

Milelands Limited

# Holme House Care Home

## Inspection report

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



### Overall summary

The inspection of Holme House took place on 5 October 2015 and was unannounced. We also visited a second time on 14 October 2015, this visit was announced. We previously inspected the service on 1 September 2014 and, at that time; we found the registered provider was not meeting the regulations relating to respecting and involving people who use services, supporting workers, assessing and monitoring the quality of service provision and records. We asked the registered provider to make improvements. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Holme House is a nursing home currently providing care for up to a maximum of 68 older people. The home has three distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 56 people were living at the home.

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

# Summary of findings

People told us they felt safe and staff understood their responsibilities in keeping people safe from the risk of abuse.

Risks to people's welfare had not been robustly assessed and relevant risk assessments had not always been implemented. Although accidents and incidents were analysed the analysis did not take into account the location or time of the accident. A personal emergency evacuation plan (PEEP) had been completed but this was stored on the computer and was not readily available for staff in the event of an emergency. We were unable to evidence that all the staff at the home had participated in fire drill training.

This demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a procedure in place to ensure staff recruitment procedures were thorough and a dependency tool was used to assess the number of staff required by the home.

We saw people's medicines were administered safely and the registered provider had implemented an audit system. However, this audit did not assess all aspects relating to the safe management of people's medicines.

Staff were supported in their role through supervision and training.

Our discussions with the registered manager and staff showed they had an understanding of the Mental Capacity Act 2005 and how they would act in people's best interests if they lacked capacity to consent.

People's feedback regarding the meals they were served was mixed. However, on the day of our inspection we did not evidence any concerns with the meals provided to people.

We have made a recommendation about dementia friendly environments.

Staff were kind and caring. We saw staff respected people's privacy and took steps to maintain people's dignity.

Care plans were detailed and person centred but not all the records we looked at detailed the name of the person or the date. Life history documentation was incomplete in three care plans.

The registered provider had a complaints procedure in place.

The home had an experienced registered manager in post. Feedback from staff about the management of the home was positive and the registered provider had a system in place to continually monitor the quality and safety of the service people received. This included management reports, staff meetings and service user's feedback.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

People told us they felt safe.

Care and support was not always assessed in a way which reduced risks to people's safety and welfare.

Recruitment processes were thorough and medicines were administered safely.

**Requires improvement**



### Is the service effective?

The service was not always effective.

Staff received on going training and support.

We saw evidence that capacity assessments were completed and care plans reflected people's ability to make decisions.

Not all the people we spoke with were complimentary about the quality of the food they were served.

**Requires improvement**



### Is the service caring?

The service was caring.

People told us staff were kind and caring.

We observed staff to act in a friendly and caring manner.

People's privacy and dignity was respected.

**Good**



### Is the service responsive?

The service was not always responsive.

People's care plans provided detailed information about their needs, although there was limited information about people's life history.

There was a complaints system in place.

**Requires improvement**



### Is the service well-led?

The service was well led.

Feedback from staff was positive about the management of the home.

The registered provider had a system in place to monitor the quality of service people received.

**Good**



# Holme House Care Home

## Detailed findings

### Background to this inspection

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

This inspection took place on 5 October 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor with experience in dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in caring for older people. One inspector visited the service again on 14 October 2015.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the local

authority contracting team. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We also used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who were living in the home, five relatives and two visitors to the home. We also spoke with the registered manager, a nurse, a senior carer, two care staff and four ancillary staff. We also spent some time looking at seven people's care records and a variety of documents which related to the management of the home.

# Is the service safe?

## Our findings

People we spoke with told us they felt safe. Relatives also told us they felt their family member was safe. One relative said, “(Name of person) is safe here.” Another relative said, “I can go away at night content, knowing that (relative) is safe and looked after.”

We saw from the registered providers training matrix that of the 63 staff listed, 57 had completed safeguarding training. Each of the staff members we spoke with told us they had completed this training. Staff were able to identify different types of abuse and understood their role in relation to reporting any incidents or situations which may put people at risk of harm. The registered manager told us they also completed role specific safeguarding training with the local authority and were confident in their knowledge of what constituted a safeguarding concern. This showed that staff were aware of how to raise concerns about harm or abuse and recognised their responsibilities for safeguarding people who lived at the home.

We observed staff warning people of possible hazards. For example, one person wanted to go outside, the staff member said, ‘Take care on the decking as it has been raining and might be slippery’. When asked about risk assessment, the nurse we spoke with said, “We assess, we have forms for risk assessments, such as falls. We assess the resident, we need to make sure all measures are put in place to keep people safe.”

Each of the care plans we reviewed contained a number of risk assessments. For example, nutrition, skin integrity, mobility and falls. In two of the care plans we reviewed staff had recorded ‘does not have a falls risk assessment in place at present as this is not necessary’. A further entry on both the care plans noted ‘bed rails and bumpers in place to reduce risk of falls from bed’ and we saw both of these people had bed rails fitted to their beds to reduce the risk of falls from the bed. The care plans for these two people also recorded that they required the use of a shower chair when being supported to shower. Neither of the care plan files contained risk assessments pertaining to the use of this equipment. This meant that risks to people’s welfare had not been robustly assessed and relevant risk assessments implemented.

We reviewed the care file of a person who had moving and handling needs and found information in the risk

assessment to lack the detail required in a moving and handling risk assessment. We also found the moving and handling plan did not provide adequate instructions for staff to follow to ensure the assessed method was utilised. This posed a potential risk that staff might undertake a manoeuvre that was not prescribed for the person being assisted

Equipment was available for people, for example low beds, pressure reducing mattresses and cushions, bed safety rails, movement sensor mats, hoists and ceiling tracking. We observed two pressure mattresses were set in ‘static’ mode. This meant the inflation of mattress cells was not alternating which meant the person may not get the benefit of the pressure reducing system. This may increase the risk of the person developing a pressure sore. Neither person was on their mattress at the time and we brought this to the attention of the nurse and the registered manager.

We saw one person who was sat in an easy chair in a lounge. The chair was not an appropriate size for them as their legs were not supported by either the chair or the floor. They had slipped in the chair and they were in a reclined position. This person used a zimmer frame to mobilise and did not require the use of a hoist. This meant that when staff helped the person to get up from the chair they held the person’s arms to pull them forward. This is not an appropriate moving and handling techniques for staff to use with people due to the risk of harm to the individual and to staff.

During the inspection we observed one person with a large bruise to their temple. We spoke with their relative who said their family member had been provided with a sensor mat to sit on which alerted staff when they tried to mobilise. They said when they visited the home the sensor mat was not always in position on their relatives chair, we checked on the day of our inspection and saw the person was sat on a sensor mat. We reviewed the care plan and saw an amendment had been made which recorded a sensor mat had been put in place, however, this entry was not dated so we were unable to evidence when this was actioned. We reviewed an accident record for this person, dated 26 September 2015 which recorded ‘walked into lounge and found (person) ‘layed on the floor’. This meant the sensor mat had not alerted staff that the person had left their chair and the accident log did not detail if the sensor mat had been in place at that time.

## Is the service safe?

We asked the registered manager how they analysed and reviewed accidents and incidents within the home. The registered manager showed us where all accidents and incidents were logged. This included an individual analysis sheet where trends may be identified. This also included a three monthly review by the registered manager and recorded action which had been taken to reduce future risk to the person. However, we noted that while the location and time of falls were logged on individual records there was not an overriding system in place to review all falls to identify patterns within the service as well as by each individual. This meant there was a risk that opportunities to reduce the risk of people's falls may have been missed.

We asked a member of ancillary staff what action they would take in the event of the fire alarm being activated. They told us they would report to the main entrance where the fire panel was located and the senior person in charge would decide on the course of action to be taken. We asked the registered manager if each person had a personal emergency evacuation plan (PEEP) in place. They showed us a document which was filed on the computer. This meant that in the event of people needing to be evacuated from the building, this information was not readily available for staff.

We saw regular checks were made on the fire detection system and the training matrix recorded that 56 of the 63 staff listed had received fire training. We asked the registered manager if staff attended a regular fire drill. They told us fire drills were completed at regular intervals and we saw one had been completed in June 2015, however, a record was not kept to evidence that all staff employed at the home had attended a fire drill. Staffs participation in regular fire drills helps to ensure they are confident in their role and the actions required of them in the event of a fire.

We asked the registered manager if regular checks were made of water temperatures for all sinks and baths in the home. The registered manager showed us a document which recorded the temperature of some of the water outlets within the home, this was to meet the recommendations of a legionella risk assessment. A water temperature record was not kept for all sinks and baths in the home. If hot water used for showering or bathing is above 44 °C, there is increased risk of serious injury or fatality.

People's safety and welfare was not protected. These examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff files and saw staff members had completed an application form, gaps in employment had been explored and references gained. Potential employees had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. One of the staff files we reviewed was for a member of nursing staff, we saw evidence the registered provider had confirmed their professional registration was current. This showed the provider had ensured staff members were continuing to meet the professional standards that are a condition of their ability to practise.

We asked a number of the staff we spoke with if they felt there were enough staff on duty to meet people's needs. One staff member told us they felt there were enough staff on duty to meet people's needs. They said that in the event the home was short staffed and their own staff could not cover the shifts then agency staff were used. The nurse we spoke with told us a dependency tool was used to decide the number of staff required for the home, this was confirmed when we spoke with the registered manager. The registered manager also said they were supernumerary and the deputy manager also had a number of allocated supernumerary hours each week to enable them to fulfil their management duties. They also said a staff member was also allocated to be a 'floater' on a daily basis. They explained this person was there to provide support where needed which included providing cover on the different units when staff were taking their breaks.

The registered manager showed us a week's duty rota which also provided evidence of the dependency tool which was used to assess the number of staff hours required. While we noted this incorporated a number of physical tasks people may need support with, the tool did not reflect the particular needs of people who were living with dementia. For example, supporting people who may be resistive to care interventions by staff. This meant there was a risk the dependency tool was not an accurate reflection of people's holistic care and support needs.

As part of our inspection we reviewed how people's medicines were managed. One person we spoke with said,

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"I get my medicines on time." We saw a monitored dosage system (MDS) was used for the majority of medicines with others were supplied in boxes or bottles. We checked a random selection of three people's boxed medicines and found the stock tallied with the number of recorded administrations. We saw a stock balance sheet was in place for all boxed medicines. A member of staff told us this helped to reduce the risk of errors in the administration of people's boxed medicines.

We checked one box of eye drops and saw the date of opening had been annotated on the pharmacy label. This ensured medicines with a limited shelf life were not used when they may no longer be effective. We saw a record was maintained on one of the units for the temperature of the room where people's medicines were kept. This was to ensure the medicines were not being stored at a temperature which may reduce their effectiveness. On another unit we saw the record had not been documented for five out of fourteen days. Although the temperature of the room did not feel to be unsuitable for the storage of medicines.

We asked two staff members whose remit was to administer medicines if they had received training. They both said they had. When we reviewed staff personnel records, we noted two of the staff were responsible for administering people's medicine. We saw evidence they had completed recent training and had their competency assessed. This meant people only received their medicines from people who had the appropriate knowledge and skills.

Our inspection on 1 September 2014 found the registered provider did not have a documented system in place to identify any concerns or discrepancies in the management of people's medicines. On this visit we saw regular audits were carried out to by the deputy manager to ensure the records for the stock for controlled and boxed medicines tallied with the number of recorded administrations. However, the audit system did not evidence that checks had been made on any other aspects of medicine management, for example, receipt, storage, disposal and other aspects relating to the recording of medicines on people's MAR's.



