

HC-One Limited

Aberford Hall

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

The inspection took place on 02 February 2016 and was unannounced. We carried out an inspection in April 2014, where we found the provider was meeting all the regulations we inspected.

Aberford Hall provides nursing, personal and social care for up to 42 people. The home is purpose built and accommodation is provided over two floors in 40 single and one double room with en suite facilities. The first floor is accessed by a passenger lift. There are well maintained gardens that can be accessed by the people living there. Local amenities are available within a reasonable distance including shops.

At the time of the inspection, the service had a manager registered with the Care Quality Commission (CQC). However, they were no longer in day to day control of the service and a relief manager was managing the service. 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.

The records we looked at showed staff had completed training about the Mental Capacity Act. However, this was not embedded and the care plans we looked at showed the provider had not assessed people in relation to their mental health and capacity.

We found people were cared for, or supported by, sufficient numbers of suitably qualified and experienced staff. Robust recruitment procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work. However, some staff who supported new staff were unsure of their responsibility within the induction process. Staff received the training and support required to meet people's needs.

People told us they felt safe in the home and we saw there were systems and processes in place to protect people from the risk of harm. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines safely.

People's care plans contained sufficient and relevant information to provide consistent, care and support. People's mealtime experience was good. People received good support which ensured their health care needs were met. Staff were aware and knew how to respect people's privacy and dignity. There was opportunity for people to be involved in activities within the home or the local community, however, these were limited.

The service had good management and leadership. People had opportunity to comment on the quality of service and influence service delivery. Effective systems were in place which ensured people received safe

quality care. Complaints were welcomed and were investigated and responded to appropriately.

You can see what action we told the 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?

Good ●

The service was safe.

People told us they felt safe. Staff knew how to recognise and respond to abuse correctly. Individual risks had been assessed and identified as part of the support and care planning process.

There were enough staff to meet people's needs. The provider had effective recruitment procedures in place.

We found that medicines were well managed.

Is the service effective?

Requires Improvement ●

The service was not always effective in meeting people's needs.

The records we looked showed staff had completed training about the Mental Capacity Act. However, this was not embedded and the care plans we looked at showed the provider had not assessed people in relation to their mental health and capacity.

Staff training provided equipped staff with the knowledge and skills to support people safely and staff had the opportunity to attend supervision and appraisal. Staff completed an induction when they started work. However, some staff who supported new staff were unsure of their responsibility within the induction process.

People enjoyed their meals and were supported to have enough to eat and drink. People received appropriate support with their healthcare.

Is the service caring?

Good ●

The service was caring.

People told us they were happy with the care and support they received and their needs had been met. People valued their relationships with the staff team.

We saw people's privacy and dignity was respected by staff and staff were able to give examples of how they achieved this.

Is the service responsive?

Good 

The service was responsive to people's needs.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support.

There was opportunity for people to be involved in activities within the home and the local community, however, these were limited.

Complaints were responded to appropriately.

Is the service well-led?

Good 

The service was well-led.

The provider had systems in place to monitor the quality of the service.

People who used the service, relatives and staff members were asked to comment on the quality of care and support through surveys, meetings and daily interactions.

Aberford Hall

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 02 February 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a nurse specialist advisor and an observer who was a member of administration staff employed by the Care Quality Commission.

At the time of this inspection there were 33 people living at Aberford Hall. We spoke with seven people who used the service, three relatives, five staff members, deputy manager and the relief manager. We spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at five people's care plans.

Before the inspection, the provider had completed 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 also reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Is the service safe?

Our findings

People we spoke with and their family members confirmed they felt safe in the home. We asked one person if they felt safe who told us, "I would think so." Another person told us, "Nothing worries me here."

Staff we spoke with were able to identify different types of abuse and could describe the signs they would look for which might indicate a person was being abused. Staff told us they would report any concerns about abuse to the manager. They felt confident their concerns would be listened to, but also said they could pass on details to the Care Quality Commission. The staff training records we saw showed staff had received safeguarding training and some had completed this during induction.

