Sun Healthcare Limited

St Margarets

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

Summary of findings

Overall summary

This inspection took place on 21 and 22 March 2018 and was unannounced on the first day. At the last inspection in September 2015, the provider was compliant with regulations in all areas we assessed.

St Margaret's is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Margaret's, is a single storey building and accommodates 59 people across three units: Mews, Wybers and Royal. Royal Unit specialises in providing care to people living with dementia. There were also six self-contained bungalows on the site. At the time of our inspection there were 48 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with 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.

Although staff had a good understanding of the need to gain consent from people prior to carrying out care tasks, we found there was inconsistency regarding the application of the Mental Capacity Act 2005 (MCA). The 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, when restrictions were in place. You can see what action we told the provider to take at the back of the full version of the report.

People who used the service had an assessment of their needs, risk assessments and a care plan. There was inconsistency in the care files, with some people having good, informative person centred care plans for specific areas, whilst others contained minimal information to support people's wishes and preferences for their care. We have made a recommendation about reviewing the care files to address shortfalls.

There was a quality monitoring system in place, which consisted of audits, checks, surveys and meetings. We found aspects of the audit programme were limited and had not been effective in identifying and addressing all the issues highlighted during our inspection. These included shortfalls in care records, including those to support consent and the renewal programme. We have made a recommendation about reviewing the audit programme.

Staff had been recruited safely. There were sufficient numbers of staff on duty at all times and with an appropriate skill mix, to meet people's assessed needs. Staff had access to induction, training, supervision and support, which enabled them to feel skilled when supporting people who used the service. Staff said they received good support from the management team who were always available to give advice and guidance. A new staff rewards scheme had been introduced.

Risks to people in relation to their needs had been assessed. Staff were confident about how to protect

people from harm and what they would do if they had any safeguarding concerns. The registered manager maintained records of accidents and incidents, which gave them an overview of any trends. The safety of the premises and equipment was maintained. The home was clean and tidy during the inspection and staff were seen to follow infection control procedures.

People's health care needs were met and they had access to community health care professionals when required. The registered manager and staff team had developed good working relationships with health colleagues to support the provision of joined-up care. Arrangements were in place to support people at the end of their life.

People received their medicines safely from trained staff. People who were being cared for in bed were regularly seen by staff to make sure they remained comfortable.

People were treated with kindness, respect and compassion and they were given emotional support when needed. Staff understood the importance of respecting people's human rights, offering choice and promoting independence. The staff we spoke with demonstrated caring values.

People's nutritional needs were met. However, the full range of snack options wasn't offered to people during the inspection, which the registered manager confirmed they would follow up. Menus provided people with choices and alternatives. Staff contacted dieticians and speech and language therapists in a timely way when they had concerns.

Feedback from people who used the service and relatives was very positive about the activity programme, which included one-to-one sessions, group activities, entertainers and community trips.

There were systems in place through meetings and surveys to enable people to share their opinion of the service provided and the general facilities at the home. The provider had a complaints policy and procedure and staff knew how to manage complaints. Relatives told us they felt able to raise concerns if required. All nine relatives spoken with described an open culture and accessible management. They were happy with the service their family member received.

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.

People were protected from harm and they received the support required to keep them safe and manage any risks to their health and safety. Staff followed infection control procedures.

People received their medicines as prescribed.

There was a robust staff recruitment process and sufficient numbers of staff employed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been inconsistent application of mental capacity legislation. This meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions, and important documents had not been completed.

People's health and nutritional needs were met. They received input from community health care professionals when required. People were offered choices and alternatives at mealtimes.

Staff received induction, training, supervision and appraisal to ensure they felt confident supporting people who used the service.

Is the service caring?

Good

The service was caring.

Staff had a kind and caring approach and had developed good relationships with people who used the service.

Staff supported people to maintain their independence as much as possible and promoted privacy and dignity.

Staff used various tools to help make communication and information accessible to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People who used the service had risk assessments and care plans but we found some care plans were not sufficiently person centred to reflect preferences around their care.

People had good access to meaningful occupations and activities. These included those arranged in the service and those accessed in the local community.

The provider had a complaints policy and procedure which was displayed in the service. People felt able to raise complaints and concerns and staff knew how to manage them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Aspects of the systems for quality monitoring required strengthening in order to identify all shortfalls and support effective improvements.

The culture within the organisation and in the service was described as open and positive. The registered manager had developed close working relationships with the staff team and other health and social care professionals.