# Is the service effective?

## Our findings

Our inspection on 1 September 2014 found the registered provider was not meeting the regulations regarding supporting workers. On this visit we checked and found that improvements had been made.

Staff we spoke with told us they had received training in a variety of topics. This included moving and handling, infection prevention and control, first aid and dementia care. This was confirmed when we reviewed four staff training records and the registered providers training matrix. We saw the matrix listed each staff member and their role. The matrix also detailed the name of the course and the time frame in which the course required a refresher to be completed.

Each of the staff we spoke with confirmed they received regular supervision with their manager. One staff member told us when had their supervision they had discussed their training needs and they had been given the opportunity to discuss any concerns they may have had regarding the home. Another staff member said, “It’s a good place to work, I feel supported.” We saw documented evidence in each of the four staff files we reviewed that regular supervision had taken place. This showed that staff were now receiving regular management supervision to monitor their performance and development needs.

We spoke with one staff member who had told us they had received an induction when they commenced employment at the service and had shadowed a more experienced member of staff for a couple of shifts. We also saw documented evidence in each of the four staff files that staff had received an induction. This demonstrated that new employees were supported in their role.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff we spoke with told us they had completed training in MCA and DoLS. When we looked at the registered providers training matrix we saw 80% of staff had attended training in this subject. One of the staff we spoke with told us some staff had felt they needed extra support to fully understand

this legislation and how it impacted upon their role. They said the registered provider had arranged some extra support sessions for staff to attend to enable further discussion and learning. This demonstrated the registered provider was supporting staff in their role.

A nurse told us, “Every person has mental capacity until it is proved they don’t. “The nurse also went on to explain about making decisions in people’s best interest and how people could be supported with the decision making process. This demonstrated the nurse had understanding of mental capacity and how decisions might be made in someone’s best interest if they lacked capacity. A member of care staff said the MCA was about, “If people have the capacity to make decisions. If they can’t make a decision, we do an assessment of them.” They told us about one person they supported who had a DoLS in place and the reason for the restriction.

The registered manager told us they had completed training in MCA and DoLS with the local authority. They told us they had begun to submit DoLS application to the local authority. They said some applications had been approved and they were awaiting feedback regarding other applications. This showed that although some people had been deprived of their liberty, the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person’s rights were protected and was awaiting the outcome of other applications.

We reviewed the care plan for one person and saw an assessment of their capacity had been completed. This recorded their capacity in relation to making decisions about their daily care and support needs and noted that extra support would be needed for this person to make more complex decisions. This evidenced that people’s care and support was planned in line with the MCA 2005.

When we asked people about the meals at Holme House, feedback was mixed. One person said, “Broccoli only needs a couple of minutes but they boil it to death and it just falls through your fork it’s so mushy.” Another person told us, “I enjoyed the dinner today but the food varies. Sometimes it’s good sometimes it not so good. I’ve never eaten so much corned beef since I came here. I don’t really like the teas. You’re ok if you like pie and peas and watery soup but I don’t.” People also gave negative feedback about how meals were served to them. One person said, “I like hot food to be served on hot plates. They say they can’t do that



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because people might burn themselves but plates could be warmed rather than stone cold.” And, “I don't like the way they serve the food on the plate. They just slap it on. You'd think we were in prison.”

However, another person said “The foods great and I've got a good appetite. If I didn't like the choice I would ask for a sandwich. You can always ask for more. A relative we spoke with said, “(Family member) is well fed and they eat what they like.”

The registered manager said that as part of their quality assurance programme a member of the management team would eat lunch once a month with people who lived at the home. They said this was not announced to any staff in advance and they ensured they reviewed this across each unit. We saw a record which detailed the date, name of the unit, identity of the staff member and the feedback given to relevant staff regarding their findings. This demonstrated the registered manager had a system in place to review the meal service provided to people and make suggestions for service improvement.

On the first day of the inspection, the expert by experience ate lunch with people who lived at Holme House. They were served pork steak with cabbage, carrots, corn, mashed potato and gravy. The meat was tender and the vegetables, although soft were not mushy. Dessert was sponge and custard, this was light and of an appropriate texture.

Each unit of the home had a kitchenette area which enabled staff to provide drinks for people throughout the day. The kitchen staff told us they went to the units to serve lunch while the care staff served breakfast and tea. We asked the kitchen staff how they got to know if a new person came to live at the home or if there were any changes to people's need. They showed us a file which contained a record of each person's dietary needs, likes and dislikes. They said this was supplied to them when a new person was admitted to the home and either the nurses or care staff updated the record if people's needs changed. This evidenced the catering team were provided with the relevant information to enable them to support people's individual nutritional needs.

On each unit we observed staff offering people a choice from the menu. We saw one person could not decide and was served a small portion of each option on the menu for them to try. One staff member said, “Its only right we offer a choice, not everyone wants the same.”

People who required support to eat and drink where assisted and people were given sufficient time to finish their meal. However, we observed one person who was sat in a specialist chair. They were served their meal on a table at the left hand side of them yet we observed the person eating with their right hand. This meant they had to stretch over to enable them to eat. We saw them eating their meal using their fingers. A member of staff provided the person with a spoon. We asked the staff member if this was how the person was usually served their meal. They said there was a table which went ‘right up to the chair’, but this was not put in place by staff. There was no plate guard on the table to enable the person to scoop the food on to their spoon and after a short period of time we saw the person put the spoon on the table at begin to use their fingers to eat again. This showed this person had not been provided with adequate support to eat their meals in way which promoted their dignity and independence.

One person we spoke with said, “I make my own appointments for the chiropractor. I can have her visit whenever I want.” Another person told us, “I went to the dentist last week.” We saw evidence in each of the care plans we looked at that people received input from external health care professional. For example, the GP, optician, physiotherapist and dietician. In one person's record we saw an entry which noted an occupational therapist had visited the person in May 2015 but had not been able to complete the assessment as the person was drowsy. The notes recorded they intended to return the following week but we were unable to evidence this. We spoke with the registered manager and they assured us they would follow this up.

Holme House had three separate units. Memory Lane supported people who were living with dementia and the décor was styled to meet their needs. Bedroom doors were painted in various colours and the name of the person who lived in that room was displayed on the door. There were also memory boxes outside each bedroom. A memory box can prompt a person to recall people and events from the past, enabling conversation with staff, families and visitors. Toilet and bathroom doors were painted yellow and doors

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which were not accessible to people who lived at the home were painted to blend in with the wall colour. Handrails were also painted in contrasting colour to the walls to enable people to see them more clearly. At the end of one of the corridors there was a garden bench to enable people to sit down. In one of the communal toilets the seat colour was in a contrasting colour, this helps to draw people's attention to the key features of the room.

There was lack of directional or pictorial signage for people throughout the home, to point people towards, for example the toilet or lounges. However, Red House Road and Oakwell Avenue had some signage on the walls which indicated the location of people's bedrooms. We recommend that the service finds out more about dementia-friendly environments in relation to the specialist needs of the people who were living at the home.

# Is the service caring?

## Our findings

Our inspection on 1 September 2014 found the registered provider was not meeting the regulations regarding respecting and involving people who use services. On this visit we checked and found that improvements had been made.

People told us staff were caring and kind. One person said, "I'm always having to go to the toilet and they help me. I don't know what I'd do without them." A relative we spoke with said, "I've never missed a day. I feel that (relative) has been well looked after and they spoil them rotten. They are really well looked after. I can't complain." Another relative's comment was, "I was very satisfied with the way they looked after my (relative)."

People's feedback was generally positive, however, one person said, "It's alright. Some of the young staff think that because you're old you don't have your wits about you. It could be better." A relative also told us, "Sometimes when I come my (relative) has food debris on their face. I wish they would run a comb through (relative's) hair to make them look better presented."

During the time we spent at the home we observed staff to be pleasant, helpful and friendly. We saw examples of staff bending down to be at the person's eye level when speaking with them and explaining. This demonstrates respect towards the person you are speaking with and enables people to feel staff are paying them their full attention.

We spoke with one staff member about one person's needs. They demonstrated knowledge and understanding of the person's individual needs. However, they referred to people in terms of 'singles' or 'doubles'. While we did not hear this being communicated in the public domain this staff member referred to people as tasks and not as named individuals with specific care and support needs.

Throughout the day we saw staff knocking on people's doors prior to entering and doors being closed prior to any personal care being commenced. Staff also told us they ensured they closed people's curtains when they were providing personal care and they checked people who were supported in bed regularly throughout the day to ensure their dignity was not compromised. Information was on display throughout the home giving advice to people and staff about the importance of maintaining people's dignity.

The nurse told us they encouraged people to do things for themselves. For example, when showering people they said staff would encourage people to wash themselves as much as possible. Enabling people to maintain their independence where possible can improve people's quality of life.

Each of the care files we looked at contained a document signed by either the person or their family member which confirmed their agreement for information relating to their health and social care to be shared with other health care professionals. We saw documents relating to people's care and support were not left in public areas. This showed staff ensured confidential information was not left where unauthorised people may have access.

# Is the service responsive?

## Our findings

Two people spoke positively about the activities provided for people. One said, “We do a lot of things here. The activity coordinator is very good. There's something going on all the time. We are making papier mache balloon Christmas decorations at the moment.” Another person said, “We do well for activities when (staff name) is here.” They also added that when the activity person was not on duty there were no activities.

On the day of our inspection we saw a visitor who had brought two dogs to the home. They told us they let people stroke the dogs. We also saw information in the home about a Pets as Therapy (PAT) dog who visited the home. There was also a fish tank in Oakwell Avenue's lounge for people to watch.

There were displays around the home showing the events that have taken place. For example, owls had visited and the care home had incubated its own chickens in 2014. There was a display about Yorkshire and another about knitted squares to show the different knitting stitches used. We also saw a notice which congratulated the winner of a recent ten pin bowling competition.

Our inspection on 1 September 2014 found the registered provider was not meeting the regulations regarding records. On this visit we checked and found that some improvements had been made although we still saw examples where recording of information required further improvement.

We saw some documentation did not record the person's name or the date. For example, one person's medicine risk assessment was not dated but there was no designated place on the document for staff to record this information. Observations records for another person did not record the person's name on two of the five documents we looked at. We looked at the food records for one person and saw that while staff recorded how much food the person consumed, the document did not record how much they had been given. For example, they ate all the sandwiches they had been given but we were not able to evidence if this meant they ate one sandwich or three.

The care plans we looked at contained a document where people's life history could be documented but the

information which was recorded in three of the plans was very limited. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences. Life history can also aid staff's understanding of individual personalities and behaviours.

Each care plan we looked at was organised and documents were easily located. The information was written in a person centred way and provided detailed information about the individuals care and support needs, including their personal preferences.

Care plans were reviewed on a regular basis. One relative told us, “I am invited to my (relatives') reviews.” At the front of each care file there was a care plan and risk assessment evaluation sheet. This recorded the date, details of the review and a number which identified which care plan had been reviewed. As the risk assessments in peoples care plans were not individually numbered, we were unable to clearly evidence that they had also been reviewed on a regular basis.

We asked one of the relatives we spoke with what they would do in the event they were not happy with any aspect of the care provided. They said, “If I wasn't happy I would let the staff know and I would feel they would take me seriously.” One relative was very concerned that they were constantly purchasing underwear and nightclothes for their relatives as it was always ‘going missing’. They said, “I get exhausted mentioning about the laundry situation.”

The nurse we spoke with said people were free make complaints, they said no one had raised a complaint with them but they said in the event someone did, they would aim to resolve the issue and report it to the registered manager.

The registered provider had a complaints procedure, this included information on how to raise a complaint and the time frame for the registered provider to respond. We looked at the complaints log and noted each entry detailed the date, details of the complaint and the action taken by the registered manager to address the issues. We did not see evidence the relatives concerns regarding the missing laundry were logged. This meant that not all concerns may be getting reported to the registered manager.

# Is the service well-led?

## Our findings

Our inspection on 1 September 2014 found the registered provider was not meeting the regulations regarding assessing and monitoring the quality of service provision. On this visit we checked and found that improvements had been made.

The home had an experienced manager in post who had been employed at the home for five years. They were knowledgeable about the people who lived at the home and their staff.

One person we spoke with said, “The managers alright.” One of the relatives said, “Staff turnover has been much higher recently. There are some lovely delightful staff. The management has been consistent. They are approachable and they act.”

Staff told us they felt supported by the management at the home and felt they were involved in the development of the service. Staff also told us they felt comfortable in raising concerns they may have with the management team. This demonstrated there was an open and transparent culture at the home for staff. The nurse said, “We work as a team, from the beginning of the shift to the end.” Another staff member said, “We see (name of manager) all the time, walking around the building, they are very supportive.”

Staff told us staff meetings were held at the home, one said, “We have regular meetings to air our views.” We saw minutes of staff meetings, these included general staff meetings and meetings aimed for nurses and senior carers. We saw minutes included discussions around care delivery, communication and infection prevention and control. The registered manager told us a daily meeting was held at 11am each day. They said this was an opportunity for senior staff to share relevant information.

The registered manager told us they conducted random, unannounced night visits to the home. We saw these visits were logged and detailed the findings and action taken as a result of the findings. We also saw evidence the registered provider visited the home on a regular basis. We saw the report generated from their visit in March, July and September 2015. The registered manager showed us an in depth audit which had been completed by the area

manager in February 2015. They showed us the action plan which had been developed following the audit and we saw identified issues were signed off to confirm they had been addressed.

Random audits of peoples care plans was completed on a monthly basis. The registered manager said these were done by themselves and the deputy manager and they aimed to audit seven plans per month. We saw evidence of the audits which had been completed for September 2015, where issues were identified, and these were signed and dated to evidence the actions had been completed. The registered manager said the audits had identified issues with documentation relating to the MCA and this had led them to review this aspect of the care planning process.

The registered manager showed us an audit of people’s bedrooms which was completed by the housekeeper each week. The registered manager said any issues identified in this audit were then fed back to the relevant staff, for example the domestic or maintenance staff. Regular documented checks were also completed on the passenger lift, window restrictors and pressure mats. A monthly check was also made to ensure the nurse call system was functioning. This audit did not clearly evidence that staff had ensured the call system was fully functioning in both the person’s bedroom and en-suite. We brought this to the attention of the registered manager to enable them to improve the document.

We saw a notice on display advertising dates in 2015 for resident meetings and we looked at the minutes for meetings held in March and September 2015 the minutes included discussions about potential trips out and menus at the home. We also saw minutes relating to a relatives meeting held in April 2015.

In July 2015 52 surveys had been issued to people who lived at the home or, where appropriate, their relative. The majority of the feedback was positive, there were only four negative comments. One related to concerns regarding maintenance issues, we saw each issue had been signed as having been addressed on the survey form. The demonstrated people were asked for their views about their care and support and their comments were acted upon.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>People's safety and welfare was not protected.</b>
Treatment of disease, disorder or injury	<b>Regulation 12 (1) (2) (a) (b)</b>