

Alhambra Care Limited

Elm Lodge Residential Care Home

Inspection report

Cluntergate
Horbury
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Tel: 01924262420

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 21 June 2016. The inspection was unannounced which meant the staff and the registered provider did not know we would be visiting.

Elm Lodge Residential Care home provides accommodation and personal care for up to 17 older people. Respite care is also provided. The home is arranged over two floors with bedrooms on each floor. In the grounds of the home there is a car park and a patio area. The centre of Horbury and local amenities are several minutes away.

The service was last inspected in April 2014 and they were in breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010

Assessing and monitoring the quality of service provision registered person did not protect service users, and others, against the risks of inappropriate or unsafe care and treatment by operating an effective system to regularly assess and monitor the quality of the service provided; and did not operate an effective system to identify, assess and manage risks relating to the health welfare and safety of service users and others. Regulation 10(1)(a) and (b). The registered person did not analyse incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10(2)(c)(i). At this inspection we found accidents and incidents were monitored and analysed each month to see if any trends were identified. Where needed the relevant people were contacted for example the falls team. The registered manager carried out regular audits. However, none of the audits had picked up on the concerns we raised. Therefore we would question the effectiveness of these audits.

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

We looked around the service and found that where window restrictors were in place these could easily be removed or were broken. One upstairs window had no window restrictor and could be fully opened. We tried to check a window in a person's room but they became upset and asked us not to touch it as it was broken and the last time someone had tried to open the window it was difficult to fix and they were cold enough. Two people who mainly stayed in their rooms upstairs complained it was cold on the day of inspection. Some windows did have gaps of up to an inch wide which would cause drafts. We pointed these out to the registered manager.

We found issues around the cleanliness of the service. We found some areas could do with a deep clean. The bath also had a large hole around the edge where the side of the bath seemed to have slipped. In one room the carpet had been torn up by placing the bed therefore could not be properly cleaned and posed an infection control issue. In another room there was a hole in the carpet which could present a trip hazard.

A new stair lift had recently been fitted, this obstructed the bannister on the stair case and there was no handrail on the opposite wall. This could prove difficult for people who used the stairs not the stair lift.

Water temperatures were recorded as being too low. The registered manager carried out fire drill scenarios where staff could discuss what could happen. However no actual fire drills took place. We found the Personal Emergency Evacuation Plans (PEEP's) did not contain enough information and the summary of people who used the service was out of date.

The service had purchased some new sit on weighing scales. However there was no evidence that these had been calibrated.

Staff we spoke with knew how to administer medicines safely and the records we saw showed that medicines were being administered and checked regularly. However the key to the treatment room was hung up outside which meant that everyone had access to it. The keys for the medicine cupboard and controlled drugs cupboard were left in a tub on top of the trolley. This meant that once someone had access to the treatment room they also had access to all the medicines. We highlighted this straight away to the registered manager who removed the key from outside and made sure the keys were kept with the designated person. Temperatures were not taken daily of the room the medicines were stored; therefore we could not guarantee the medicines were stored at the correct temperature which is not above 28 degrees. At the time of our inspection the room felt very warm.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were protected. Where appropriate, the service had not always worked collaboratively with other professionals to act in the best interests of people who could not make decisions for themselves.

People were supported to maintain their health through access to food and drinks. The majority of people were happy with the food on offer and they were provided with plenty of choice.

Staff we spoke with understood the principles and processes of safeguarding. Staff knew how to identify abuse and act to report it to the appropriate authority. Staff said they would be confident to whistle blow [raise concerns about the service, staff practices or registered provider] if the need ever arose.

The registered provider followed safe processes to help ensure staff were suitable to work with people living in the service.

There were sufficient staff to provide the support needed and staff knew people's needs well. However staff we spoke with said they found it difficult to provide support to people at teatime when there was no cook on duty.

We saw that all people who used the service had access to an advocate if needed and information was available. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. At the time of inspection no one was using an advocate.

We found care plans to be person centred. Person centred planning [PCP] provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person.

Activities took place between 2:00pm and 4:00pm each afternoon. The service had a file on what activities had taken place and how much people enjoyed them. One to one activities also took place.

The service worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met.

The service had an up to date complaints policy. Complaints were properly recorded and fully investigated.

Staff felt supported by the registered manager.

Feedback was sought on a regular basis from people and their relatives on the quality of the service.

Staff and people who used the service had regular meetings.

The registered manager understood their roles and responsibilities, and felt supported by the registered provider.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Not all risks to people were identified and recorded. People were not always protected from the risk of unsafe or unsuitable premises.

Systems were in place for the management of medicines so that people received their medicines safely. However medicines were not stored safely.

There were enough staff on duty. However staff felt under pressure at teatime. Staff were suitably trained. Staff were recruited safely.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected. However people classed as not having capacity had not had capacity assessments.

Staff were supported through a regular system of supervision and appraisal, and received regular training.

People were supported to maintain a healthy diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good ●

The service was caring.

Staff knew people well and demonstrated a very kind and caring approach

People were treated with dignity and respect.

People were encouraged to remain independent.

The service supported people to access advocacy services.

Is the service responsive?

Good ●

The service was responsive.

Care plans provided information on person-centred care and were reviewed regularly.

Activities took place and were analysed to see how popular they were.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Quality assurance checks were undertaken on a regular basis. However the checks did not highlight the issues we found

Staff felt supported by the registered manager.

Feedback was sought from people and their relatives on the quality of the service.

The registered manager understood their roles and responsibilities.

Elm Lodge Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 June 2016 and was unannounced. This meant the registered provider did not know we would be visiting

The inspection team consisted of two adult social care inspectors.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we spoke with eight people who lived at the service. We looked at three care plans, and four people's medicine administration records (MARs). We spoke with seven members of staff, including the registered manager, deputy manager, senior care staff, three care staff and the cook. We spoke with one visiting relative. We reviewed four staff files, including recruitment and training records. We spoke with the registered provider via the telephone after the inspection.

We also completed observations around the service and in communal areas

Is the service safe?

Our findings

The service was last inspected in April 2014 and they were in breach of regulation 10 HSCA 2008 (Regulated Activities). The registered person did not analysis incidents that resulted in, or had the potential to result in, harm to a service user. At this inspection we found the service recorded accidents and incidents in an accident/incident log and these were analysed monthly. Any actions that were triggered by the accidents or incidents were clearly recorded and referrals sent to the relevant team such as the falls team. This meant that there was an effective monitoring system in place that would identify any trends or action needed and thereby keep people safe from the risk of accidents. At the time of the inspection the accident and incidents were very few.

People we spoke with said they felt safe living at the service. One person said, "I feel safe, staff take all the precautions to keep us safe." Another person said, "I do feel safe here. The doors are locked and people have to ring the bell and say who they are before they come in."

A relatives we spoke with said, "Yes [person's name] is safe, nothing is too much trouble for them [staff]."

Staff we spoke with said, "People are safe here, we do our best to make sure they are safe."

We looked around the service and found that where window restrictors were in place these could easily be removed or were broken. One upstairs window had no window restrictor and could be fully opened. This was a risk to people who used the service as they could have easily climbed out of the window onto the roof below and fell to the ground floor. Health and safety executive (HSE) states 'Serious injuries and fatalities have occurred when people have fallen from or through windows in health and social care premises. Windows that are large enough to allow people to fall out should be restrained sufficiently to prevent such falls. The opening should be restricted to 100 mm or less. Window restrictors should only be able to be disengaged using a special tool or key.' We asked the registered provider to action this immediately and we followed this up after the inspection. We were told that the windows had been secured and new window restrictors would be fitted by Monday 27 June 2016. We were provided with evidence that this had taken place on the 24 June 2016.

We tried to check a window in a person's upstairs room but they became upset and asked us not to touch it as it was broken and the last time someone had tried to open the window it was difficult to fix and they were cold enough. We reassured the person that we would not open the window. On the day of inspection two people who mainly stayed in their rooms upstairs complained it was cold. Some windows did have gaps of up to an inch wide which would cause drafts. In one of these rooms we were told the thermostat on the radiator was broken. We pointed this out to the registered manager.

We found issues around the cleanliness of the service. We saw faeces under a bath hoist chair and we also saw faeces on a person's bedding in an upstairs room. The floor around the toilet in this bathroom was very dirty with debris around the base of the toilet. There was an empty box that had contained personal protective gloves but no other gloves were in situ. We found some areas were in need of a deep clean. The

bath also had a large hole around the edge where the side of the bath seemed to have slipped. In one room the carpet had been torn up by placing the bed therefore could not be properly cleaned and posed an infection control issue. In another room there was a hole in the carpet which could present a trip hazard. The registered manager said they were planning on getting new carpets and also arranged for a deep clean to take place on the 28th June 2016.

