

# High Hilden Limited

# High Hilden

## Inspection report

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12 August 2016

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We inspected High Hilden on 11 and 12 August 2016. The inspection was unannounced. High Hilden is a residential care home providing care support and accommodation for up to 40 older people. At the time of inspection there were 36 people living at the service. The service has a hair salon, two dining rooms, garden, administration office and a quiet room.

There was a registered manager in post who was registered with the CQC. 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.

At our last inspection on 12 and 13 May 2015, we asked the provider to take action and make improvements on staff training and guidance on safeguarding, and this action has been completed.

People were protected against abuse and harm. Staff were trained to identify the types of abuse and knew who to report to if they had any concerns. Staff were aware of the policies and procedures regarding abuse.

Staff were not correctly managing medicines. We found discrepancies between the records and stocks of medicine being stored by the service. No protocols or guidance was available to staff for homely remedies. Staff were administering medicines to people in a safe way.

The service appeared clean and tidy. The provider had ensured that the premises were safe for use by having up to date certificates of safety.

There was sufficient staff to provide care to people throughout the day and night. When staff were recruited, they were subject to checks to ensure they were safe to work in the care sector.

People's needs had been assessed and detailed care plans developed. Care plans contained appropriate risk assessments that were specific to the person's need.

At our last inspection on 12 and 13 May 2015, we asked the provider to take action and make improvements on management and staff understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and this action had been completed.

People were being appropriately referred to health professionals when needed. Care plans showed referrals to GP's and nurses and these were done in a timely manner. People were also supported to attend routine appointments such as health checks with a GP, chiropodist and opticians.

People were supported to have a healthy and nutritious diet. People could choose what they wanted to eat

from a set menu or ask for an alternative meal. The snack trolley did not offer those who had diabetes low sugar options on all rounds. We have made a recommendation regarding this in our report.

People and their relatives told us they were involved in the planning of their care. Care plans and risk assessments were being reviewed by staff on a monthly basis or when a person's needs changed.

People told us they were very happy with the care staff and the support they provided. Relatives told us they were happy with the service their loved ones received. Staff communicated with people in ways they were able to understand when giving support.

Staff respected people's privacy and dignity at all the times. The provider had ensured that people's personal information was stored securely and access only given to those that needed it.

At our last inspection on 12 and 13 May 2015, we asked the provider to take action and make improvements on activities that are on offer to people living at the service, and this action had been completed.

People told us they were happy with the activities on offer at High Hilden. Activities included quizzes and games run by staff, visits by external entertainers and days out. The service also had garden parties and staff would actively encourage people's relatives and friends to get involved.

People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

The provider had ensured that there were effective processes in place to fully investigate any complaints. The registered manager communicated outcomes of the investigations to relevant people.

At our last inspection on 12 and 13 May 2015, we asked the provider to take action and make improvements on the quality monitoring processes and improvements had been made. However, we found that the information was not being collected together to identify potential trends at a service level. We have made a recommendation about this in our report.

The registered manager had not ensured that all records were accurately showing where good practice was taking place. We have made a recommendation about this in our report.

The registered manager was approachable and supportive and took an active role in the day to day running of the service. Staff were able to discuss concerns with the registered manager at any time and had confidence appropriate action would be taken. The registered manager was open, transparent and responded positively to any concerns or suggestions made about the service.

On this inspection, we found one breach in the Regulations. 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?

**Requires Improvement** 

The service was not always safe.

Medicine stocks were not being correctly managed and there were discrepancies between records and stock levels. There were no protocols or guidance for homely remedies.

People were protected against abuse by staff that had the knowledge and confidence to identify safeguarding concerns.

The provider had ensured that there were sufficient numbers of staff in place to safely provide care and support to people.

### Is the service effective?

**Good** 

The service was effective.

The principles of the Mental Capacity Act 2005 (MCA) were applied in practice. Staff and management had a good knowledge of MCA.

The registered manager had ensured that appropriate applications were made regarding deprivation of liberty safeguards.