Staff told us they felt supported by management and worked well as a team.

St Margarets

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 21 and 22 March 2018 and was unannounced. On the first day of the inspection, the team consisted of three adult social care inspectors. The second day of the inspection was completed by one inspector.

Before the inspection we reviewed the information we held about the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let the Commission know about.

We contacted the local authority safeguarding and commissioning teams. We also contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including activities and meal times.

We spoke with ten people who used the service and nine relatives who were visiting the service during our inspection. We also spoke with the registered manager and a selection of staff; these included the deputy manager, two qualified nurses, two support workers, the cook, the laundry assistant, the activity coordinator, the maintenance person and a member of the housekeeping staff.

We looked at six people's care records, two staff recruitment files and reviewed records relating to the management of medicines, complaints, staff training and maintenance of the premises and equipment. We checked how the registered manager and provider monitored the quality of the service; we also looked around the environment.

Good

Is the service safe?

Our findings

People told us that they felt safe living in the service. We saw evidence of people being supported to maintain their feeling of safety. We observed two members of staff supporting a person transfer from their wheelchair to an armchair using a hoist. They were speaking to the person in a friendly manner and explaining what they were doing. They worked well as a team, re-assuring the person all the time. The transfer went smoothly and was professionally done. We observed the person appeared calm and happy throughout the manoeuvre.

One person told us, "I definitely feel safe here." A relative said, "I trust the staff and they make [Name of family member] feel safe." Some people were unable to verbally express their views to us. We saw people looked comfortable with staff supporting them and some people approached staff and made physical contact such as holding hands or giving them a hug.

Recruitment of staff remained robust and thorough. Appropriate checks had been undertaken before staff began working for the service. These included an application form to assess gaps in employment history, obtaining references, a disclosure and barring service (DBS) check, which would highlight any criminal record, and an interview. Registered nurses were employed at the service and employment checks included making sure they were appropriately registered with their professional body. This all helped the provider to make safer recruitment decisions.

The provider made sure all staff, including ancillary staff, knew how to recognise and report any suspicions of abuse. All staff we spoke with said they would not hesitate to raise any concerns and all were confident that action would be taken to keep people safe. Where allegations had been made the registered manager had worked in partnership with appropriate authorities to make sure issues were fully investigated.

Individual risks to people had been assessed in areas such as weight loss, skin damage, choking, the safe moving and handling of people, falls and the use of specific equipment such as bedrails. Staff were aware of people's individual risks and how this could impact on a person's health, wellbeing and safety. Where risks were identified, suitable control measures had been considered and put in place to mitigate the risk or potential risk of harm for people who used the service. We noted that checks were not made to ensure pressure relieving mattresses remained correctly set, to ensure people received maximum benefit. Following the inspection, the registered manager confirmed they had received information from the equipment supplier that the mattresses self-adjusted to individual needs and staff had been made aware of the monitoring needed.

People told us there were always sufficient numbers of staff available to provide the support required to meet their care and support needs. People confirmed that staff responded in a timely manner when they used their call alarm to summon staff assistance. One person told us, "Very quick response to the call bell, even at night." Another person told us, "The staff are very attentive. There are busy times when they get lots of requests, but the staff do their best and we don't have to wait anytime at all."

The majority of relatives we spoke with considered the staffing levels were appropriate, although one relative felt the staff often seemed busy and it could appear the home was understaffed. Staff confirmed there were enough staff to meet people's needs. Staff were visible throughout the home when we visited and available, should people require assistance. We saw they had time to spend with people. Staffing levels were planned around individual needs and staff were assigned roles on each shift to ensure people's needs were met.

Medicines were managed safely and people received them as prescribed. We checked a sample of the stocks of medicines, including controlled drugs, and found that records tallied with the stock we counted. When medicines had been prescribed to be taken 'as required' there were detailed instructions for staff to follow to ensure people received these when needed. Where creams or lotions had been prescribed we could see from the records these were being consistently applied. We observed qualified staff administering medicines to people and this was completed in a patient and safe way.

There were some minor recording and storage issues. These included some gaps on medication administration records (MARs) where staff had not signed or recorded a code to support non-administration. Photographs of people were not held on their MARS and some thickening agents and topical medicines were not stored securely in people's rooms. The registered manager assured us these issues would be addressed.

Suitable measures were in place to prevent and control infection. People's rooms and communal areas were generally clean and tidy and there were no unpleasant odours. The laundry and kitchen areas were clean and organised. There were ample supplies of personal protective equipment such as gloves and aprons. Staff had received training and understood how to prevent the spread of infection.

People told us they felt the home was clean. Their comments included, "They clean every day and there are no smells" and "I am happy with home, they keep it very clean and tidy." A relative considered cleaning practices in their family member's room could be more thorough at times and pointed out some items of furniture which required a deeper clean. We mentioned this concern to the registered manager to follow up.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. Staff told us they received feedback on incidents and accidents. Records showed arrangements were in place to analyse accidents and near misses so that they could establish how and why they had occurred. Actions had then been taken to reduce the likelihood of the same thing happening again. For example, referrals to a specialist falls team, specialist monitoring equipment provided and additional staff training.

Health and safety related checks were completed regularly to help keep the premises and equipment safe for people. These included fire safety checks and fire drills. Hoists, electrical, gas and water safety were also tested. There were policies and procedures for dealing with emergency situations.

Requires Improvement

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 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. Whilst we found some people had capacity assessments and decisions made in their best interest recorded when they lacked capacity, others did not. Some people had restrictions in place such as bedrails, a recliner chair, lap straps, sensor equipment , their medicines administered covertly and one person was wearing mittens to prevent skin damage from scratching. However, their capacity to make these decisions had not been fully completed and the decision for the restrictions had not been discussed and recorded as in their best interest and as the least restrictive option for people.

Nursing staff had signed the consent records on behalf of some people, when records indicated the person did not have capacity to consent to the decision about their care. Where consent forms had been signed by family members; there was no clear indication as to whether the family member had Lasting Power of Attorney (LPA). LPA is legal authority for someone to make important decisions on a person's behalf. The absence of LPA records meant the provider could not be assured relatives were making decisions with proper authorisation.

Not working within the principles of MCA was 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.

The registered manager confirmed these shortfalls had been identified in a recent assessment by an officer from North East Lincolnshire Clinical Commissioning Group. They had provided the registered manager with a more up to date MCA assessment and best interest decision form and the registered manager confirmed they were in the process of completing these for relevant people and staff training had been booked as a priority. Records showed this work had commenced.

Throughout the inspection we heard staff offering people choices and explaining the care and support they wanted to deliver before doing so.

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 found the provider had made appropriate applications for DoLS to the local authority. There were four people who had DoLS authorised and applications had been made for thirteen people and these were awaiting assessment.

The home was divided into different areas which were equipped to meet people's differing needs. There were adequate communal spaces, including safe and secure gardens, which enabled people to choose where they spent their time. In the area which cared for people living with dementia we saw contrasting paint colours, memory boxes, pictures on doors and pictorial signage supported people's orientation. People's bedrooms were personalised.

Some redecoration had taken place and new flooring provided, but we found some areas of the home required refurbishing, with worn and tired furniture and carpets needing replacement. The registered manager ordered three new beds and new bed rail protectors during the inspection and confirmed they would complete a full audit and schedule the remainder of the improvement work. One relative said, "There has been some redecoration but more needs to be done now. The drive is poor, but I think that work was delayed due to the bad weather."

Staff had completed a range of essential training to ensure they had the skills and abilities to meet people's needs effectively. The training records showed any outstanding training had been identified and booked. Specific training to meet people's individual needs had also been completed by relevant staff. The staff we spoke with had recently completed training on acquired brain injury and considered the course was excellent and very informative.

New staff completed an induction programme and those without a national qualification were expected to complete the Care Certificate. This is an identified set of standards that care workers adhere to in their daily working life.

Staff told us they felt supported and valued by the registered manager. The registered manager had introduced a programme of themed supervisions which included topics such as dignity, oral hygiene, location of information, dining experience, pressure care, nail care and records. These sessions included an assessment of competency which ensured the carers were knowledgeable and skilled to complete tasks consistently to the required standard. An appraisal programme was in place.

People's health care needs were met. Records showed they had access to health care professionals in a timely way and attended hospital appointments when required. Staff were knowledgeable about specific issues, such as the prevention of pressure ulcers and how to spot the signs of a urinary tract or chest infection and the action to take. People told us their healthcare needs were well managed. A relative told us, "The nurses are very responsive when we enquire about our family member's health and medications."