A new stair lift had recently been fitted, this obstructed the bannister on the stair case and there was no handrail on the opposite wall. This could prove difficult for people who used the stairs not the stair lift as there was no handrail to support themselves and if they lent over the stair lift to reach the bannister this could be a falls risk. The registered manager followed this up to say a new handrail had been added to the homes maintenance schedule and a risk assessment was now in place.

A person who used the service had complained that the water temperature in their room was cold. The registered manager had taken the water temperature every day for about a month and the outcome was you need to run the water for ten minutes to get it to a good temperature. The temperatures the registered manager had recorded were also low but we could not see evidence that anything had been done about it.

Water temperatures were recorded as being too low. The temperature of the bath was 37.4 degrees Celsius. Thermostatic Mixing Valve Manufacturers Association (TMVA) recommended that temperatures should be between 41 and 44 degrees Celsius. We tested the hot water and it took a good ten minutes for the water to become warm. The service's legionella testing was due in March 2016, this had not taken place. One relative we spoke with said, "I am planning on bringing a flask of hot water in so they [relative] can wash their hands." We discussed this with the registered manager and questioned whether people should wait ten minutes to wash their hands. The registered manager said, "This is an historic matter for our residents who do not want to wait 10 minutes they are offered a bowl of warm water or water up to temperature requirement. Alcogel is also available in every room should a resident want to immediately clean their hands." However we did not see evidence of this on the day of inspection.

The registered manager carried out fire drill scenarios where staff would discuss what could happen. However no actual fire drills took place. One person who staying in their room upstairs struggled with mobility, this person's personal emergency evacuation plan (PEEP) stated, in the event of a fire to mobilise with one staff member and zimmer frame. At the time of inspection this would have proved extremely difficult. The registered manager said this person is up and down with their mobility. The PEEP should reflect this and state how to support evacuation when their mobility was not good. We found the PEEP's did not contain enough information and the summary of people who used the service was out of date.

Staff we spoke with knew how to administer medicines safely and the records we saw showed that medicines were being administered and checked regularly. We observed part of a lunch time medicine round and saw that medicines were administered and recorded safely.

Medicines that are liable to misuse, called controlled drugs were stored in a locked cupboard within a locked cupboard and correct records for administration were in place. However the key to the treatment room was hung up outside which meant that everyone had access to it. The keys for the medicine cupboard and controlled drugs cupboard were left in a tub on top of the trolley within the treatment room. This meant that once someone had access to the treatment room they also had access to all the medicines including controlled drugs. We highlighted this straight away to the registered manager who removed the key from outside and made sure the keys were kept with the designated person.

We looked at people's medication administration records (MARs). A MAR is a document showing the

medicines a person has been prescribed and recording when they have been administered. Medicines that were discontinued were still left on the MAR chart and new medicines which had started mid cycle were missing from the MAR charts. The missing items had to be handwritten on the MAR and each month the discontinued items had to be crossed off the MAR chart. This meant that due to the pharmacy not providing accurate up to date records there was a potential for errors. The registered manager said they would discuss this with the pharmacy.

The service had no individual protocols for "when required" medicines (PRN), explaining why, when and how each PRN should be administered. This information is important, to ensure that staff can make safe decisions about when PRN medicines are needed and how they should be used. The service did keep records of PRN stock.

Whilst checking the stock for one person's medicine we could not find the full stock that was documented on the MAR chart. The senior carer said they were probably stored in the registered manager's office. We checked with the registered manager who said that excess medicine was stored in a locked cupboard in the office. This cupboard also contained other items such as files etc. The registered manager said they kept excess medicines in here so they could keep control of stock and prevent overstocking. We discussed finding an alternative storage area as this cupboard was used daily for other items such as files. This meant that the medication could be accessed by everyone.

Temperatures were not taken daily of the room the medicines were stored in or the office where excess medicines were stored, therefore we could not guarantee the medicines were stored at the correct temperature which is not to go above 28 degrees Celsius. The medication policy needed updating to reflect the service's medication procedures and The National Institute for Health and Care Excellence (NICE) guidelines.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Risks to people were assessed and plans put in place to minimise the chances of them occurring. Risk assessments were in place for wheel chair use, falls and diabetes. The risk assessment documented what the potential risk was and the agreed action to prevent the risk. Where one person was at risk of a diabetic coma, full information on the signs and symptoms of a hyperglycaemic or hypoglycaemic attack was documented.

We looked at the recruitment records of four staff. We saw evidence that pre-employment checks had been undertaken prior to staff starting work. Application forms were fully completed. We saw a Disclosure and Barring (DBS) checks had been carried out for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with children and vulnerable adults.

Through our observations and discussions with people and staff members, we found there were sufficient staff to meet the needs of the people who used the service. However, staff raised concerns around tea time staffing. At the time of the inspection there were 16 people who used the service. We saw duty rotas which confirmed that there were one senior carer and two carers per shift plus the registered manager and head of care. A domestic was on duty from seven to eleven am and after that it was the responsibility of the staff to support with cleaning and laundry. Staff said this was no problem although the registered manager may want to look at staffing levels due to the issues we found around cleanliness. The cook finished their shift at

3pm, before finishing they prepared sandwiches and soup for the teatime meal. Staff on duty at teatime found the extra pressure of offering choice such as egg on toast difficult. On the day of inspection one staff member was in the kitchen heating soup, frying and scrambling eggs, another staff member was providing drinks which left one staff member to assist people and support where needed. Staff we spoke with said, "I believe we need a cook until 5pm. We're rushed off our feet at teatime. It's really hard to do meals, see to residents and assist with feeding." And another said, "Sometimes there is not enough staff on duty the cook leaves at three and it puts extra pressure on." We discussed this with the registered manager who said they would look into it.

Staff demonstrated a good knowledge of safeguarding procedures. They were able to describe types of abuse, the signs to look for and the correct action to take.

The service had a whistleblowing policy that was available to staff. Whistleblowing is when a person tells someone they have concerns about the service they work for. The policy included clear instruction on raising a concern internally and externally with full contact details. One staff member we spoke with said, "I'd whistle blow if I saw anything. I'd go through the right procedure, obviously, if I saw something. I'd definitely go to the manager if I had to."

The service had an up to date business continuity plan. This meant if an emergency was to happen the service was prepared.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were protected. Where appropriate, the service had not always worked collaboratively with other professionals to act in the best interests of people who could not make decisions for themselves. At the time of inspection one person was subject to a DoLS authorisation. Another person's care file we looked at stated throughout that they did not have capacity. During a review in February this year it said a DoLS was to be submitted. However there was no evidence of this. On every care plan for this person it stated "[Person's name] is unable to retain information or make their own decisions. " and "Staff to gain consent or make a best interest decision to enable i.e. personal care interventions. However we could see no evidence that an MCA assessment had taken place or a best interest meeting. Therefore we could not evidence how these decisions had been made. This practice did not follow the registered providers internal policy.

Staff had received training on MCA and DoLS but could not demonstrate a clear understanding of the basic principles of the Act. Staff we spoke with said, "DoLS and MCA is if people can't make decisions we make them for them." And another said, "DoLS is making a best interest decision for the person who can't make a decision themselves."

There was some evidence within care plans of consent being sought prior to care being given. However, consent was not sought or documented for all care needs, for example the use of bed rails or sharing a room. We also saw consent signed by a family member but there was no evidence the family member had power of attorney over health and wellbeing.

These findings evidenced a breach of Regulation 11 (need for consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014

At the last two inspections we had identified bedrooms looked in particular need of refurbishment. The previous registered manager informed us the registered provider had improvement plans in place to update the bedrooms and bathrooms within the home. We asked the registered provider to send us a plan regarding the improvement works and anticipated timescales. We received this information which detailed that a full refurbishment would be completed in 2013. We found this had not happened and the registered

provider had not informed us of this.

During this inspection we found the building was old and a number of areas were in need of repair, the decor was also in need of updating. Some people whose rooms were on the first floor complained that their rooms were cold and we saw that one radiator was not working. The registered manager said she was aware of this and was arranging for it to be fixed. A window on the landing had dropped within its frame leaving a one inch gap that would cause significant draft. In some places the floor was uneven which could result in a trip hazard, particularly for those people less steady on their feet. The registered manager provided a risk assessment that was in place for the uneven floors. A relative said they were planning on decorating the bedroom for their relative themselves and planned to take the curtains home to wash. The relative was also looking to buy a heater to keep their relative warm. We discussed with the registered manager whether they felt this was the family's responsibility. The registered manager acknowledged that the registered provider was responsible for this type of maintenance but said that the family did not want to wait for the planned refurbishment.

These findings evidenced a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

People were supported by staff with the knowledge and skills they required to carry out their role.

The registered manager provided information on recent training and we saw certificates in the files we looked at to evidence this.

Staff received support through regular supervision and annual appraisals. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff we spoke with found the supervisions to be useful. One staff member said, "If we have any concerns then that is our time to bring them up, our chance to have our say." Discussions at supervisions included training, medicines, fire procedures and any concerns the staff member may have.

New staff undertook an induction process. The service recognised that new staff need close supervision and support throughout the 12 week induction period. Therefore they had a 'safe to leave' policy which stated that before a new member of staff was allowed to work on their own or with experienced colleagues the service carried out a full assessment of their competency to do so. New staff also worked towards the care certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. This covered 15 standards of health and social care topics. One staff member said, "I have just done my NVQ level 2 in medicines, I shadowed other staff as part of my induction and I have done all the booklets."

We saw evidence that people were seen by health professionals such as dentists, opticians and district nurses. People had a hospital passport. The aim of a hospital passport is to assist vulnerable adults and to provide hospital staff with important information about them and their health if they are admitted into hospital.

We asked people who used the service what they thought of the food on offer. People we spoke with said, "The food is good. There's always something that takes my fancy and if not they will find something for me." However another person said, "They are always serving up salty gammon. The food is absolutely rotten, everything is on the cheap."

A relative we spoke with said, "My relative has struggled with the food, it was not hot enough, but they put it

in the microwave now to warm it though and that is fine."

The kitchen currently has a three star hygiene rating from environmental health. This was due to the incorrect storage of food and cleaning issues. We were told a new cleaning regime had been put in place since receiving this rating. The cook had completed food hygiene training. The statement of purpose we were provided with on the 21 June 2016 stated that the service had a food hygiene rating of five, the highest attainable rating. We recommended that this was updated immediately. We were since sent an updated version.

People were offered a choice of food. On the day of inspection the choice was fish or sausage casserole. If people did not like what was on offer they could chose something else such as an omelette, or jacket potato. The cook told us that they go around the service at 11am to ask people for their lunchtime menu choices. They then go around again ten minutes before lunch is served to check that people haven't changed their minds. Two plates of food are prepared so that people can be shown the options to help them choose. We observed a lunch time meal and saw people were not provided with the two plates to offer choice. However, nobody complained about what they were offered. A menu for the full week was on the table and a picture board menu was also on display in the dining room. The cook told us, "We try to cater for what people want. I'm quite up on what people like and what they don't like."

People had choice where to eat their meals. The majority of people came to the dining room but three remained in the lounge and two people preferred their meals in their rooms. No matter where they ate people were offered condiments.

People also had choice around the time they had their meals. The cook said she would make a fresh meal for someone rather than keeping a meal warm if they wanted their lunch later for example.

The cook said that the menu was updated every six months and they have tried to introduce new things but the traditional dishes go down best with people. The cook said, "Things like curry aren't popular so we stick with what they know."

The cook was knowledgeable about any special dietary requirements people had. They explained how they fortified food with full fat milk and cream for those who need extra nourishment. Low sugar biscuits, jams and marmalades were available for diabetics. One person needed fork mashable food and we saw comprehensive information on this in a file that was kept in the kitchen. Two people needed a pureed diet and the cook explained how every item is pureed separately and presented as nicely as possible. They had requested moulds to assist with presentation for pureed food and was hoping to have the budget for these agreed in June 2016.

Staff demonstrated knowledge of people's dietary needs. One staff member said, "[person's name] has soft food and needs a thickener in their drinks." The staff member could explain how much thickener was needed.

We did see appropriate dementia signage around the service. Signage can help those with declining cognitive ability to make the right decisions when finding their way around an interior, as well as feeling informed and aware of where they are. This meant the environment supported and enabled people living with dementia.

Is the service caring?

Our findings

We asked people what they thought of the staff. One person said, "The staff are wonderful." Another person said, "Staff are lovely, very kind." And another person said, "I am not complaining, staff are very busy but it is not a care home, if you press your buzzer [nurse call] no one comes. I am not complaining though" We rang the nurse call in an upstairs room, it took a while for a member of staff to attend, when they did they just switched the nurse call off and did not check as to why it was ringing.

One relative we spoke with said, "It [the premises] is not perfect but I cannot fault the girls, they are lovely. As long as my relative gets the attention that is the main thing and they do." They also said, "It has a nice feel, everyone is kind, it is homely, I bring in heat packs that need to be warmed in the microwave, and that is not a problem, nothing is too much trouble."

Through our observation staff demonstrated a very caring approach. They knew the people who used the service well and the atmosphere was very homely.

People's privacy and dignity were respected and promoted. Staff were seen to be kind, friendly and caring. We asked staff how they supported people to maintain their dignity and privacy Staff we spoke with said, "I always close the door and curtains and I also ask them if they would like me to wait outside." Another staff member said, "If it is a shared room I always use the room dividers." And another staff member said, "If it's a double room we always put the screens up. We always explain what we are doing, it's important to talk to people."

Staff were happy in their job and had a positive attitude about the care provided by the service. One staff member said, "I like it here. It's the only home I've worked in so I can't compare it to other places but it is a really homely environment." Another staff member said, "We are a small friendly home, we know everyone's family as well." And another staff member said, "We do our very best every day."

We asked staff how they promote people's independence, staff we spoke with said "If a person walks with a frame we continue to encourage this no matter how long they take, rather than going into a wheelchair." Another staff member said "We encourage them, that is what you do isn't it."

We saw that all people who used the service had access to an advocate if needed and information was available in the 'service user guide' and in people's rooms. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. At the time of inspection no one was using an advocate

End of life care plans were in place that documented an extremely detailed plan of people's wishes and preferences for that time which also supported maintaining dignity and respect. The care plan provided step by step guidance from starting end of life care to what was needed afterwards.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We looked at care plans for three people who used the service. People's needs were assessed and care and support was planned and delivered in line with their individual care plan and in partnership with them. Individual choices and decisions were documented in the care plans. The service used a computer system for care plans.

Care plans were reviewed monthly or more frequently if needed. The care plans we looked at were person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were legible, up to date and personalised. They contained very detailed information about people's care needs, for example, one person could become agitated and their care plan contained a good level of detail and described techniques to be used to alleviate the agitation such as particular memories and a funny memory that always made the person laugh.

We did find there was a lot of repetition with the care plans such as one person had two foot care plans with differing information and a nutritional care plan plus a dietary needs care plan which had the same information. We discussed this with the registered manager who agreed to look at all the care plans and see where two plans could really be condensed into one. This would mean that staff were not at risk of reading one care plan and missing information that may be on another. It would also reduce the workload for staff.

Room records such as observation charts, food and fluid intake and turning charts were maintained. On arrival we looked at one person's room chart and saw everything had been documented such as the person had received three drinks since seven am, the breakfast was recorded plus full observation records.

Daily records provided a high level of detail. Any concerns were discussed and a GP visit was arranged. Information such as consent sought for personal care was documented in daily notes.

We asked people who used the service if they felt enough activities took place. People we spoke with said, "There is always something going on, I am happy." Another person said, "We have a singer who comes in, the 'Wonderful Wendy' I enjoy that."

We were told that staff provided activities between 2:00pm and 4:00pm each afternoon. We saw that a nail care session was taking place on the day of inspection. Each Thursday it was bingo which a relative supported with, everyone said they enjoyed that. We saw people had their own set of draws in the lounge area with their name on. These drawers included everything they enjoyed doing such as colouring books and pencils, knitting, reading books etc. The service kept an activity file which they documented every activity and evaluated how it had been received by people. If something had not worked they either stopped it altogether and chose an alternative or changed it slightly to suit people's needs.

We asked staff if they had time to do activities. Staff we spoke with said, "We provide a good range of activities, it was a manicure today, although not everyone wants to join in." Another staff member said, "We have what we call 'talk the talk' times, these can be one to one or group sessions and we reminisce and talk

about everything, we all love them." And another staff member said, "We have quite a lot of activities going on. Bingo, quizzes, film days, baking all take place. There are one to one sessions too and I always talk to people every day."

We observed staff bringing round a 'tuck shop' where people who used the service could buy items such as sweets and toiletries. One person said, "I have bought mint humbugs, I love them."

We asked staff how they prevented social isolation especially for the two people who preferred to stay in their rooms. Staff we spoke with said, "[two people's names] choose to stay in their room. We keep checking on them and include them in as much as possible, we also have chats 'talk the talk' with them." We observed a member of staff going to chat with a person who preferred to spend time in their room. They engaged in a lively conversation about current affairs.

The service had an up to date complaints policy in place. We looked at the complaints file and saw that two complaints had been received in the last 12 months. These had all been correctly documented and details from the investigations were also recorded. For example, one relative was concerned that their relative had not been washed; we saw the registered manager had done a full investigation into this and the outcome satisfied the complainant. The second complaint was about water temperatures being too cold as recorded in the safe domain,

We asked a person's relative if they had ever had to complain. They said, "I have never had to complain, nothing is a problem."

Is the service well-led?

Our findings

There was a registered manager in place who had been registered with the Care Quality Commission since January 2014.

The service was last inspected in April 2014 and they were in breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010

Assessing and monitoring the quality of service provision. The registered person did not protect service users, and others, against the risks of inappropriate or unsafe care and treatment by operating an effective system to regularly assess and monitor the quality of the service provided. At this inspection we found the registered manager carried out regular audits. However, none of the audits had picked up on the concerns we raised. This meant that the audits were not effective.

These findings evidenced a breach of Regulation 17 Good governance and Social Care Act (Regulated Activities) Regulations 2014

We saw that systems were in place to monitor the quality of the care provided. These included checks of; health and safety, infection control, kitchen, environment, housekeeping, medicines, exit routes, mattresses and care plans. These checks were regularly completed and monitored to ensure and maintain the effectiveness and quality of the care. However the health and safety and housekeeping audits had not highlighted the concerns we raised regarding the safety and cleanliness of the service. We discussed this with the registered manager who agreed a more robust audit would need to take place.

We asked people who used the service and their relative what they thought of the management of the service. One person said, "The manager is fine." Another person said, "I have no problems with the manager." And another person said, "The boss is a super boss. I'd go to her if there was anything wrong and I know she would listen to me."

We asked staff if they felt supported by the manager. Staff we spoke with said "The manager is approachable and openly there for me." And "The manager is a great support, I have no doubt she would take action if need be." Another staff member said, "I've been here nine years and this is my third manager. She's very good. I would feel comfortable going to her if I had any concerns.

Meetings for people who used the service took place on a monthly basis. Here they discussed activities, food, if the person was happy with their bedroom and fire procedures. We saw evidence to show people chose what activities they wanted to do and food they wanted to eat.

Staff meetings took place monthly for all staff plus meetings for senior staff and night staff. Topics discussed included safeguarding, whistle blowing policies, fire procedures and scenarios, people who used the service needs, DoLS, and infection control. Staff we spoke with said they have a voice at these meetings and any suggestions are acted upon. For example, one staff member said they got stressed out over the paperwork

not being put away and asked if they could be in charge of this. The staff member said, "Since I have been in charge of this it is working really well."

We asked the registered manager about the arrangements for obtaining feedback from people who used the service and their relatives. The registered manager provided us with surveys they sent to people who used the service, their relatives and healthcare professionals. Where comments were made they collated these and put an action plan in place where necessary. The majority of the comments were complimentary however a few had concerns around the cleanliness and the décor of the service. Both these were also concerns we had raised.

We saw people were supported to have links with the community. One person attended a coffee morning each week at a local establishment and another enjoyed visiting the local café. One person had recently attended the local fair in Horbury.

The registered manager understood their role and responsibilities in relation to compliance with regulations and notifications were correctly made to CQC.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Policies and practice were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected. However people classed as not having capacity had not had capacity assessments.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Safety checks were not in place windows had no window restrictors, fire drills were not taking place and PEEPs needed more detail.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>A full refurbishment was meant to take place in 2013. In the August 2014 this had not taken place and there were issues around refurbishment. During this inspection we found issues relating to the premises such as worn carpets, broken windows, broken baths and general décor.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Audits were taking place but were not effective</p>

as they did not highlight any issues we found.