Staff received training that gave them the skills and knowledge required to provide care and support to people.

People were given food options that supported their nutritional needs.

### Is the service caring?

**Good** 

The service was caring.

People and their relatives were involved in the planning of their care.

People and their relatives spoke positively about staff. Staff had good knowledge of the people they supported.

Staff communicated in ways that were understood by the people they supported.

### Is the service responsive?

Good ●

The service was responsive.

People told us they were happy with the range of activities provided.

People were encouraged to make their own choices and staff respected their decisions.

People's friends and families were made welcome at the service and supported by staff.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The registered manager had not ensured that people's and staff records were identifying when updates took place.

Auditing systems were in place at the service, but, these were not always being collected together to clearly identify all potential shortfalls at a service level.

People, friends and staff were encouraged to give feedback through surveys and meetings. The manager listened to and acted on the feedback they received.

People, relatives and staff spoke positively about the registered manager. Staff told us they felt supported and enjoyed working at the service

# High Hilden

## **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 11 and 12 August 2016 and was unannounced. The inspection team consisted of two inspectors 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. At our last inspection on 12 and 14 May 2015 we issued three requirement notices in relation to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan detailing the improvements they would make.

Prior to the inspection, we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the local authority. Before the inspection, the provider 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 spoke with nine people who lived at High Hilden, five members of care staff, one administration staff, six relatives, and the registered manager. We looked at people's bedrooms with permission and all facilities at the service. We made observations of staff interactions and the general cleanliness and safety of the home. We observed people with higher support needs in a communal area to help us see how their needs were met. We looked at seven care plans, three staff files, staff training records and quality assurance documentation.

## Is the service safe?

### Our findings

People at the service told us they felt safe living at High Hilden. People we spoke to said "I feel completely safe here" and, "I have never been concerned about my safety." One relative told us they had no concerns regarding people's safety. Another relative said told us, "My relative is completely safe here." However, we found aspects of the service that were not always safe.

People's medicines were not being correctly managed. We looked at the medicines and found discrepancies between the records and stock levels. The number of tablets recorded in the MAR chart for one person did not match with the dose of medicines that had been administered. The date that medicines were received was not being recorded which made it difficult to check the amount of medicines against what had been delivered. The system in place for ordering medicines did not use existing stock balances to identify which medicines needed to be ordered or if the medicines in stock were sufficient for people's needs. This poses a risk as two boxes of tablets could be in use at the same time. People had homely remedies listed in the care plans. Homely remedies are non-prescription medicine that is available over the counter in community pharmacies. They can be used in a care home (with and without nursing) for the short-term management of minor, self-limiting conditions, e.g. headache, cold symptoms, cough, mild diarrhoea, occasional pain. The homely remedies were not labelled correctly, there were no protocols in place for their storage and use, and no guidance had been sought from the GP.

The failure to ensure the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were being given by staff that had appropriate training to do so. Only staff who had appropriate training and were deemed competent to do so would administer medicines to people. We observed staff giving people medicine and they were doing so safely. There was guidance to staff with regard to people taking medicines that were prescribed on an as needed basis (PRN). One care plan told us that a person could express pain by making certain contact and gestures. Staff people if they needed PRN medicine before giving it to them. Medicines were stored in a locked trolley and were not left unattended during the inspection. Staff were recording temperatures of the medicine storage room, records showed that there were no concerns identified. A member of staff told us, "We check the temperature of the storage on a daily basis and it must not go above 25 degrees Celsius as this could result in the medicines not being as effective." Staff were aware of actions to take in the event that the temperature of the medicine storage room went above or below the appropriate range.

At our previous inspection in May 2015, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that people were not protected from the risk of harm because staff had not identified potential risks, how to respond to risk and there was a lack of guidance to follow. We issued a requirement notice in relation to this breach in regulation and an action plan had been submitted by the provider detailing how they would be meeting the legal requirements. At this inspection, we found that improvements had been made.

Risk assessments were being completed and were individualised to people's needs. The risk assessments included the risk of falls, moving and handling, bathing and pressure areas. One person's moving and handling risk assessments identified that the person required the support of one member of staff to transfer. People's falls risk assessments identified the risks that people may have and what equipment should be used to reduce the risk. People had additional risk assessments that were specific to their needs. For example when a person had to stay in bed due for medical reasons the risk assessment told staff that there were risks of skin deterioration. The risk assessment also gave guidance on how often staff should check on people and this was documented in their daily records. Records showed that risk assessments were being reviewed on a regular basis and when required by staff.

At our previous inspection in May 2015 we recommended that staff training and information regarding safeguarding is updated to ensure staff have clear guidance to follow in order to keep people safe. On this inspection, we found that improvements had been made.

People were protected against potential abuse. The provider had an effective system in place to recognise, record, investigate and track any safeguarding incidents. Staff had received appropriate training and could identify abuse and the action they should take. Staff told us they had a good understanding of safeguarding and the providers' policy. Staff we spoke to said "Safeguarding is to protect people from all forms of abuse such as physical, emotional and neglect" and "We should report all concerns to senior staff. We can also report our concerns to the local authority." Staff had access to the provider's safeguarding policy and written guidance on how to correctly document any safeguarding concerns. Staff were signposted to external agencies if this was required.

At our previous inspection in May 2015 we recommended that the deployment of staff is reassessed and action taken to ensure that adequate numbers are available in all areas of the home. On this inspection, improvements had been made.

There were sufficient staff to meet people's care needs, and effective processes were in place to cover leave or unexpected absence. People at the service told us they felt there was enough staff. The registered manager told us, "We have five care staff and two senior care staff until two in the afternoon. From two in the afternoon there are three care staff and two seniors. There are two waking care staff over-night." In addition to this there are staff employed to cover activities, administration, catering, laundry, maintenance and cleaning. The staff rota showed that staffing levels were consistent over a four-week period prior to inspection. Care plans showed that the registered manager was using the Barthel Index to assess levels of independence. The Barthel Index consists of 10 items that measure a person's daily functioning, particularly the activities of daily living and mobility. The items include feeding, transfers from bed to wheelchair, to and from a toilet, grooming, walking on a level surface, going up and down stairs, dressing, continence of bowels and bladder. One Barthel Index showed that one person was independently mobile and another told staff that a person required assistance with transfers from chair to walking aid. This was consistent with the person's care plan.

There were arrangements in place to keep people safe in an emergency and staff understood the procedures and where information was kept. People at the service had an appropriate personal emergency evacuation plan (PEEP) in place that was individually designed to keep them safe in case an emergency evacuation was required. For example, one PEEP told us that a person required the assistance of two carers to evacuate in an emergency. The PEEP also told staff what action to take for a person depending on what room they are in when an alarm went off. There were emergency contingency plans in place for the service that clearly identified what action to take if an emergency occurred and where to relocate people in the short term.



The provider followed safe recruitment practices that ensured that staff were safe to work in a care setting. We looked at the personnel files of three members of staff. The information provided included completed application forms, two references and photo identification to ensure that the members of staff were allowed to work in the United Kingdom. The records showed that checks had been made with the Disclosure and Barring Service to make sure staff were suitable to work with vulnerable adults. During this inspection, we found that a new member of staff had not provided the registered manager with photographic identification. The file showed that the document had been seen. We informed the registered manager who told us, "I have seen it as it is part of our process to obtain it, I will make sure that we get a copy." The copy was obtained from the original and put in the file.

# Is the service effective?

## Our findings

People and their relatives told us staff knew people well and provided them with the care they needed. One person told us, "The staff know me well; they understand how to help me." Relatives we spoke to said "They look after my relative very well" and "Since moving our relative has put on some positive weight. They know and understand how to help."

At our previous inspection in May 2015, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that staff and management did not demonstrate an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Assessments of people's capacity to make decisions had not been carried out in line with the 2005 Act. We issued a requirement notice in relation to this breach in regulation and an action plan had been submitted by the provider detailing how they would be meeting the legal requirements. At this inspection, we found that improvements had been made.

Staff and management demonstrated understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had received training to support them to identify if someone may need an assessment. The management understood when a Deprivation of Liberty Safeguards referral was required. The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards, which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005.

The registered manager and staff were taking into account people's mental capacity and demonstrated a good understanding. The 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. The registered manager told us, "It is a person's capacity to make specific decisions." One member of staff told us, "If someone does not have capacity to make specific decisions then an assessment must be completed followed by a best interest meeting." The training schedule showed that all staff had undergone training for MCA and DoLS. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager and staff demonstrated a good understanding of DoLS and could identify when an application should be made. The registered manager told us, "There is currently no one at the service under DoLS but a recent application had been made for someone who has recently left the service." This application showed the process through to the sending of the application and included involvement of the GP and other professionals involved with the person. The registered manager told us, "Due to the nature of the home we are unable to provide full support for those under DoLS as people are free to leave and we do not lock the front door. We assist people and their families to find safe and suitable accommodation when this arises and apply for a DoLS to protect the person whilst this happens." We observed during inspection that people were exiting the premises through the front door to gain access to the large gardens that were located around the service. One person told us, "I can go out whenever I like."

There are no restrictions."

Staff asked people for consent before assisting them with personal care or activities. One person told us, "They ask us if it is ok to help." One member of staff told us, "I ask people if it is ok before I help them to wash and dress." During inspection, we observed staff asking for consent prior giving support in a way that was understood by the person about to receive support. However, in some people's care plans where a signature was required to give formal consent to receiving personal care, it had been signed by a family member. The registered manager was able to explain the medical reasons as to why a person may not be able to sign and that these conditions were documented in the care plan. This information was available in the person's care plan. The registered manager told us, "We will review our system to ensure that the information as to why a person may not be able to sign is made clear." Following inspection, a new form was in use that clearly identified the reason why a person had not been able to sign the consent form.

At our previous inspection in May 2015, we recommended that the training provided be reviewed in accordance with staff and people's needs. At this inspection, improvements had been made.

The provider ensured that staff were competent to carry out care tasks for people living at the service. Staff were receiving a full training schedule that gave them the knowledge and skills required to support people. The training schedule identified that staff have recently undergone mental capacity training that included deprivation of liberty, equality and diversity, end of life care, dementia care and medication awareness. Staff told us that they had been on a lot of training and could demonstrate this in practice. For example, where people were being supported to move this was being done safely and in a manner that was documented in their care plans. New staff went through an induction process as part of the 12-week probation period that included an enrolment in care certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. A member of staff told us, "When you are a new member of staff you shadow a senior member of the care team who gives you continuous support and you are tested to show that you can work with the people living here." Records showed that staff were being tested for their competencies during the probationary period. Staff and the registered manager told us that spot checks were being completed for staff who had completed their probationary period to test their competencies but these were not being formally recorded.

People told us that they enjoyed the food that was on offer at the service. One person told us, "The food here is excellent." Another person told us, "The food is ok, some meals are better than others." The registered manager told us, "People get two choices at meal times and we have alternatives on offer." During inspection, we observed someone change their mind about what they wanted and staff offered them a choice of alternatives. The meal was prepared promptly so that the person was able to enjoy the dining experience with their friends. The food on offer looked appetising and was well presented. Residents were seen to be chatting to each other throughout mealtime. We observed that where people needed assistance they were given support. For example, people were given aprons, beakers, and cushions to provide support. People were being weighed on a monthly basis and this would be changed to weekly if there were any significant change recorded. We saw examples of this in people's care plans. Care plans showed that the GP was called if there was any significant weight loss and the GP guidance was documented. People who had specific dietary needs were being catered for during meal times but not on the tea rounds. One person's care plan showed us that they were a diabetic and a risk assessment was completed for this that included guidance for staff. However, the snack trolley only contained limited options that were suitable for diabetics. A member of staff told us, "We can get fruit from the kitchen if it is wanted and we tend to put fruit on the evening round." We recommend that the registered manager seek guidance to provide a range of snacks that are suitable to all people's dietary requirements.

People at the service were supported with routine health appointments. One person told us, "I see a chiropodist, dentist and the optician comes out." Care plans showed when people were being seen by other professionals and any changes and guidance was being recorded. Care plans also showed that people were being referred to medical professionals if there was an identified change in need. For example, if staff identified a potential pressure sore this was reported to the district nurse. A visiting district nurse told us, "They make referrals promptly and they are all appropriate. There are no concerns regarding pressure area care." Records showed that if a person was being treated for a pressure sore a separate body map was used. The district nurse confirmed that they visit the service, manage the wounds, and provide verbal handover to staff after each visit. The guidance given by the district nurse was documented along with body maps. Staff were also documenting their actions, for example, one care plan told us that a staff member had washed and applied cream to the area as per the district nurses instructions.

## Is the service caring?

### Our findings

People and those close to them spoke highly of the staff. People we spoke to said, "Staff are very friendly" and "I love living here, the staff are so kind." The relatives we spoke to said "The staff are lovely. They are genuinely caring" and "the staff are very efficient and very caring."

Staff were seen to be kind and compassionate towards people. When people were on their own in the communal lounges staff would regularly check in on them to see if they needed a drink, snack or to go to the toilet. Staff ensured that walking aids were within reach of people so they could easily get up if they wanted to. Those that required further support had call buttons to hand if they needed any assistance. When staff communicated with people sitting down they would go down to their level before asking if they required any further assistance. Staff were seen to have time to spend with people. People were not rushed and staff were seen to be calm and caring, explaining their actions when providing support. We saw a member of staff talk a person step by step through the actions to transfer from the chair to walking frame clearly and the person was responding that they understood. In the morning, after people had finished having breakfast staff went around the communal areas asking if people were warm enough and offered blankets and drinks. Staff respected people's religious preferences and these were documented in the care plan. There is a weekly service held on site every Sunday and we were told that around 15 people like to attend.

People and their relatives told us they were involved with the planning and review of care plans. One person told us, "I am involved with the care, they always keep us informed." Relatives told us, "My relative tells me what is going on" and "They keep us informed of changes with the care plan." However, it was not clearly documented in people's care plans when they and their relatives were involved with the planning and reviews of care plans. This would demonstrate good practice to identify who was involved and any discussions had regarding a person's care. Relatives we spoke to told us that staff were good at communicating any concerns. One relative told us, "The staff are very good at giving us information regarding the care." Another relative told us, "They let us know straight away if there are any concerns."

People's privacy and dignity was respected at all times. One relative told us, "The member of staff was very nice and did not make my relative feel embarrassed at all." People's confidential information was kept private and secure. People's personal information was not discussed in front of others and staff handovers took place in a private area of the home. Senior carers would pass information to all incoming staff at the beginning of each shift.

People told us that they lived a life that allowed them to be as independent as possible. People we spoke to said, "I can go to my bedroom anytime I wish." and "I can just take myself out when I feel like it." It was observed during inspection that people were free to come and go when they wanted to. Staff told us that it was important that people were encouraged to be as independent as possible. Staff had good knowledge of the people that they supported. Care plans included details about people medical history, personal life stories and preferences. The activities coordinators had spent time with people at the service to record a list of likes and dislikes and this was communicated to care staff. We spoke to staff about the people they supported and they could clearly demonstrate how that person would like to be supported.

People and their relatives were given support when making decisions about their preferences for end of life care. People, their friends and relatives wishes were heard and respected during this process. The registered manager told us "At this time we use an end of life care plan. We use the services of a local hospice to assist with end of life care." Care plans showed that those who were under end of life care had an additional plan in place to provide them with all the support they needed and to respect any previous choices and lifestyles the person liked. Records showed involvement of the local hospice team and any guidance from them.

## Is the service responsive?

### Our findings

People at the service told us that they enjoyed taking part in the activities on offer. People said, "The activities are very good" and "All the people they get in to entertain are very good." One relative told us, "My relative really enjoys the activities on offer, there seems to be something for everyone."

At our previous inspection in May 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that some people had little activity to stimulate or interest them in order to meet their needs or preferences. At this inspection, improvements had been made.

People had access to a range of activities that were tailored to their own preferences. The activities were provided by staff at the service or by external entertainers that visited the home. One person told us, "I love classical music and today we have a harpist coming today that I am really looking forward to." People had an activities profile that identified their likes, dislikes and life history. One life history told us that a person likes to attend pampering sessions and the physical exercise sessions. The registered manager told us, "Since our last inspection we have employed an additional activities coordinator and we have seen improvements with the service." The service had an activities schedule for each month. The activities provided by staff included exercise sessions, playing games, cards, and a chitchat club that included topics for discussions and quizzes. The last four months activity schedules showed us that there was one external entertainer each week and a service that brought in dogs for people to stroke and play with. The information available to residents reminded them that staff could buy items they wanted from local shops, there were books available including large print or audio books, and a range of films could be played on the large screen in a communal lounge upon request. One member of staff told us, "People can ask for anything they want and we will try to provide it. For example, a few people wanted specific history books and these were sourced for them." Recent external trips included cream tea trips to local garden centres, a boat trip, a concert at a local school with afternoon tea, a day out on a local steam railway with fish and chips and a trip to lavender fields. The activities coordinators arranged large activities at the service that would involve people's friends and families and the local community. Upcoming events included an open day and a house/garden party.

People told us they were able to keep relationships with family and friends. Relatives were made welcome by staff, they could visit at any time and they were encouraged to take part in activities. Relatives we spoke to said "They always make us feel welcome; we get offered teas and coffees when we are here" and "I can visit when I like I don't have to ask in advance." People and their relatives had access to quiet rooms they could use throughout the home on all floors.

People were encouraged to make their own choices at the service. People's rooms were decorated to their own choosing and included their choice of furniture and personal items. People had choice over what they would like to eat. Each day people could choose from a selection of food choices and drinks. One person told us, "I can do what I like, if I want to go out I do and if I do not want to take part in anything I do not. There is no pressure put on us." We observed people with higher support needs in a communal area for one

hour to help us see how their needs were met. Staff checked on the people regularly, asking if they wanted to go to the toilet and offering them food and drink. People were individually asked if they wanted to join an activity that was going to take place in another part of the home. All the people in the room chose to stay. During the activity staff continued to check regularly that everyone was well and to see if they required any assistance. One person decided that they wanted to go back to their room and staff supported them to do this.

At our previous inspection in May 2015 we recommended that care plans follow best practice guidelines on personalised care planning and that the plans are maintained and accurate to reflect people's needs. At this inspection, improvements had been made.

People's care plans contained information that was specific to their needs and these were being reviewed on a regular basis by staff. Care plans were being updated when required. One care plan showed us that one person preferred to have a bath but was updated to identify that due to a significant change in need this could no longer happen and put in place an alternative plan that took into consideration the person's preferences. Another care plan showed us that one person required additional support from staff due to a change in mobility. The person's moving and handling risk assessment was updated to reflect this. People's likes and dislikes were also being updated. One person's care plan told us that staff should offer the full menu to make their food choice. This was changed to offer their preferred options of minced meal due to a change in need. Each person had a key worker who updated the care plans. One member of staff told us, "We talk people through any changes and document them in the care plans and daily records." Daily records detail all care given to people and areas where further support was required. The daily records also included who visited, care given, fluid and food intake and how the person was feeling on that day.

People moving to the service had a pre-admission assessment that was designed to identify and meet their needs. The initial assessment that was usually carried out in the person's home included essential information about their present medical condition, any current medicines, GP and next of kin details and personal preferences. People were invited to spend a day at the service prior to committing to a four-week trial. The registered manager told us, "We use this method so people can get to know us and we know them and so we can assess fully whether their needs can be met." One person told us, "They wanted to know just about everything about me." One relative told us, "There was a full day assessment and our relative came for a four week stay to see if she would like it."

People and their relatives were encouraged to communicate their views on the service they received. There was a resident meeting every three months and this was communicated in the activities schedule. From a recent meeting it was discussed with people the idea of having an outside smoking shelter and this was responded to positively. The smoking shelter is now in place at the service. The provider had a complaints procedure in place that was on display in the entrance lobby. People and their relatives told us they knew how to complain and if they had any concerns they would tell the management. All recorded complaints were kept in a complaints file and included all investigations, outcomes and how this was communicated to the people involved.



## Is the service well-led?

### Our findings

People and staff spoke positively about the registered manager and the home. One person told us, "It is a privilege to live in such a home." Another person told us, "It is absolutely brilliant, I cannot fault it. The manager is first class" One member of staff told us, "I love working here." Another member of staff told us, "The manager is very supporting and we all get on well." One relative told us, "It has been a very positive experience for the whole family."

At our previous inspection in May 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. We found that people who use the service were not always protected against the risk of falls because the registered provider did not have effective monitoring systems in place. At this inspection, we found that some improvements had been made.

The registered manager had introduced measures to identify when people were falling through risk assessments and fall charts. The registered manager kept copies of the fall records to track any trends and if any improvements could be made for people using the service. Staff demonstrated that they fully understood the process for reporting a fall and this was documented in care plans. Health and safety meeting took place that documented any potential risks and that the individual risk of falling was managed effectively. Staff we spoke to told us that falls did still occur, but there had been significant improvements.

However, the information from the risk assessments was not collected together in one document to clearly identify if there are any trends at a service level. This could lead to records not showing areas within the home where falls could be occurring more often. We also found that while the auditing system for medicines and pharmacy was thorough and took place regularly, it did not include a visual stock take of medicines that were being stored at the service. We reported this to the registered manager who told us, "We will make sure that we check stocks and we will let the pharmacist know." Following inspection the registered manager told us that they have had a meeting with the pharmacist and stock taking is included in both audits. We recommend that the registered manager seeks guidance to ensure that effective auditing systems are in place to identify all potential shortfalls within the service.

The registered manager had put systems in place that assessed and monitored some aspects of the quality of the service that people received. People and their relatives completed a client questionnaire every two months. The questionnaire included questions on the food, staff, activities and their overall view of the service. Recent surveys showed that people were happy with the service.

The registered manager had not always ensured that people's and staff records included evidence to show good practice was taking place. People's care plans did not include documentation to identify when people and their relatives were involved with the reviews of their care plans. People, relatives and staff told us that people were involved but this was not being effectively recorded. Staff and the registered manager told us that competency checks were taking place in areas such as safeguarding, medicines and moving and handling but this was not being recorded at the service. We recommend that the registered manager seek guidance from a reputable source in relation to accurately maintain complete records of people living at the

service and staff.

The registered manager ensured that meetings took place so that information was communicated with staff. A recent senior staff meeting identified that staff were free to contact a GP if they feel it is required and it does not necessarily have to go through senior staff. This information was passed to staff during a general meeting and staff told us they know they could contact a GP themselves but they prefer to seek guidance from senior staff.

The registered manager was seen to be open and transparent. People we spoke to said, "I just go up to the office and knock on the door if I want to talk to the manager" and "The manager talks to us openly." One relative told us, "The manager is very approachable and always give you time if you need to talk." One member of staff said, "I am happy to approach the manager with a problem and I am confident that she will help me." The registered manager had ensured that all notifications required as per the Health and Social Care Act 2008 legal requirement were being made to the care quality commission.

The board of trustees were actively involved in the monitoring of the service. A member of the board of trustee told us that they made regular formal and informal visits. We were told that each trustee had a specific responsibility, for example, building maintenance or medicine. One member of the board of trustees told us, "We are there for everyone at the service. We interview the person and their families two months after they have moved to identify if there have been any concerns." The board of trustees also carries out an inspection of the service once a month.

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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person was not ensuring safe and effective processes for the proper and safe management of medicines.</p> <p>Regulation 12(2)(g)</p>