People's nutritional needs were assessed and met. A screening tool was used to identify any concerns. Staff monitored people's weight and referrals were made to health professionals when required. Special diets were catered for and some people required their meals to be served at a specific consistency to minimise the risk of choking. One person's relative considered some meals were too hard for their family member to swallow and chew and we passed these comments to the registered manager to follow up. Drinks and snacks were served in-between meals. Although we were told a selection of milk shakes, cakes, yoghurts, fresh fruit and corn snacks were readily available, we observed the snacks offered to people during the inspection were mainly limited to biscuits. We mentioned this to the registered manager to follow up.

A number of people required assistance to eat, ranging from prompting to physical help. During the meal, there was an unhurried atmosphere and people were encouraged and supported to be as independent as possible, some people were provided with plate guards and beakers. The organisation of the meal service in Royal Unit on the first day was inconsistent, with some people waiting for their meal and for support. On the second day, we found improvements with the meal service on the unit, staff were attentive and people were

provided with meals and support in a timely way. The food looked nicely presented. People gave us positive comments about the food and these included, "The food is good and there's always a choice. They will make you something else if you don't want what is on offer" and "[Name of family member] loves the meals, it's their only pleasure now."

Good

Is the service caring?

Our findings

People told us they were treated with care and kindness by staff. Their comments included, "I'm so happy here, they treat me like a queen", "All the staff are lovely and the night staff are so bright and cheerful" and "They make time to be with us and we really appreciate their kindness and compassion." Relatives we spoke with also told us staff were kind and caring. One relative said, "[Name of family member] has very complex needs and we can see in their body language they are happy here. They communicate with their eyes, which really light up when certain members of staff come in their room. It's lovely to see that bond and relationship which has developed with the staff." Another relative said, "The atmosphere is warm and friendly and so are the staff."

We found the service ensured people were treated with compassion, respect and were given emotional support. We saw positive interactions between staff and people. Staff were chatting and reading to people and the atmosphere across the whole service was calm and caring. Staff spoke kindly to people and were attentive to their needs. They were observant and intervened if people looked as though they may need something. We saw a member of staff take time to sit with one person who was anxious and upset; they held their hand and chatted with them about their family and later when they became anxious again, the member of staff brought them a basket of laundered socks and they spent time pairing them all up. It was clear the person enjoyed the task and spending time with the member of staff as they chatted about everyday things and their family.

The service had a number of dignity champions. We spoke with one of the dignity champions who explained how they attended local dignity network meetings to discuss different ways to promote dignity within the home. They also attended a provider dignity forum with three people who used the service. Much of their work so far involved developing the activity programme and garden areas. They explained how they had recently sent out questionnaires about dignity to people who used the service and would be developing an action plan from the responses received. They celebrated national dignity action day this year with a Valentine's themed meal and party, which people told us they enjoyed.

People's privacy, dignity and independence were respected and promoted. We observed staff knocked on people's bedroom doors and called them by their preferred name. People told us staff were respectful when they provided personal care and they had never felt undignified or embarrassed. A health professional said, "The nursing and care staff have always shown compassion and respect towards the patients in their care. This has also been extended to the patient's family and significant others."

Visitors were made welcome and some continued to provide hands on care to their friends or relatives. We heard staff asking relatives how they were and asking about their wider family members. We spoke with two relatives who came regularly to support their family members at lunchtime. One visitor told us, "We like to do our bit and help with our relative's care where we can and meal times are a good opportunity for this." Other comments from people and relatives included, "Staff are very welcoming and there is a nice homely atmosphere here" and "Very friendly staff team. I think they care about us just as much."

The provider had an equality and diversity policy to support staff in promoting the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. The provider had ensured the majority of staff had been trained in equality and diversity during induction. Staff were aware of the individual wishes of each person, relating to how they expressed their culture, faith and sexuality. We found the assessment record did not cover all these values and the registered manager confirmed the care documentation would be reviewed and updated to include this information. We observed people were supported to live a life that was reflective of their individual wishes and values.

Some people experienced difficulties or were not able to communicate their needs and wishes and staff used various ways to enable them to express themselves. One member of staff told us they used picture cards to help a person to communicate their wishes and make choices about activities. The staff member said, "We use cards to show the person pictures of the shower and bath and other activities to help them choose." People's communication needs were identified in their care plans and information was provided in accessible formats, for example an easy read complaints procedure was provided in each person's care file.

People had access to independent advocates if they wished. Advocates provide independent support for people to express their views and ensure their rights are upheld. Staff were aware of the need for confidentiality and held meetings or telephone conversations with relatives or health and social care professionals in private. Personal records were stored securely and computers were password protected.

Requires Improvement

Is the service responsive?

Our findings

Assessments of people's needs had been completed before they came to live at the service. Records showed staff had consulted with each person about the care they wanted to receive and had recorded the results in an individual care plan. Some care plans had detailed information about how to support the individual in a person-centred way, but this was not consistent throughout all the care plans we looked at. For example, some care plans identified that people required assistance with their personal care but did not provide staff with clear directions on how to meet people's preferences and maintain their skills with this. We also found gaps in two people's care files where the support required around their behaviour which challenged the service and management of their urinary catheter was not clearly detailed. Improvements were made to these records during the inspection. In discussions with the registered manager, they acknowledged that the overall quality of the care records required improvement and this would be completed as priority.

We recommend the information in care files is reviewed and the system of planning care updated to ensure all the care plans consistently record how staff are to deliver care and support in line with people's preferences.

Care plans were evaluated monthly, or sooner, according to people's needs. Where changes in people's needs were identified these were responded to promptly. For example, one person had experienced weight loss and changes to their skin condition and we saw referrals had been made to the dietician and tissue viability nurse (TVN).Their care plan reflected the TVN had visited to complete an assessment and their advice had been recorded. The dietetic service had phoned staff for an update on the person's weight and this had been recorded.

Supplementary records were used to document some peoples' change of position and their food and fluid intake, although we found staff had not always ensured the records were completed consistently. People's individual optimum fluid targets had not been recorded and fluid intake and output was not totalled for staff to monitor. We raised this with the registered manager to follow up.

Despite the gaps in personalised information in some care files, we observed staff knew the people who used the service very well. They were able to describe people's needs and how they provided support to meet them. The care described by staff and observed in practice was very individualised.

Staff told us how they involved people and their relatives in discussions about their care plans. Two of the relatives we spoke with told us they had been involved in putting a care plan in place for their family member. One relative said, "We helped with writing the care plan and have completed a document to take with them to the hospital if necessary, which gives a clear overview of [Name of person's] needs." Another told us, "We have always been consulted about [Name of person's] care and staff involve us with everything."

People told us staff were responsive to their needs. One person said, "I had a chest infection and they got the doctor in right away." A relative told us, "It's a relief knowing they are safe and looked after so well." A

health professional told us, "It is a good home. The staff are organised and follow my instructions and call us in a timely manner [for advice]."

People were supported at the end of their lives. Staff in the home had received training in 'palliative and end of life care' and worked closely with specialist NHS staff who provided on-going guidance and support. Nursing staff had completed more specific training around pain management, verification of death and use of syringe drivers. End of life wishes were recorded in care files where people had been happy to provide these.

The activity coordinator explained how they worked with people and their families to develop comprehensive life history folders, which included information and photos of people's lives before they moved to the home and whilst they lived there. The life history folder was presented to the person's family after they had died if they chose to have this. The service had received some very positive feedback about the caring approach and kindness of staff, in relation to the end of life care provided to people's family members. A health professional told us, "I feel that the service provided by the home does meet the palliative patients' needs. I have witnessed choice, independence and dignity with palliative patients residing at St Margaret's."

The service employed two enthusiastic activities co-ordinators who were supported by a small team of volunteers. People were encouraged to join in a varied range of group activities, trips and entertainment. Many people were cared for in bed and the programme included regular one to one sessions, including sensory support with the mobile sensory unit. Each person had an activity care plan that highlighted their interests and preferences with regard to their involvement in activities. The co-ordinator regularly reviewed the activity programme and consulted with people about new activities and entertainment.

During our inspection we observed a number of activities taking place. For example, some flower arranging for the forthcoming craft fair, games, films, looking at books and a visit from a local lay preacher to share tea and hot cross buns. People were supported to access the local community to attend activities, clubs and events. These included a flower arranging club, a local dominoes and bocce [type of boules] league, local disability sports forum, local shows and day centres. One person had a timetable and spent time with the cook and maintenance person assisting with tasks. Another person had always wanted to travel abroad and the activity coordinator had facilitated this making all the arrangements, which included assisting the person to apply for their passport. Photos were on display showing past activities people had taken part in.

We noted that staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs. For example, a person continued to visit their local church regularly to attend services.

People were positive about the activity programme and comments included, "There is always something going on. We have lovely tea parties" and "They have really good singers that come in, I enjoy those best." Relatives told us, "Trips and entertainment opportunities are good" and "The staff will often just sit and read to [Name of relative]" and "The activity ladies are marvellous and put a lot of effort into the programme here. Excellent programme, there is always something going on; it's good to keep people occupied and stimulated like this."

The provider had a complaints policy and procedure, a copy of which was displayed in the service. This detailed who to refer complaints to and timescales for acknowledgement and completion. Records showed complaints were investigated and responded to appropriately. When we spoke with people they told us they knew how to raise concerns. A relative told us, "I have emailed the manager and had meetings; issues have

been followed up."

Requires Improvement

Is the service well-led?

Our findings

There was a quality assurance system, which consisted of audits, checks, surveys and meetings. We found aspects of the programme were not effective and had not identified some of the shortfalls we found during the inspection in relation to supporting consent to care; ensuring care plan records were person-centred and timely renewal and refurbishment.

The registered manager completed a home audit every three months and although this covered many areas of the service, we found the content was limited and few issues were identified. The renewal programme did not detail all shortfalls and many timescales for improvement work were 'on-going.' Care plan audits were completed, although we found the focus was on the presence of the records in the care file and not the quality of the recording.

We saw action plans were produced when issues had been identified in relation to infection control, weights, and medicines. Accidents and incidents were recorded and a system was in place for analysing information about them to identify the causes and reduce risks of reoccurrence. There was a maintenance book for staff to highlight any faults or repairs and these were addressed. External audits on medicines systems, infection control systems and pressure damage prevention had been completed in 2017 and records showed action had been taken by the management team to make improvements where necessary.

A member of the provider's quality team visited the service every two months to complete a review. The reviews were mapped to the Commission's key question outcomes and included discussions with staff, people who used the service and the registered manager. An action plan was completed following each visit. We noted that concerns had been identified around records to support consent, but these had not been included in the action plan.

We recommend the audit system is reviewed and updated to ensure it effectively identifies shortfalls in service provision and drives necessary improvements.

We found the management team demonstrated an open and responsive approach during the inspection. They accepted that some of the recording and administration systems now required review and updating and confirmed they would be consulting with the provider to upgrade and develop these. Following the inspection, we received evidence of improvements made to care records including those relating to consent to care. We also received a plan of refurbishment work with scheduled dates for completion. Two bedrooms had been redecorated, furniture replaced and more had been ordered.

Meetings were held for residents and relatives in order to gain their input and views of the quality of the service. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent resident and relative surveys in November 2017 were generally positive about the service, with some negative feedback about the environment and condition of the drive.

The registered manager had been in post since 2011 and the deputy manager had been recently appointed along with two new qualified members of staff and this new team was just getting established. The registered manager worked in partnership with various organisations, including the local authority, local clinical commissioning group, community nursing teams, local GP services and mental health services to ensure they were providing holistic care. The registered manager attended leadership meetings within the organisation and provider meetings in the community to share experiences and exchange information. Staff also attended community link meetings for infection prevention and control, dignity and end of life care.

The staff described the culture of the service as warm, open and positive. They said the service was very organised and the registered manager was approachable and supportive. Comments included, "It's a great place to work. The management are supportive and we all strive to do the best we can. [Name of registered manager] listens to staff and we are confident in her approach" and "The manager is not shut behind her door. We have a good staff team here and are always looking at new and different ways of working to make a difference to people's lives."

Communication within the service was good. Staff had handovers of shifts, which were recorded. These detailed who was on duty, whether there were any issues changes in people's health and wellbeing or medication to follow up. There was also a communication book that staff used to record important information such as medical appointments or reviews of people who used the service. There were staff meetings and records of these showed staff were able to raise concerns and make suggestions. Staff told us they were kept informed about important issues.

The registered manager had introduced annual staff awards to recognise and reward those staff who have gone the extra mile or completed work to an outstanding quality. The activity coordinators and domestic staff had won 'team' awards for their excellent contributions. The registered manager considered the initiative was working well and demonstrated that staff were valued by the management team.

People told us they felt confident in the way the home was managed. One person told us, "I'm very settled and happy with everything here", "The home is well-managed and the staff put in 110% for us and we appreciate their hard work and dedication" and "The home has a good reputation in the town; we are very happy with the care and haven't been let down yet."

The registered manager was aware of their registration responsibilities and notified appropriate agencies of incidents which affected the safety and wellbeing of people who used the service.

We saw staff and people who used the service and relatives had been involved in fundraising. In 2017 they had completed a sponsored walk over the Humber Bridge and monies had been raised for charities of the staff and people's choices such as Alzheimer's UK.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity.