Molescroft Nursing Home (Holdings) Limited

Beverley Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
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 5 June 2017 and was unannounced.

Beverley Grange Nursing Home provides accommodation and care for a maximum of 75 people over the age of 18. The service provides support for people who may be living with dementia or who may have a physical disability. At the time of our inspection there were 56 people using the service.

The provider is required to have a registered manager as a condition of their registration for this service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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. At the time of our inspection, the service did have a registered manager and we have referred to them as 'the manager' throughout this report.

Quality assurance and record keeping within the service needed to improve. There was a lack of effective auditing within the service. We found that care plans, risk assessments and food/fluid charts were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

People told us they felt safe and were well cared for. The provider followed robust recruitment checks, to employ suitable people. There were sufficient staff employed to assist people in a timely way. Medicine management practices were being reviewed by the manager and action was taken to ensure medicines were given safely and as prescribed by people's GPs.

Staff had completed relevant training. We found that the care staff received regular supervision and yearly appraisals, to fulfil their roles effectively. However the frequency of supervision for new starters and the trained nurses needed to be more consistent.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to and they received care and treatment from external health care professionals when necessary, such as the district nursing team and speech and language therapists.

People had access to adequate food and drinks and we found that people were assessed for nutritional risk and were seen by the Speech and Language Therapy (SALT) team or a dietician when appropriate. People who spoke with us were satisfied with the quality of the meals.

People were treated with respect and dignity by the staff. People and relatives said staff were caring and

they were happy with the care they received. They also confirmed they had been included in planning and agreeing the care provided. People had access to community facilities and most participated in the activities provided in the service.

People and relatives knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with.

People told us that the service was well managed and organised. People and staff were asked for their views and their suggestions were used to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

There were processes for recording accidents and incidents. These records were analysed and risk assessed by the manager.

There were sufficient numbers of staff on duty to meet people's needs. Medicine management practices were reviewed by the manager and action was taken to ensure medicines were managed safely and people received them as prescribed.

Is the service effective?

Good

The service was effective.

Care staff received relevant training and supervision to enable them to feel confident in providing effective care for people. However, the frequency of supervisions for new starters and trained nurses needed to be more consistent.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005.

We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good

The service was caring.

People who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans did not always clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but judged that the care provided was not well recorded. Risk assessments had not always been reviewed and monitored appropriately.

People were able to make choices and decisions about aspects of their lives. Staff encouraged people to join in with social activities, but respected their wishes if they declined.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Record keeping within the service needed to improve. We saw evidence that medicine records, care plans, risk assessments and food/fluid charts were not always accurate or up to date.

People who used the service said they could chat to the manager and relatives said the manager was understanding and knowledgeable.

People told us that the service was well managed and organised. People and staff were asked for their views and their suggestions were used to continuously improve the service.

Beverley Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 5 June 2017 and it was unannounced. The inspection team consisted of four adult social care inspectors, two pharmacy inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and people living with dementia.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held about the service, including notifications sent to us by the provider. Notifications are when providers send us information about certain changes, events or incidents that occur within the service, which they are required to do by law.

During the inspection we spoke with 14 people who used the service and eight relatives. We spoke with the manager, deputy manager and one of the owners of the service whom we have called 'the provider' in this report. We also spoke with six members of staff. We used the Short Observational Framework Tool for inspection (SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and looked at the level of support provided to people throughout the day.

We looked at five people's care records, including their initial assessments, care plans, reviews, risk assessments and medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS) to ensure that when people were assessed as

lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation created as part of the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for four members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Good

Is the service safe?

Our findings

We asked relatives if they felt their loved ones were safe in the service. We received positive responses from those who spoke with us and two visitors told us, "Absolutely. I think [Name of relative] is very safe here" and "Every care is taken to make sure my relative is safe, we asked for small gates to be put across their door to stop anyone wandering in and the service did it." People who used the service told us, "I just feel safe, they listen to me", "They are always popping around and seeing if I am okay, I have no reason to feel unsafe" and "The carers talk to me when they pop in."

We saw that one member of staff had raised concerns about staff practice and attitudes during one of their supervisions. We spoke with the member of staff who told us, "My concerns were due to staff inexperience." We looked into this further and found that the manager had ensured the staff concerned were given further training and support to improve their practice.

Staff received training on making a safeguarding alert so they would know how to follow local safeguarding protocols. They told us they would have no problem discussing any concerns with the manager and were confident any issues they raised would be dealt with immediately. There was written information around the service about safeguarding and how people could report any safeguarding concerns. Safeguarding notifications were submitted appropriately to CQC and to the local authority. The level of staff knowledge about the different types of abuse and how to report it was good. They were aware of whistle blowing procedures and confident of reporting any issues to outside agencies if needed.

We were told there were no staff vacancies. A dependency tool to calculate staffing levels was available, but it was not used regularly. The last four weeks staffing rotas showed that the service maintained minimum levels of one nurse and 11 care staff (five ground floor and six first floor) during the day and one nurse and five care staff (two ground floor and three first floor) at night. Additional ancillary staff were employed to cover maintenance, domestic, kitchen and laundry duties. At times, the rotas showed additional care staff were on duty. At the time of our inspection there were 54 people who used the service, of whom 29 were living with dementia.

We asked people who used the service and relatives if they felt there were enough staff on duty and if staffing levels ever impacted on their quality of life, such as having to wait for care or not being able to attend activities. Everybody who spoke with us was full of praise for the care and dedication of the staff and said they were totally satisfied with the level of staff within the service. A visitor told us, "Yes, there are enough staff available. I think there are six staff upstairs today, the staffing levels are usually okay and the staff are very kind and caring." Staff told us, "Staffing was a problem a year ago, but not now. We have a lot of bank staff and agency staff available to us, so shifts are covered. We often have eight staff upstairs and four or five downstairs. The main problem is when people ring in sick at the last minute, but it is difficult to anticipate this."

Our observations during the inspection were that people were settled and relaxed in the service. Any calls for attention throughout the day were dealt with straight away and people received a good standard of care.

The lunch time experience was organised and people were given assistance with their meals as needed.

We looked at the recruitment files of four members of staff and saw the staff recruitment process was safe. It included completion of an application form, full work history check, previous employer references and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents and these showed what action had been taken and any investigations completed by the manager. The CQC had been notified by the manager of any serious injuries or deaths within the service and the information we gathered was measured against national statistics for similar services. This showed there was no evidence of risk identified with the service with regard to the number of reported incidents.

We observed that staff used the correct equipment and safe moving and handling techniques when assisting people to mobilise. When needed, people had been provided with equipment such as pressure relieving mattresses to reduce the risk of them developing pressure sores.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the majority of the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. However, identified risks were not always recorded in the care plans we looked at. For example, one person had a risk assessment for choking that documented in May 2017 they were deemed by the staff to be at a high risk of choking. However, there was no corresponding care plan and no mention of this in the nutrition and hydration care plan. The care plan also did not give staff guidance about positioning the person when eating or drinking. This left the person at potential risk of harm. We found however, that the staff we spoke with demonstrated a good understanding of people's needs and were aware of the choking risk and knew what action to take to reduce the risk of harm. Please see the well-led section of this report for the action we have taken in relation to this issue.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. A copy of the fire procedures was on display and a fire risk assessment had been carried out in July 2016 and was due to be reviewed. People who used the service had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. Fire drills were undertaken to ensure people knew what action to take in the event of a fire. Relatives and people who used the service were aware of the fire precautions in place as they told us, "There was a fire drill a few days ago", "Alarms are checked on Fridays" and "Fire alarms are tested and all the doors shut."

Service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by staff, maintenance team and nominated contractors. These environmental checks helped to ensure the safety of people who used the service. The staff told us

the provider was, "Really good at replacing anything that needs to be, such as mattresses, as soon as any concerns are identified."

People we spoke with said that they got their medicines regularly and thought they were given as they should be. Comments we received included, "I just take them, on time I think" and "Nurses couldn't be better. I had some dizzy spells and the nurses looked after me. The nurse does my tablets at pill time."

We looked at 15 medicines administration records (MARs) and spoke with one senior carer responsible for medicines and the deputy manager. We saw that although there were some minor actions needed to improve practice, people received their medicines safely and as prescribed.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the home's policy.

Room temperature where medicines were stored were recorded daily, and these were within recommended limits. We checked medicines which required cold storage and found records were completed in accordance with national guidance. However, on the upstairs unit temperatures had not been recorded on 26 days in April 2017 and 18 days in May 2017; no action had been taken. This meant we could not be assured that medicines requiring refrigeration were safe for use.

MARs contained photographs of service users to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. Documentation was available to support staff to give people their medicines according to their preferences.

Administration records had been completed fully to show the treatment people had received. In some MARs we found guidance to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'when required' or 'PRN'. However, we found that in 11 out of the 15 records we checked guidance was not available. Staff did not always record whether one or two tablets were given when variable doses of pain medicines had been prescribed. This meant that records did not always accurately reflect the treatment people had received.

Instructions for medicines which should be given at specific times were not always available in the MARs or in the care files. For example, one person was prescribed a medicine to be taken 30 minutes before breakfast when the stomach is empty. Another person was prescribed a medicine which should be taken whilst upright and 30 minutes before eating or drinking. Not administering medicines as directed by the prescriber increases the risk of the service user experiencing adverse effects from the medicine, or the medicine not working as intended.

We checked the quantities and stocks of medicines supplied outside of the monitored dosage system for 15 people on four units and found the stock balances to be correct. This meant that medicines had been given as signed by staff. Staff had received medicines handling training and their competencies were assessed regularly to make sure they had the necessary skills.

We saw the use of patch charts for people who were prescribed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application.

Body maps and topical MARs were also in use, and these detailed where creams should be applied and provided clear records of administration.

We gave feedback to the provider and manager at the end of our inspection. They told us they would take action to review the process to record fridge temperatures daily in accordance with national guidance; implement "PRN" protocols for each person who used the service, improve the recording of variable dose medicines prescribed as or when required and ensure that special instructions for the administration of medicines were included on MAR sheet

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for their capacity to make specific decisions, and where appropriate DoLS authorisations had been sought. There was recording of Best Interests decisions and the manager told us they were working on ensuring that families provided copies of Lasting Powers of Attorney's (LPA) where they had been registered with the Office of the Public Guardian (OPG).

Staff showed awareness of people's rights and the MCA. In discussions staff were clear about how they gained consent prior to delivering care and treatment. For example, one person was being given medicines covertly (disguised in food or drinks). We checked care records and found appropriate assessments had been undertaken and decisions made in accordance with the Mental Capacity Act 2005.

People told us the staff supported them to remain as independent as possible and offered them choices in their daily lives. People said, "The staff do not bother you much. I can come and watch television in my room when I want and the staff pop in to see if I am alright" and "The staff ask you if want help. They let you get on with it if you choose to be more self-sufficient, but are around if you need them."

People and visitors said they felt there was a good level of communication between themselves and staff. They told us they were involved with decisions about care and two people said, "I just tell them what I want and they do it" and "I am fully involved and informed". Visitors commented, "I ask staff about my relative and they tell me how they are doing" and "They involve me, I have lasting power of attorney."

We asked people if the staff knew them well and whether they listened to them and responded positively. One person told us, "I think they know me, they listen to me most of the time." Visitors said, "They know my relative's name and they listen", "When I phone up and ask after my relative they are able to tell me things straightaway" and "Yes, they know how to deal with my relative."

There was a robust induction and training programme in place for all staff. New staff were mentored by more experienced workers until their induction was completed. We saw that staff had access to a range of training deemed by the provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding

and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity. The manager told us that they monitored the effectiveness of the training sessions through the use of feedback forms for staff at the end of sessions, discussions about learning during supervisions and direct observation of staff practice.

The provider told us that all staff had moving and handling training at the start of their induction and completed other 'mandatory' training during their first 12 weeks of employment. This was confirmed by information in the staff files and on the staff training plan. Staff were happy with the level of training provided. They told us, "The managers put up training information and let us know if we are due to do refresher sessions. We have a mix of classroom based training and e-learning. Most of the training is in-house."

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. We saw that care staff supervisions were taking place every two months and the staff told us they felt very supported by the manager and their open door policy meant that staff could talk to them when they needed to. One staff member told us, "I get supervision every six weeks or so. The deputy manager does mine and I find them really useful." Annual appraisals for all staff took place. However, we saw that, over the last six months, new staff had not received additional supervisions during their induction period and the trained nurses supervisions were not taking place. The manager told us that the timescales for these had slipped due to them being busy managing two services. They assured us that these would be brought up to date as soon as possible. We did see that the trained nurses received support from the provider and manager to complete their registration requirements (revalidation) for the Nursing and Midwifery Council (NMC). Each nurse had their own portfolio for training, reflection and feedback. When the time came for them to renew their registration their portfolio of work was discussed with the manager who then signed it off.

Information in the care files indicated people who used the service received input from health care professionals such as their GP, dentist, optician and podiatrist. People told us, "When you need doctors or health professionals this is arranged quickly" and "I have seen a GP while I have been here. The district nurse has been in to dress a blister on my leg." One person said, "I went to the opticians they said I didn't need my glasses anymore and it has been great, no headaches or anything without them." A visitor told us, "The care that my relative gets is good. Their GP has said the care they get has extended their life expectancy. They were given five to ten years, but it is now nearly 11 years since their accident."

Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. The staff completed food and fluid charts daily when people were deemed to be at risk of poor nutrition or dehydration. However, some of these were not completed appropriately. See the responsive section for action we have taken in response to this issue.

We saw people being offered choice of drinks and snacks during our inspection. We spoke with one visitor who assisted their relative with eating and drinking. They told us, "I am not concerned that staff would not feed [Name of relative], but I enjoy doing this as it is something we can do together."

We asked people about the quality of the meals they were served and we received a very positive response. People told us they liked the food and were offered plenty of choice. One person told us, "The food is quite good, I don't need a lot as I am chair bound. Staff ask what I want in the morning and I have specially requested omelette and chips today. There is always plenty to drink, and I get whiskey too." Another person told us the food was, "Very good. Fish and chips is nice." One person who used the service said, "The food is

excellent, I'm a vegetarian" and another said, "Every day we get something different and it's really well cooked. They're doing everything they can for us."

Observation of the lunch time meal showed that people were given a choice of where to sit in the dining room and lounge areas; some people chose to eat in their bedrooms. Portion sizes were adequate and people were given their choice of food, which was served to them by the staff. We noted that each meal met with the person's dietary needs and people were able to ask for extra portions if they wanted. Care staff offered people support and help with cutting up food and the meals looked and smelt appetising.

Good

Is the service caring?

Our findings

We received positive feedback from relatives and people using the service about the care and support they received from staff. We spoke with one visitor who told us, "My friend has been in here a few months now. They have settled in really well and I am made welcome whenever I visit." We saw that they were sat together and staff had provided them with a tray of drinks and biscuits.

People were able to move freely around the service, some required assistance and others were able to mobilise independently. We saw that people and staff had a good rapport with each other. Observations of people in the lounge, dining room and around the home indicated that individuals felt safe and relaxed in the service and were able to make their own choices about what to do and where to spend their time. People told us, "I have some independence and I am happy here" and "I do as much as I can for myself as the staff work so hard." One person said, "I have some back pain, but remain fairly independent. I walk with my frame."

People said they were treated with compassion, dignity and respect. People and visitors confirmed to us that staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when completing care tasks. One visitor told us, "I come most days to see my relative. I am confident they are looked after when I am away from the service and I don't need to ring up to find out how they are doing."

Staff told us, "We protect people's privacy and dignity by knocking on doors before entering, always explain what we are doing before carrying out a task and ask the person first if that is okay. We keep them covered when doing personal care and always treat them as you would wish to be treated" and "People who are living with dementia may not always realise their behaviours are inappropriate. So we would approach them in a sensitive way and direct them away from the view of others or distract them with something else to do." We observed staff practice during the inspection and found appropriate actions taking place.

The SOFI we carried out showed that staff interacted with people appropriately and continually checked that they were happy and their needs were being met. One visitor told us, "Most of the staff come and chat, they are friendly. My relative is safe here. There are lovely gardens and we spend a lot of time in the garden. There's always plenty of books and the rooms are adequate." We observed one member of staff assisting one person who remained in bed with eating and drinking. There was a nice relaxed atmosphere in the room and both individuals were chatting and engaging in the task.

The bedrooms we entered with people's permission were nicely personalised, clean and had call bells. Care staff though-out the day were seen to be happy, friendly and approachable. We noted that people who used the service looked clean and were appropriately dressed with shoes/slippers on. One person told us, "The staff here are wonderful. I'm quite happy to be on my own in my room and have a 'bit of banter' with staff when they come in. They are very respectful. The staff are caring and kind."

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion

with staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation was recorded in the care files.

Information was provided, including in accessible formats, to help people understand the care available to them. Discussion with people and relatives revealed that they had been involved in assessments and plans of care. Two people told us, "There is a care plan somewhere, revised at some stage but I can't remember when" and "Oh yes, I am involved with my care. I've got a key worker." A visitor said, "Care plans were reviewed last week, not signed by me yet. When it is written up I will sign if happy with it - we have been here that long I feel happy to tell them anything." For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. An advocate is an independent person who supports someone so that their views are heard and their rights are upheld.

People's wishes and choices around end of life care were documented in their care files. Care plans recorded when people had a 'Do Not Attempt Cardiopulmonary Resuscitation' order (DNACPR) in place and staff had 'Just in case' medicines in stock for certain individuals. These medicines are prescribed by GP's and are used to ensure people on end of life care are kept comfortable and pain free.

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people's care plans did not always clearly describe their needs or record the care being given. We saw no evidence that people were not receiving the care they required, but noted this information was not always well recorded.

We found care files contained old records that needed archiving, risk assessments were not always up to date, care needs were not detailed and staff relied on their own personal knowledge to give the correct care. Feedback on this was given to the manager and provider at the end of our inspection.

For example, in one file we looked at we found the 'All about me – my story' document was blank and there was no recording on the activity records after March 2016. Following our inspection we were provided with information from the provider that activities were being recorded in a different format and separate to the care files.

In the same care file we noted that the long-term care plan for epilepsy advised the reader to refer to the risk assessment for seizures, but this was not in the file. Risk assessments were in place for a wheelchair lap strap and dehydration and sunstroke, but these had last been reviewed in July and August 2016. A risk assessment completed for urinary tract infections (UTI's) did not include any signs or symptoms for staff to look out for.

Identified risks were not always recorded in the care files we looked at. For example, one person had a risk assessment for choking that documented in May 2017 they were deemed by the staff to be at a high risk of choking. However, there was no corresponding care plan and no mention of this in the nutrition and hydration care plan. The care plan also did not give staff guidance about positioning the person when eating or drinking. This left the person at potential risk of harm.

Following our inspection the provider gave us evidence that one page profiles of people were available for staff so they could quickly see the needs of each person; however, this did not mitigate the risks that we found and which are detailed above.

Discussion with staff showed they knew which people were at risk of choking and what thickness of fluids they needed and which textured diet they ate. One member of staff told us, "We take everything at their pace as people vary. You have to be aware of their swallowing in case they retain food in their mouth and make sure they are positioned correctly whilst they are eating. If they are in bed or in a chair or wheelchair we make sure they are sat upright with their head in a good position to aid their swallowing reflex. We get advice from the speech and language team (SALT)." The information from the staff and observations during the lunch time meal indicated that although there was a lack of recording of risk, staff knowledge and practice reduced the risk to people who used the service.

Food and fluid charts were recorded but there was no evidence that staff took any action when the amount of fluids consumed dropped. For example, one person's records documented that between 29 May 2017 and

4 June 2017 they drank 1100mls, 1450mls, 705mls, 1100mls, 2 June 2017 the record is blank, 610mls and 575mls. The care plans in the care file did not include any information on the type or amount of fluids the person was expected to consume on a daily basis. We went to check on this person and observed them to be well hydrated and watched them consume fluid over the lunch time period. They were able to drink with assistance so we could only presume that staff were not recording the amounts of fluid correctly on the chart. The charts did not record output - it is very important if a person is catheterised that an accurate record of fluid in and out of their body is recorded so any fluid retention can be monitored and acted on quickly.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were able to give us detailed information about different people's needs. They knew people's preferences regarding eating and drinking, activities, spiritual beliefs and could describe what people liked regarding personal care. For example, one member of staff told us that, "[Name of resident] does not like soap products with a strong smell and they like moisturiser applying after their bath/shower. They like their hair curled twice a week and always have this done. We apply their make-up daily and make sure their nails have polish on them." We observed this person during the inspection and their appearance confirmed what the staff said.

We asked family members if they had been involved in the care planning process and we received a positive response from everyone. Visitors told us, "We have just revised my relative's care plan", "Not that I know of but happy with things" and "They phone me and ask me questions." People told us that the support they received was how they wanted it to be and said, "Yes, it is just right" and "I don't think that they could do more."

There were two activity co-ordinators employed by the provider. We spoke to one of them during the inspection and they told us they had only been in the role since April 2017. They worked 9am - 4pm five days a week. There was an activity board on display which showed the days' activities as 'Shop' in the morning and 'Knit and Natter' in afternoon. At 2.40pm there were eight people in the ground floor day room with two ladies from the local church leading a 'Knit and Natter' group. Three people were knitting 'blanket squares' for donation to a local community group.

We spoke with the provider who told us their philosophy was the people who used the service came first. They said, "The home is how they want it because it's their home. For example, they sit here in the entrance hall because they like to see what's going on - who's coming and going. This is because they don't wish to feel forgotten about." We could see that people enjoyed watching the hustle and bustle of the service and they asked visitors who they were and why they were at the service. We sat with three people listening to their experiences of living at the service. It ended up with a group of eight people talking about their experiences. They all really liked living at the service and felt safe and well looked after.

The activities co-ordinator told us that a multi-denominational church service was regularly held at the service for people who wished to attend. We saw there was a poster for a monthly service in the home. In addition, two people living at the service went out to local churches to meet their spiritual needs. Representatives from Beverley Minster came to the home for a service every second Sunday and Toll Gavel Church (Methodist) came in every third Monday.

There was a planned activities programme with people coming in to entertain; events were organised and there was an activities board in the entrance hall. One visitor told us, "My relative seems to respond to music

and they enjoy sitting in the lounge listening to the entertainers that come in." People told us, "I play bingo, they give me a list of weekly activities, personally I think there is enough" and "I have a big television and I watch this. I don't want activities, I am lazy."

People were able to get out and about in the community with assistance from family and friends. One person told us, "My partner takes me out most days, which I really like" and a visitor said, "I take my relative to watch the Rugby – Hull FC once or twice a season." Other visitors told us, "I visit nearly every day and bring my relative books in" and "My relative gets lots of visitors and there are no visiting time restrictions."

People had access to a copy of the provider's complaint policy and procedure in a format suitable for them to read and understand. There was a complaints form for people to complete as they wished and we saw that formal complaints were responded to in writing by the manager in-line with the provider's policy and procedure.

The people we spoke with said that they would have no issues if they had a complaint and were confident about talking to the staff or the manager. One visitor told us, "I feel able to raise any concerns and I am confident they would be addressed straight away."

Staff were confident about using the complaints process. One member of staff said, "Yes, I have used the process to raise concerns. What I said was kept confidential and was dealt with by the manager. It was handled really well and resolved quickly."

Requires Improvement

Is the service well-led?

Our findings

Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We found that there was a quality assurance system in place but it was not always effective.

We spoke with the provider and manager about our findings that staff supervision and medicines management were not always completed consistently and they told us how these would be monitored and up dated. The audits completed by the manager did not highlight any of the concerns we found around inaccurate and inadequate record keeping. For example, we saw evidence that medicine records, care plans, risk assessments and food/fluid records were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with the provider and the manager about the quality assurance system. The manager was running two services at the time of our inspection. It was discussed whether the increased burden of overseeing two sites had resulted in things not always being picked up and acted on through the quality assurance processes. The provider told us that they were arranging for an interim manager at the other service so the manager could concentrate on this service.

There was a manager in post who was supported by a deputy manager and qualified nursing staff. The majority of people who spoke with us was able to tell us the name of the manager and were confident about raising any issues with them. One person told us, "The manager is very good. They are approachable, friendly and genuine. They communicate with you very well and take action when you ask them to."

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and the manager sought ideas and suggestions on how care and practice could be improved. The manager was described as being open and friendly and there was an open door policy as far as they were concerned. The previous rating for the service was on display on the noticeboard in the entrance hall of the service.

We spoke with staff about the culture of the service and they told us, "It is really nice to work here. It is very open and honest about what we do and there is always someone from the management team about if you need to talk." Staff told us, "[Name of provider] is marvellous. They have time to speak with you no matter what your issue is. They are really, really lovely" and "I would be happy to approach any of the managers if I had any concerns. They like us to put any issues in writing so they can be dealt with appropriately."

Feedback from people who used the service, relatives, health care professionals and staff was usually

obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the manager and where necessary action was taken to make changes or improvements to the service. We found an engaged, friendly and experienced staff team in place.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 17 HSCA RA Regulations 2014 Good governance Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17 (1) (2)