The home had policies and procedures for safeguarding adults and we saw the safeguarding policies and relevant contact telephone numbers were available and accessible to members of staff. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse.

We looked at five care plans and saw risk assessments had been carried out to cover activities and health and safety issues. The risk assessments identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. For example, we saw the malnutrition universal screening tool was being used to determine people's nutritional status. We saw one person had lost a significant amount of weight in one month which had resulted in a referral to the GP, and subsequently to the dietician, who had put in place a plan to increase the person's weight. We saw the person was being monitored on a daily basis on what food and drink they were consuming. We saw people were being risk assessed for falls, moving and handling, choking and pressure sores. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions.

We observed staff assisting people to transfer from wheelchair to armchair using a stand aid and saw this was calmly done. Staff let the person know what was going to happen next and reassured them throughout the process. The provider information return we received before our inspection stated; 'we have recently ordered an extra stand as there are now 11 residents who use this aid on the ground floor and currently we have only one aid. This will promote independence'. The home was purpose built, in a good decorative state and window restrictors were present on windows. People were provided with equipment to help reduce the risk of harm and keep people safe. The home had detailed records when falls or incidents occurred.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. We looked at the records for fire safety and saw evidence of weekly fire checks taking place. We saw the alarm had been sounded from different parts of the building to ensure it was functioning in all locations. Fire extinguishers and fire blankets were also checked on a regular basis. Staff we spoke with able to confidently describe the action they would take if the fire alarm sounded. We found regular maintenance checks were carried out which included lifts, routine room checks, emergency lighting, emergency exit sensors, generators, wheelchairs and water temperature checks. We saw where staff had identified maintenance issues in the

home they recorded this in a log which then resulted in prompt action being taken to carry out the necessary repairs.

We found staffing levels were sufficient to meet the needs of people who used the service. On the day of our inspection the home's occupancy was 33. The relief manager told us the staffing levels agreed within the home were being complied with, and this included the skill mix of staff.

The relief manager explained how staff were allocated on each shift. They said there was one nurse and three care staff for each floor during the morning and this went down to one nurse and two care staff on each floor during the afternoon. They said where there was a shortfall, for example, when staff were off sick or on leave, existing staff worked additional hours or agency staff were used. Staff we spoke with confirmed this. The relief manager said they only used specific agencies and the same staff were used which ensured there was continuity in service and this maintained the care, support and welfare needs of the people living in the home. They said they were in the process of recruiting for night staff and were looking at the deployment staff on each shift.

One member of staff told us, "I think they're a bit understaffed at times." Another staff member said, "Sometimes, I think it can be quite bad." A third member of staff told us, "Staffing levels have been horrendous. Sometimes, we've got two staff on."

We reviewed the recruitment process to ensure appropriate checks had been made to establish the suitability of each candidate. We found recruitment practices were safe and the service had clear policies and procedures to follow. We saw relevant checks had been completed, which included a disclosure and barring service check (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

The administration of medication was observed being carried out by a member of staff. The staff member sat with people whilst they took their medication. One person asked not to be stood over so the staff member stood back whilst the person took their medication.

There were appropriate arrangements in place for obtaining medicines and checking these on receipt into the home. Adequate stocks of medicines were maintained to allow continuity of treatment. People's medications were stored in individual boxes which had the person's name and room number on them. For recording the administration of medicines, medicine administration records (MARs) were used. The MAR showed staff were signing for the medication they were giving. Each of the MARs had the person's photograph, name and room number on the front cover.

We looked at eight people's MAR's and saw allergies were documented and how people liked to take their medicines, for example, one person only took their medication with a hot drink. Of the MAR's we looked at we saw there had been three recording errors where the number of tablets in the bottle did not match the number written in the MAR's. The staff member was informed of this and said they would address this immediately.

We saw the medication room and fridge was kept at the appropriate temperature and was checked daily. Disposal of medicines was carried out in line with the medicines policy. We saw information on the safe disposal of medicines was displayed. Medicines that required disposal were separated from other medicines and collected by the pharmacy.

People were asked if they required pain relief if they were prescribed 'when required' (PRN) medication. We saw a PRN protocol was in place. We observed the administration of a controlled drug by two staff members. Both staff members checked the medication and signed the controlled drug register. We saw controlled drugs were stored in a locked cupboard in the medication room which was kept locked at all times. The controlled drugs were all checked and all were correct.

We saw one person was being given covert medication (hidden in food) which had been discussed with the GP and a care plan was in place which gave clear information as to how the medication was to be administered. We saw an up to date medicines policy was in place which followed current professional guidance about the management and review of medicines. The policy had information on the administration of homely medicines. Where people were given homely medicines a care plan was in place which documented what medicine the person was given and the reason for it.

We saw staff medication competency assessment were carried out, however, these had not been done since June 2014. The relief manager told us these were carried out annually and they were a little behind with them. They said they would arrange for these to be completed immediately.

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).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The relief manager told us there was no-one subject to a DoLS authorisation. They told us if this changed they would work with and seek advice from the local authority.

We saw one person's general psychological health care plan stated '[name of person] has early on set dementia and has short term memory loss. Is occasionally confused requiring staff guidance and reassurance'. We also saw a family member had signed elements of the person's care plan. There was no mental capacity assessment present in the person's care plan. We looked at another person's care plan which contained a pre-assessment dated March 2013. This stated they did not require a best interest decision or mental capacity assessment. We found this person's capacity had not been assessed whilst they had lived in the home. Staff we spoke with confirmed this person would be unable to make all day-to-day decisions. However, we did see one person had a mental capacity assessment. This had been carried out because staff were concerned about the person falling out of bed and wanted to determine whether the person had capacity to make a decision about putting bed rails in place. We were not able to see mental capacity assessments in all of the people's care plans we looked at and the relief manager told us these had not been completed. They said, "If it's not there, I can't defend that."

The training records showed that 89% of staff had completed understanding the mental capacity act and DoLS training.

The care plans we looked at did not contain appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. This is a breach of Regulation 11 (need to consent); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said, "staff are very good, all of them. I can talk to them and ask questions."

We looked at staff training records which showed staff had completed a range of training sessions, which were e-learning or conducted face to face. These included emergency procedures, food safety, infection control, safer people handling and understanding equality and diversity. The relief manager said they had a mechanism for monitoring training and what training had been completed and what still needed to be

completed by members of staff. We saw available training in February 2016 included falls awareness, manual handling and peg feeding.

Staff told us the majority of their training was provided online, although moving and handling training was delivered as a practical session. Training covered included safeguarding, fire safety and health and safety. Staff told us they took a competency test at the end of each e-learning topic to check their understanding. However, they told us they were able to retake the competency test if they had not been successful.

The provider information return we received before our inspection stated; 'we will continue our staff training programme and our schedule of meetings to ensure that all staff are equipped to provide an effective and efficient service'.

We were told by the relief manager staff completed an induction programme which included orientation of the home, policies and procedure and training. They also said each new staff member was allocated a mentor and given a workbook to complete. We looked at staff files and were able to see information relating to the completion of induction. Staff we spoke with told us they received a satisfactory induction which included training and shadowing experienced workers over several days. However, some staff who supported new staff were unsure of their responsibility within the induction process. The relief manager was in the process of addressing this. We saw agency staff were required to complete an 'orientation booklet' prior to working at Aberford Hall. This included reading specific information and answering questions.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. One staff member told us they had not received any supervision or appraisals. Another staff member said, "I haven't had one for a while." A third staff member said, "I can't remember when I last had that." When we looked in staff files we were able to see evidence each member of staff had received individual supervision and an annual appraisal. However, these were focused on information giving rather than a one to one discussion regarding the performance and progress of the individual staff member. The provider's policy stated 'supervision covers, all aspects of practice associated with the provision of care to residents and the colleague's career development needs'. We spoke with the relief manager who agreed they were not very person centred and would look at this.

We saw tables were laid with tablecloths, napkins, cutlery and glasses. Quiet music was playing in background whilst people were waiting and eating their meal. We saw the menu was clearly displayed on the wall with different options for the day and this was in a pictorial.

During the morning we saw staff supporting people with their breakfast. Staff were seen giving people different options for their breakfast. Staff took the time to ask one person who wanted some tea and toast exactly how they wanted it. They were asked if they wanted some jam and whether they wanted sugar in their tea. Staff told us they thought the food looked appetising. One staff member said, "It smells like it tastes nice."

One person told us, "Food is not bad, quite a range to meet everyone's tastes." We saw comments from people about the food recorded in a log in the dining room. One entry we saw stated, '[name of person] said the fish was brilliant and lovely to eat'. Another person said, 'chicken chasseur and rice was lovely and tasty'. We asked people about the quality of the food and they told us, "It's always good." Another person said, "Food's not bad. There's quite a range." A third person described the meal they were having as, "Excellent." A fourth person said, "I've enjoyed all my food here."

We observed the lunchtime experience and saw staff were assisting some people with eating their meal. We

saw one staff member was supporting one person to eat their meal, they checked they were okay and the food was not too hot. The support staff provided was unhurried, although we noted there was limited interaction between staff and people. We saw one staff member asking a person, "Do you want a little more?" Later, we saw staff asking people if they wanted a drink. Staff ensured they checked with people how they wanted their drink to be made. One relative told us, "She never complains about food."

We found records concerning people's dietary requirements were well managed in the kitchen area. Each person had a record which indicated whether they had any food allergies and details of any soft diets or additional supplements were noted for staff who were preparing food and drink to access. We saw snacks and drinks were available throughout the day and staff checked if people wanted a drink.

We saw the relief manager carried out a 'meal service checklist' and observed 'dignity in dining'. Any identified issues were addressed.

We saw evidence in the care plans that people received support and services from a range of external healthcare professionals. These included GP's, community psychiatric nurses, podiatrists and dieticians. On the day of our inspection we saw two GP's visiting the home.

People told us they would tell the nurse if they weren't feeling well and said they were happy with the response from staff. One relative we spoke with told us their family member had walked to the dining room noting, "It's the furthest he's walked in months."

Is the service caring?

Our findings

People were very comfortable in their home and decided where to spend their time. We saw some people sitting in one lounge area watching television and some people were spending time in their bedroom. People's care was tailored to meet their individual preferences and needs. People looked well cared for. They were tidy and clean in their appearance which was achieved through good standards of care.

One person we spoke with told us, "They go at the pace I want to go." Another person said, "I don't think there's any of them I don't like." A third person commented, "The staff are good. Very, very good. They're on top of the world." One relative we spoke with described staff saying, "They always seem to be very helpful. They're always kind. They accommodate her needs." Another person told us some of the agency staff were good, but added others were difficult to understand due to their lack of English.

During our inspection we observed positive interaction between staff and people who used the service. Staff were respectful, attentive and treated people in a caring way. For example, we saw two staff members respond to an activated sensor for one person. One staff member stayed with the person for a few minutes and asked if they wanted to go somewhere and they would walk with them if they so wished.

The home operated a key worker system for the people who used the service. When asked, the care staff explained the role mainly involved ensuring a person's personal care and effects were appropriate and in order and liaising with their relatives and health professionals. People and/or their family member we spoke with told us they were involved in developing their care and care plan.

We saw 'dignity in care' information was displayed in the main corridor on the ground floor, which gave information and tips of how to maintain people dignity. This included, 'little things make a big difference', 'knock on people's doors', 'make sure drinks are available' and 'ask people how they are'.

People told us they were treated with respect and their privacy and dignity was taken care of. One person said, "They know when I'm getting changed and they knock on the door."

We asked staff about their role in protecting people's privacy and dignity. One staff member told us, "I think the home is quite good. They don't talk down to residents." Other staff members said they would ensure doors were closed and people were covered when they provided support with personal care. We observed staff knocking on people's doors and asking them for permission before entering their room.

Relatives we spoke with confirmed they could visit their relatives at any time and added they were always made to feel welcome.

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. Information was gathered from a variety of sources, for example, any information the person could provide, their families and friends, and any health and social care professional involved in their life. This helped to ensure the assessments were detailed and covered all elements of the person's life and ensured the home was able to meet the needs of people they were planning to admit to the home. The information was then used to complete a more detailed care plan which should have provided staff with the information to deliver appropriate care.

People's care plans reflected the needs and support people required. They included information about their personal preferences and were focused on how staff should support individual people to meet their needs. We saw evidence of care plans being reviewed regularly and the reviews included all of the relevant people.

Each care plan had information on assessments being carried out in areas such as personal hygiene, continence, eating and drinking, activities, mobility, and night time routine. We saw information on people's individual's choices. For example, what time people wanted to get up, where people wanted to eat their meals and what their food likes and dislikes were.

People's care plans contained information on an advanced care planning; which identified people's wishes at end of life. We saw two of the records held information on a do not attempt cardiopulmonary resuscitation (DNACPR). We saw family members had been involved in decisions on the DNACPR's being in place and were acting in the best interest of their family members.

Aberford Hall were assessed in 2014 and 2015 to be part of the 'Gold Standards Framework for end of life care'. Gold Standard Framework is a systematic, evidence based approach to optimising care for all patients approaching the end of life. The provider information return we received before our inspection stated; 'we aim to continue to attend training that is ongoing for the Gold Standards Framework in order for us to maintain a high standard of specialised, palliative an end of life care'.

We saw people living at the home were offered a range of social activities. We saw an activities planner was placed on display on both floors, although this information was not on display at the beginning of our inspection. We saw exercises were scheduled for every morning. Other activities listed included one to ones, bingo, an entertainer, hair and nails and pampering. We observed the exercise session in the morning and saw evidence of people receiving pampering in the afternoon.

We saw pictures of previous activities were on display along with individual pictures in people's bedroom of activities they had been involved with. We saw respect shown to those people who did not want to take part, and those who did take part were engaged. We saw people that originally did not want to take part became interested once the activity had started. We saw the garden area was well kept and there was a range of seating on a patio area. However, we found the activities were limited and found people were not always provided with a level of stimulation.

One person we asked about activities told us, "They're old. They're not very good." Another person told us, "I have enough to keep me occupied."

The relief manager said, "We could extend the range a bit." They also agreed that more trips out could be provided and the minibus did not get a lot of use.

The relief manager said people's complaints were fully investigated and resolved where possible to their satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records and saw the home had received one recent complaint. We saw the issue concerned space within the home for when family members visited. The relief manager told us they were looking into the possibility of creating a room to provide privacy for residents and family members. We saw there was a clear procedure for staff to follow should a concern be raised and a copy of the complaints policy was displayed in the entrance to the home.

The provider information return we received before our inspection stated; 'discussions have taken place with our estates department and they are looking into the possibility of having a conservatory installed. Whilst this is being completed, the home is looking at all spaces and looking at how we could make a more private area for relatives other than bedrooms which can feel crowded once a couple of people are in them'.

People we spoke with said they knew how to complain and felt confident any concerns would be taken seriously. One person we spoke with said, "I'd have a word with [name of relief manager]. She's lovely." Another person said, "I would speak to [name of relief manager]." A third person commented, "If there's something wrong, I would tell staff." We spoke with a relative who told us they had raised a complaint, but were satisfied with the response from the provider.

Is the service well-led?

Our findings

At the time of the inspection, the service had a manager registered with the Care Quality Commission. However, they were no longer in day to day control of the service and a relief manager was managing the service. The relief manager worked alongside staff overseeing the care given and providing support and guidance where needed.

Staff we spoke with said about the registered manager, "You could go to her with anything." Some staff told us they felt there was some lack of communication from management following changes in the management structure. One staff member commented, "No one introduced us to [name of relief manager]. Communication used to be quite good. Now we don't feel like we get that respect. Since we had the meeting it's been better." Another staff member commented, "She came in with an attitude. We seem to be more happy now." A third member of staff told us, "We don't feel appreciated." One staff member told us, "I think we've got a really good team."

Staff we spoke with confirmed the area manager carried out visits of the home and took time to speak with them and people living in the home. One staff member told us, "I've definitely seen them in doing audits."

The relief manager told us they monitored the quality of the service by quality audits, resident and relatives' meetings and walking around the home. We saw a calendar of monthly and quarterly audits, which included falls, medication, catering, infection control and care plans. The audits were detailed and we saw evidence which showed any actions resulting from the audits were acted upon in a timely manner. We also saw an out of hours and weekend visit report completed by the regional manager in January 2016 which included resident care, internal and external security, medication management and colleague feedback. A manager daily walk round was completed, which included infection control, dining experience and resident care. This meant the service identified and managed risks relating to the health, welfare and safety of people who used the service.

We saw a care home self-assessment had been completed in June 2015 by the registered manager. The self-assessment was structured to reflect the CQC five domains of safe, effective, caring, responsive and well-led. A rating was also allocated along with any actions that had been identified. We saw the rating for the June 2015 self-assessment was 'good'. The relief manager told us a monthly return to the provider which included gathering information from some staff members. For example, pressure care issues, falls and any hospitalisations. They also said they carried out 'spot checks' before the information was submitted.

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence.

Although people could not tell us if they had been involved in giving feedback of any kind other than day to day conversation, the relief manager told us surveys had been sent out to relatives and residents and these were due to be returned by the end of February 2016. They said they would send the 2014/2015 survey results on to CQC. Following our inspection we did not receive the results of the 2014/2015 residents and

relative's survey.

We saw a resident and relative meeting schedule for 2016. We looked at the last meeting minutes for January 2016 and these showed discussion included food, laundry, hairdresser and hearing aids. We saw actions were identified and who was responsible for completion. We saw compliments had been received by Aberford Hall. For example, one person stated, 'I don't think there is a better home in Leeds' and another person stated, 'from the moment we arrived at Aberford Hall we just knew it was the right place for dad'. A third comment stated, 'thank you all so much for the care and kindness you gave to [name of person]. We as a family always knew he was being looked after so well'.

The relief manager told us they held a 'flash' meeting each morning with staff members from each department. We saw the notes from the 'flash' meeting held on the 1 February 2016 and saw discussions included care, clinical or nursing issues and feedback from the manager. We saw staff meeting minutes dated January 2016. These included discussion regarding policies and procedures, mystery shopper calls, pagers, room charts, wheelchairs, showers, leave, nurse call points and clinical waste. We saw daily shift handover meetings were also carried out.

The provider information return we received before our inspection stated; 'we will ensure that all staff completes their e-learning. We will hold, at minimum, monthly staff meetings where issues can be discussed and ensure monthly falls meetings take place or more often if needed. Health and Safety meetings will also be held at least monthly. Resident and relative meetings will be held monthly and posters will be displayed with this information on in order for Relatives to be aware when the meetings are going to take place. Staff will continue to receive regular supervisions and appraisals and we will continue with our nurse forum meetings'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The care plans we looked at did not contain appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected.