights and door closures, and moving and handling items such as hoists, slings and wheelchairs. The nurse call and fire alarm systems were tested weekly and bedrails and the temperature of hot water outlets were checked. The checks helped to identify any areas which needed adjustment or items which needed replacement. The service had a business continuity plan which provided staff with information and guidance on what to do in cases of emergencies and evacuation. Fire drills and first aid training were completed to ensure staff knew what to do in cases of emergencies.

Requires Improvement

Is the service effective?

Our findings

The three people we spoke with said they liked the meals, they could see health professionals when required and staff knew how to look after them. Comments included, "Yes, the food is really good; you get plenty", "You get what you want [food]", "We see the hairdresser and chiropodist and all the medicals come here", "They [staff] know what they are talking about" and "I have no grumbles."

Visitors we spoke with thought the staff had the skills to meet their relative's needs and they said staff supported people to access health professionals. Comments included, "They seem to know what they are doing; they understand how to look after my wife", "The staff are really good, they are calm and professional", "They call the doctor if she needs him, they keep an eye on her", "I get told if they get the doctor or if anything's wrong with my wife" and "I go to the hospital if they have to attend any appointments; they keep me well informed." Visitors told us they were happy with the food provided to their relatives. They said, "The food is really good and they make sure she eats", "A member of staff spends time with her making sure she has enough to eat" and "They walk around with her encouraging her to eat; they are really patient."

Health care professionals told us staff contacted them to keep them informed of issues. Comments included, "Good environment. Very rare we get any issues from the district nurses about the service" and "They have a nice garden and shop; it's a good environment."

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 found the application of MCA was inconsistent. Some people had restrictions in place such as the administration of medicines covertly, gates at their bedroom doors and bedrails, however, their capacity to make these decisions had not been assessed. Also the decision to administer medicines covertly and to provide bed rails had not been discussed and recorded as being in their best interest. We saw one person had been assessed as lacking capacity and a best interest meeting had been held about the use of a gate at their bedroom door, however, the actual decision section of the form was blank. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered provider was working within the principles of the MCA for some of the people who used the service. There were currently 72 people who used the service, which was specifically for people living with complex needs associated with dementia. A significant number of them would meet the criteria for DoLS but the registered manager confirmed there were only 14 applications undergoing assessment by the local authority. We found the registered manager and staff had completed training in MCA and DoLS.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social

Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We found people had access to health care professionals when required. These included GPs, district nurses, community psychiatric nurses (CPNs), a clinical psychologist, dieticians, speech and language therapists, emergency care practitioners, opticians and chiropodists. A psychiatrist and CPN held a surgery at the service every six weeks; this enabled staff to discuss specific people, medical treatment to be adjusted and guidance provided to staff. Staff recorded in each person's care file when they were visited and treated by health care professionals. Staff also supported people to visit outpatient appointments when relatives were unavailable. Staff were able to describe to us how they supported people to access health care professionals when they need to. They said, "If anyone's ill we call their GP", "We always speak with the nurses and ask them for advice", "The GPs are good, they will come out if the residents needs them", "You know when someone is ill, they can be a bit different and more confused. This might mean they've got a urine infection or had a slight stroke or something" and "We need to keep a close eye on those residents who might develop pressure sores and make sure they are turned and watched; we work with the nurses who come in and they advise us what to do."

We found that a week prior to the inspection, a district nurse had requested one person had their fluid intake increased as part of the management of their catheter; we were unable to audit the person's fluid intake to check this had taken place as a daily fluid monitoring and balance form had not been completed. This was important as the person was prone to urinary tract infections and this was mentioned to the senior in charge of the shift to commence straight away.

We saw people's nutritional needs were met. Menus were varied and provided choices for people. We saw meals were provided by an external company, re-heated by kitchen assistants and served by staff at the service. This enabled them to manage portion size in line with their knowledge of people's preferences. People had an assessment of their nutritional needs and any risks were identified. We saw people were weighed in line with their risk assessment and dieticians were contacted for advice and treatment when people lost weight. We observed the lunchtime experience for people on one of the communities. People who used the service were provided with choice regarding where to sit and who with for their lunch, and with what they wanted for their meal. The lunch time was very relaxed and no one was rushed; the main meal was served, then a drink and then the second course. Most people remained seated to eat their meal and when some of them got up and left the table before the dessert was served, staff made sure they had one. Staff communicated with each other about people's choices and who had eaten what. One person declined all the food offered so sandwiches were made, however she did not eat these so staff made a note of it and were later seen offering more food. We observed drinks and snacks were served in between meals.

We found staff had access to training relevant to their role and tasks. These included first aid, fire safety, safeguarding adults from abuse, moving and handling, infection control, health and safety, food hygiene, dementia care, pressure area care and data protection. Staff also completed training in how to manage behaviours which could be challenging, intensive interaction, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We spoke with a person from an independent company who was present in the service on the day of inspection. They delivered training in vocational related qualifications (VRQs) which ran alongside national vocational qualifications (NVQs) in care. The VRQs were short basic knowledge courses that gave a snapshot of information without an assessment of competence. These included mental health, diabetes, dementia, safeguarding, end of life infection control, medicines and health and nutrition. There was a system in place to identify when training was in need of refreshing and a training plan had been produced for the coming year.

We saw new staff to care received an induction followed by a 12 week Care Certificate course; their competence was monitoring at each stage. Staff had formal supervision meetings and appraisal. Staff told us the training they received was appropriate to meet people's needs. They said, "The training is great, you get all kinds of opportunities to do different things", "Our mandatory training is updated yearly and we get other training like dementia and diabetes", "I do all the training I can; I want to learn as much as possible." Newly recruited staff told us the induction they received equipped them to undertake the work required. They said, "It was over a few days and we did all kinds of things; we did the basics like lifting and handing, health and safety, but we also did about dementia and how this affects the residents. I shadowed senior staff for a few shifts then was part of the staff", "We get the chance to talk about our training needs and how we are progressing", "We get supervision every couple of months and we talk about how things are going and how the residents are" and "We have an annual appraisal were we get to say what training we'd like to do."

We saw the environment had been adjusted to take into account the needs of people living with dementia. Corridors were wide and had grab rails. There were pictures and memorabilia on the walls and shelves to stimulate people's thoughts as and speech as they walked by. There were courtyards attached to each of the three communities which people could access independently and safely; these had walkways, seating and flower beds. The three communities surrounded another courtyard and circular walkway which included a hairdressing salon, a shop and an area used for activities. There were pictorial signs to indicate toilets, bathrooms and bedrooms and some people had their photograph on the bedroom door to remind them it was theirs.

Good

Is the service caring?

Our findings

The three people we spoke with said staff were kind and treated them well. Comments included, "The girls are very good", "You have only got to tell them if you are a bit doubtful", "Nobody makes you get up" and "Yes, they are polite and they knock on your door."

Visitors told us they thought the staff were kind and caring. Comments included, "The staff are brilliant; they are so patient and never lose their temper, I couldn't do it", "The staff here are wonderful, they talk nicely to everyone and never raise their voices" and "They go out of their way to make sure my wife is cared for properly; they take their time with her and make sure she's happy."

Health professionals said, "Good values are observed in the way they address people and speak to service users."

We observed staff were kind and caring when assisting people with personal tasks. They were discreet when asking if people wanted to go to the toilet and explained the things they were doing. They gave people time to understand what had been said and rephrased things if people were having difficulty understanding what had been said. They showed sensitivity when helping people and understood their individual needs. Staff were friendly and cheerful when going about their work.

Staff understood the importance of respecting people's dignity. In discussions they said, "I would make sure I covered residents over while doing anything personal", "I always knock on doors and ask to come in; it's their home and we need to respect that", "If someone was in the bath, I'd make sure it was warm and all the doors and curtains were shut", "Sometimes residents want to be on their own and you've got to respect that." Staff were able to describe people's needs and how these should be met. They understood all the people who used the service were different and said, "You've got to respect people and not judge them, they need our help and support."

All the bedrooms were for single occupancy and had sinks; some had en-suite facilities of a toilet and sink. The single occupancy afforded people with privacy. Each room had a lockable facility and privacy locks were in place on bedroom, bathroom and toilet doors. The registered manager told us the service had the facility of some adjoining bedrooms for couple's who wanted to stay together and use one room as a bedroom and another as a private sitting room.

In the reception area, there was a room which could be used for relatives to see people in private. This had coffee making equipment and easy chairs. The room could also be used to hold reviews of people's care. We spoke with a health professional during the inspection and they confirmed staff always supported people who used the service when they visited them and escorted them to the privacy of their bedroom for any treatment or discussion.

We saw people were provided with information. There were notice boards to indicate which activities were to be carried out each day; these had pictures to aid recognition. On the three communities there were

notice boards which informed people about the day's menu choices for each meal. There were pictures of the managers so relatives knew who to raise issues with. There were leaflets in reception about the service, how to complain and advocacy arrangements. The food hygiene certificate and previous inspection reports were on display. Each person was provided with a welcome pack which included a 'service user guide'; this provided information about the service and staff. We saw the service had a colourful monthly newsletter which provided people with details about planned activities and outings. There was also a corporate newsletter providing information about the company as a whole. There was a leaflet on 'SHINE', a behavioural competency framework that describes the staff behaviours required to underpin the registered provider's values and vision.

There was information about likes, dislikes and preferences in care files for how care should be carried out. This showed us people and their relatives had been involved in decisions about planning their care and support. Most bedrooms were personalised and relatives had brought in items to make them homely. We saw some bedrooms looked a little sparse; this was mentioned to the registered manager to address.

The registered manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. We found people's care files in daily use were held in the staff offices on each community where they were accessible but held securely. Staff records were held securely in lockable cupboards in the main office. Medication administration records were stored in the treatment room on one of the communities. The registered manager confirmed the computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held. We saw staff completed telephone conversations with health professionals or relatives in the privacy of an office.

Good

Is the service responsive?

Our findings

The three people we spoke with said staff responded to their needs. One person said, "The girls do nail varnish and make up. I like to wear makeup; I look like a maggot without it (laughed)." We saw the person had make up and lipstick on. People told us they would tell staff if they had any concerns. They said, "I would go to the office but I have nothing to complain about", "They do their best" and "I can't think of anything they can do better."

Visitors told us they thought the activities provided were good. They said, "There always seems to be something going on", "They make sure everyone has a go, not just the same few all the time" and "The garden won a prize the other year, I helped them do it." Visitors told us they knew how to make a complaint and who these should be directed to. Comments included, "Yes, I know there's a complaint procedure, I would speak to the staff if anything was wrong", "I would speak with [registered manager's name] if I had any concerns" and "I made a complaint last year and it was soon sorted."

Health professionals commented positively on how staff supported people who used the service. Comments included, "No concerns, they manage people with dementia brilliantly", "Yes, they keep in touch about issues. They have the dementia mappers in regularly for advice" and "They know how to support people with dementia." Dementia mappers were professionals who completed close observations of how individual people interacted with staff, other people and objects so they could advise on specific approaches for staff to use.

We saw assessments of people's needs had been completed prior to their admission to the service. The assessments and risk assessments were kept under review and updated. Each person who used the service had a document called 'map of life' which detailed their family relationships, work history, previous leisure and interests. This helped staff to see the person with a rich history rather than just someone living with dementia that they are caring for. We saw care plans were developed to ensure staff had guidance in how to support people in the way they preferred. The care files had information about likes, dislikes and preferences; some of the information had been gathered from discussions with relatives as well as through observations of how the people who used the service reacted to specific care tasks. We saw staff produced temporary care plans when people had short-term issues such as the need for monitoring following a fall or bed rest following a hospital admission and discharge. We saw three of the six care plans we looked at required an update following a change in need. This was mentioned to the registered manager to address, which they did straight away. We saw people had reviews of their care plans and family were invited to check the care provided was as required and as preferred, and whether any adjustments were needed.

We saw staff provided person-centred care and responded to changes in people's needs. For example, it was recorded a person had attempted to climb over a bed rail so this was removed straight away and alternative risk management put in place. One person said they were in pain so staff were observed bringing them pain relief straight away and checking it had the right effect. One person was observed walking in a circuitous route in one of the communities. They were accompanied by staff who chatted to them, maintained the person's pace and provided them with food and refreshments during the walks. We saw specific equipment

was provided to meet people's individual needs. This included pressure relieving items for beds and chairs, sensor mats to alert staff when people at risk of falls got out of their bed or chair, and bed rails to prevent people rolling out of bed.

We saw care plans identified specific interests, for example, one person's stated they liked the radio on and preferred cd's from the 40s, 50s and 60s. It was recorded what their two most favourite songs were so staff could sing along to them with the person. It was recorded in care plans what textured diets people had and the stage of thickeners they required in drinks to assist swallowing; staff knew these instructions and we saw they were followed in practice. One person's care plan detailed the type of soap and deodorant they preferred and another person's was clear about their preference for specific clothes. One person's care plan had been updated following an incident. It gave clear and specific instructions to staff in how to support them and what approaches to use. One person's care plan described what upset the person and explained they worried about their children, often saving biscuits and chocolate for them. It described what activities may help to distract the person at these times. We saw people who used the service had 'patient passports' which were taken with them when any hospital admission was required. These were documents that provided important information to nursing and medical staff.

Staff understood the importance of providing person-centred care, observation and monitoring. They said, "We have to treat each resident differently", "I like to get to know the residents; it's really interesting and it helps you understand some of the things they do" and "Residents like to talk to you about what they've done, where they used to work and their family; it helps you to get to know them." We observed a member of staff from an agency who was providing one to one support for a person was unsure of how to respond to their changing needs. We raised this with the senior in charge of the shift to address.

The service had activity co-ordinators who planned a range of group and one to one interventions with people. These included reminiscence, pet therapy, board games, floor exercise games, bingo, arts and crafts, baking, life story work, gardening, sing-a-longs, tea dances and seasonal activities like summer fairs and crafts for Halloween, Christmas and Easter. Birthdays were celebrated with parties. There was a minibus available for staff to take people out which was used for drives around Hull to see how things had changed. There were trips to the coast, local cafes, shops, parks and garden centres and visits to other care homes within the company. Some people went to the annual Hull Fair. We saw some people who used the service had enjoyed several hours at a local park, accompanied by staff, fishing with a rod and line. During the inspection, there was an 'Oomph' session which was an interactive exercise and music activity to help improve people's flexibility. There were also dominoes and craft sessions. The service had a mobile sensory unit which included gentle lighting and mirrors to reflect pictures onto walls and ceilings. The unit was taken to people's bedrooms to provide them with stimulation and relaxation if they were feeling a bit anxious.

The activity co-ordinator spoke about the importance of working with people who were living with dementia, making a special effort to take their time when assisting them with activities and undertaking more low level activities such as reading or looking at pictures. The activities were undertaken in the main entrance area which gave people the opportunity to leave the communities and experience a different environment. This area had tables and chairs, a fish tank, radio and book case. There were rabbits in the courtyard on one of the communities and people enjoyed holding and stroking them. There was a room for people to watch 'Sky' television channels and another for people who wished to smoke.

There was a complaints procedure on display in the entrance 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. They said, "I would try and sort

it out but if they wanted they could go to [registered manager's name]", "I would speak to [registered manager's name] and ask the person if they wanted to make a formal complaint, we have forms people can fill in" and "If it's really serious I would go straight to [registered manager's name]."

Requires Improvement

Is the service well-led?

Our findings

Relatives told us they had an opportunity to have a say about the running of the service. They said, "We have regular meetings; we had a meeting about the garden and how we should make sure it was ok for the residents to use", "[Registered manager's name] is really approachable; she asks how things are and if we are happy with the way he's being looked after" and "I know there have been meetings but I find it hard to go all the time. We have had surveys sent to us which I find much better."

Commissioners of the service told us the registered manager contacted them to keep them up to date. They said, "The manager [name] will contact us if she feels one to one support is no longer required" and "I have no concerns at all. The manager [name] is very transparent, flexible and approachable. They will ring you to discuss issues and they are good with relatives."

We spoke with the registered manager about the culture of the organisation and their own management style. They said it was not about blame but more about supporting staff and ensuring they had the right skills and values. They said, "It's all about the residents and we have the 'SHINE' philosophy" [expectations of staff behaviour that underpins the organisation's values and vision], "The chief executive officer (CEO) and regional director are very supportive. We look at lessons learned, you know what we have done to make certain things happen" and "I don't ask people to do anything I wouldn't do. I support staff and I have high standards. It is a difficult job for staff so I'm open and honest with them so they know where they have to improve." The registered manager told us about SHINE awards staff could achieve through nominations from colleagues or relatives of people who used the service.

Staff told us they found the management team approachable. They said, "I can go to [registered manager's name] with anything", "I know that if there is anything wrong, they will try and help me" and "The manager is really good; she'll listen to you and try and sort stuff out."

The registered provider and registered manager were responsible for ensuring any staff who worked within the service had the right skills to perform the tasks required of them. Whilst a system was in place to check the staff employed by the registered provider, there were limited checks made upon staff who worked at the service but were employed by an agency. As the agency who supplied staff was not regulated by the Care Quality Commission, it is up to the registered provider and registered manager to undertake appropriate checks. During the inspection, we observed an incident which led us to judge the member of agency staff lacked the knowledge and skills required to meet the needs of the person they were supporting. When we checked this out, we found the agency member of staff was completing a twelve hour shift of one to one support with a specific person who used the service and who had complex needs. The member of agency staff had not completed an induction and had received only basic verbal information about the person they were supporting. The level of their training and expertise to work with people living with complex dementia care needs had not been assessed properly. We assessed the recording of the care provided by agency staff when supporting people on a one to one basis and judged this to be of poor quality. We addressed this with the commissioners of the one to one support service and the registered manager during the inspection.

We recommend appropriate steps are taken to monitor the use of agency staff and their recording of care and to ensure sufficient information sharing during their one to one support of people. Following the inspection, we found the registered provider had taken appropriate steps to manage the situation and prevent a reoccurrence. We will follow this up at the next inspection.

There was a quality monitoring system in place in the service. This consisted of audits, surveys and meetings to seek people's views. The audits had led to improvements in practice. For example, an audit of the laundry service had resulted in an additional member of staff at night to complete laundry tasks. Environmental checks had resulted in additional tasks for domestic staff in collecting pots from individual serveries on each community and removing them to the main kitchen to be washed in the dish washer. This had made the serveries cleaner and taken pressure off care staff. The registered manager told us audits on medicines had improved practice and increased compliance scores on the tool used to check them. An audit on staff supervisions had led to the registered manager and deputy manager prioritising them to make sure they caught up. An audit on care plans had resulted in more information being up to date.

The registered manager told us the quality monitoring system was currently under review but they continued to use the present one which consisted of completing a monthly 'early warning audit tool' (EWAT). The EWAT checked areas such as accidents and injuries, weight loss, pressure ulcers, any outbreaks of diarrhoea and vomiting, chest infections and urinary tract infections. We saw audits were completed in January 2016 on the environment and infection control; action plans had been prepared and dates included when tasks were completed or new furniture purchased. Finances were audited by a member of head office staff. We saw the financial audit completed in April 2016 had no actions required. Accidents were analysed to look for patterns and to ensure people with repeated falls had been referred to the correct services.

Some surveys had been completed with relatives and health professionals. There were positive comments from people about the care provided and the environment. We noted the questionnaire for people who used the service could be improved to make it more accessible and easily understood by people living with dementia. This was mentioned to the registered manager to address.

There were systems in place to cascade information to the main staff team, people who used the service and their relatives. The registered manager attended meetings with senior managers and good practice examples were discussed and shared. The information from these was cascaded to staff in each of the communities during smaller staff meetings. The CEO provided briefings to keep staff informed of corporate issues. Staff received a handover at the start of each shift. There were meetings for people who used the service and their relatives, coffee mornings including at weekends, posters about the service and a newsletter.

We observed senior staff provided guidance and advice to care workers. Care workers had a good rapport with the senior staff and were well-supported when undertaking tasks. A lot of discussion took place about work load and how this was allocated so the needs of the people who used the service were met. Staff shared information about people's wellbeing and passed on important information about visits from GPs or nurses. Staff confirmed they had regular meetings to pass on information and they were able to raise issues. They said, "Oh yes, we have regular staff meetings; we all get a chance to speak up" and "We have them [staff meetings] about once a month I think. The manager tells us about all the new ways of working and if anything is changing; she keeps us well informed."

The registered manager was aware of their registration responsibilities; we received notifications in a timely way about incidents and accidents which affected the safety and welfare of people who used the service. We saw the score awarded from a food safety inspection was displayed for people to see; this was '5', which was

the highest rating possible with '0' being the worst and '5' being the best.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This meant people had not always had their capacity assessed when decisions were made in their best interest. Applications to lawfully deprive some people who met the criteria for DoLS had not been made.