Ringdane Limited

Hollycroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Hollycroft care home is registered to provide accommodation and personal care for up to 30 people. People who live at Hollycroft care home are predominantly older people and people with dementia. The home is situated in a residential area in Ilkley.

At the last inspection in April 2015 the home was found to be compliant with all of the legal requirements inspected at that time.

We inspected the service on 12 July 2016. On the date of the inspection 18 people were living in the home.

A registered manager was in not place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been recruited who told us they would be applying for the registered manager's post.
People and relatives provided positive feedback about care at the home. They said that staff were kind and caring and treated people well. They praised the nicely decorated and homely feel of the building and said the small size of the home helped the home to retain a personalised approach to care and support.

Medicines were not safely managed. People did not always get their medicines as prescribed and appropriate protocols were not always in place to instruct staff when to provide "as required" medicines.

People told us they felt safe living in the home. Safeguarding procedures were in place which were understood by staff. Risks to people's health, safety and welfare were assessed and appropriate plans of care put in place to help keep people safe.

There were sufficient quantities of staff deployed to help ensure safe care. However there were sometimes inconsistencies in the number of care staff deployed from day to day. Recruitment procedures were in place, however they had not been sufficiently robust around the transition period when the home had changed registered providers.

The premises was well maintained with a good number of communal areas for people to spend time. Checks were undertaken on the premises to ensure it was safe.

People spoke positively about the food provided at the home. We saw the mealtime experience was a positive experience, although we identified one person was not always offered a sufficient meat free alternative.

Appropriate Deprivation of Liberty Safeguard (DoLS) applications had been made where the service thought it was depriving people of their liberty. However staff did not have an understanding of DoLS or who had one

in place. The service was not consistently acting within the legal framework of the Mental Capacity Act as best interest processes were not always followed where people lacked capacity.

People's healthcare needs were assessed by the service and plans of care put in place. People were supported to maintain good health by a multi-disciplinary team.

Staff were kind and compassionate towards people and treated them with dignity and respect. Staff knew people well and their individual likes, dislikes and preferences.

People's views were listened to and acted on both informally and formally by the staff and management team.

People's needs were assessed and plans of care put in place for staff to follow. These were largely appropriate, although we identified a lack of end of life care plans in place.

An activities co-ordinator was employed who provided people with a varied range of activities which were well received by people who used the service.

A complaints policy was in place which was displayed within the home. People told us complaints were appropriately dealt with, although there was a lack of systems in place to robustly record informal and verbal complaints and the action taken.

People spoke positively about the way the home was managed and said the manager was friendly and approachable.

Systems were in place to assess and monitor the quality of the service. We saw examples where these were successful in identifying and rectifying issues although this was not consistently the case as systems to assess, monitor and improve medicines management were not sufficiently robust.

People's feedback was regularly sought and acted on through a variety of formal and informal mechanisms.

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.

Medicines were not managed in a safe way. Some people did not get their medicines as prescribed.

There were sufficient quantities of staff deployed to help ensure people were responded to promptly and provided with regular social interaction.

The premises was homely and well maintained. Key safety checks were undertaken such as on the fire, gas and electric systems.

People told us they felt safe living in the home. Plans of care were put in place to help keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not consistently acting within the legal framework of the Mental Capacity Act (MCA). Appropriate DoLS applications had been made by the service although staff did not demonstrate a good awareness of DoLS or who had one in place.

People spoke positively about the food provided by the home. Mealtimes were a pleasant and sociable experience.

Staff were provided with a range of training on induction and at periodic updates to help ensure they had the right skills to care for people.

Is the service caring?

Good

The service was caring.

People told us they felt at ease with the staff team and were treated in a friendly and compassionate manner. This was supported by our observations of care and support which demonstrated people were treated with dignity and respect and

their privacy upheld.

People's views were sought and acted on, through both informal and formal mechanisms.

Is the service responsive?

Requires Improvement

The service was not always responsive.

In most cases we identified appropriate plans of care in place which were being followed. However this was not consistently the case and we identified a lack of assessment of people's 'End of Life' care needs.

A range of activities were provided to people by the activities co-ordinator which were praised by people and their relatives.

A complaints system was in place. We saw written complaints were appropriately responded to, although verbal and informal complaints were not always clearly recorded.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People praised the manager and said they were attentive and caring and dealt with any issues that were raised. We identified a friendly and positive atmosphere within the home.

Systems to assess, monitor and improve the service were in place. However these were not always fully robust in identifying and rectifying issues.

People's feedback was regularly sought by the service through a variety of methods.

Hollycroft 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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who use the service, two relatives, four care workers, the cook, the activities co-ordinator, the manager and the area manager. We observed care and support in the communal areas of the home.

We looked at three people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider and notifications. As part of the inspection we also contacted the local authority to ask them for their views on the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the provider's medicines policy, which complied with current legislation and best practice in the administration of medicines. Although people told us they received their medicines when they needed them, we found systems and processes in place to manage medicines were not safe or effective.

We looked at the medicines with a senior care staff member. We found medicine routines were tailored to meet people's individual requirements for example, night staff administered medicines to people who were up early in the morning and the day staff gave other people their morning medicines when they had woken.

However, we found people were not always receiving their medicines as prescribed. We saw one person was prescribed a medicine which the medicine administration record (MAR) showed was to be given before food, yet we saw the staff member gave it to the person when they were having their breakfast.

In two other cases people had been given their medicines at the wrong frequency as staff had not followed the instructions on the handwritten MARs. For example, one person was prescribed an antibiotic to be given three times a day, yet the MAR showed this had been administered four times a day over a period of three days. Another person was prescribed a food supplement to be given twice daily, yet the MAR showed this had been given three times a day. We found handwritten entries on the MAR had not been signed by two staff, which was in contravention of the provider's policy.

We found another person had incorrectly been given two doses of a medicine to treat fluid retention. This medicine had been stopped by the GP but staff had failed to realise and administered it for two extra days before the error was identified by a senior staff member. This showed the systems in place for checking the monthly MARs and medicines received into the home were not robust.

We discussed with the manager the systems in place for ordering and receiving medicines into the home. The manager told us there were no records to show the medicines which had been ordered for people each month. This meant staff were not able to check that the medicines they received into the home matched the prescribed items they had requested from the GP. The manager said they had recognised this needed to be addressed and had put a new system in place starting later this month which would resolve this issue.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely, however safe systems were not being followed. We found two anticipatory medicines (prescribed in advance to alleviate symptoms as part of end of life care) which were stored in the CD cupboard had not been recorded in the CD register. The senior staff member was unable to locate another CD which was recorded in the register. After some time, disposal records were located which showed this medicine had been returned to the pharmacy although this had not been recorded in the CD register. Other CDs we checked were correctly recorded and stock counts balanced. The provider's CD policy stated weekly CD stock checks should be completed by the registered manager or designated person. There was no evidence of these checks in the CD register and when we asked the senior staff member they told us the checks used to happen but had stopped.

We found protocols were not in place to guide staff as to when to administer 'as required' medicines. For example, we saw one person was prescribed a medicine to relieve agitation to be given 'as required' every four to six hours. There was no information to show what symptoms would indicate this medicine should be given. The MAR showed this medicine on one occasion had been given by staff incorrectly as there were only 90 minutes between two doses, when the prescription clearly stated a minimum gap of four hours.

The MARs showed whether people had any allergies. However, we found the MAR for one person recorded no allergies, yet the person's care records showed they were allergic to a medicine used to treat nausea. We raised this with the senior staff member who said they would contact the person's GP to clarify.

We observed one person was breathless and they told us they did not feel very well and they had a chest infection. We identified this person had a pre-prescribed stock of antibiotics within the home which could be used with the consent of their GP. However another GP had been to see the person the day before the inspection and prescribed the same antibiotics for which they were awaiting delivery. There was confusion within the staff team as to which medicines could be given, with night staff stating that the medicines in the stock could be used and day staff saying they were waiting for the prescription. This led to a delay in the person receiving treatment for their chest infection. We concluded the staff had failed to communicate effectively with the prescribing GP about the person's pre-existing stock of antibiotics resulting in a delay in their treatment.
Overall we found medicines were stored safely and securely. However, we found prescribed medicines for a nebuliser were stored openly in one person's bedroom which was unlocked. There were also prescribed dressings in the bedroom which were dated November 2014. The senior staff member removed both these items when we brought this to their attention.

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

We saw the senior care staff member administering medicines in the morning. We saw the staff member was patient and kind with each person giving them support where needed. We saw people were asked if they required any pain relief.

Overall we concluded there were sufficient staff to meet people's needs. People told us there were enough staff to provide prompt care and assistance. One person told us, "What I like about this place is if staff are ill someone else takes their place so we're not short." When we asked another person if there were enough staff, they said, "Certainly seem to be. They come quick enough if I need them." Another person told us their call bell was usually answered very promptly.

The manager told us planned staffing levels were four care workers during the day and three care workers at night, supported by laundry, kitchen and maintenance staff. An activities co-ordinator also worked five days a week. We looked at rotas which showed these staffing levels were generally maintained although there were some times when only three staff were on duty during the day. Staff we spoke with confirmed that on occasion this was the case and said this meant they were rushed but they said safe care was not compromised. They also said the manager helped out when they were short to ensure people were kept safe.

On the day of the inspection there were four care staff on duty. We observed care and support. We found there were enough staff deployed to ensure people received prompt care and intervention and that appropriate supervision of communal areas took place.

People and relatives we spoke with told us the building was always kept clean and well maintained. One person said, "I have a lovely room which they keep clean and spotless." There were numerous communal areas where people could spend time including two lounges, a conservatory and a large dining room. There was also a well maintained garden which people said they were supported to access. Bedrooms were spacious and appropriate for their purpose. Safety features were installed such as restricted access to staircases and window restrictors to reduce the risk of falls. We inspected the service, inspection and maintenance records of the gas safety, electrical installations, portable electrical appliances, water quality and fire detection systems and found all were up to date. We saw regular safety checks were carried out by maintenance staff to ensure the equipment used by people and staff was safe and fit for purpose.

PEEPS were in place describing how staff should assist evacuating people in the event of a fire. Fire wardens were in place and fire training was provided to staff by the maintenance man. Staff we spoke with told me they'd received fire training and understood fire procedures

We looked at the checks undertaken on staff to ensure they were of suitable character to work with vulnerable people. New staff were required to attend an interview, disclosure their previous work history and qualifications, provide references, and prove their identity. We saw interview records were in place, however these were rather brief and did not provide evidence staff competency and understanding was fully explored. For example staff were asked about their understanding of safeguarding, but records showed simply "explained" rather than recording more detail about the quality of their response.

Staff were required to undertake a Disclosure and Baring Service (DBS) check. However we identified the manager had not seen the DBS certificate of one staff member who had started work several months prior. Records showed they had declared criminal offenses during the recruitment process. Although the recruitment of this staff member had taken place under the previous provider's registration, we were concerned that there was no record to suggest the nature of the convictions had been investigated and a risk assessment undertaken to determine whether the person was suitable to work with vulnerable people. During the inspection, the manager took immediate action to rectify this.

People told us they felt safe living in the home. Safeguarding procedures were in place which were well understood by the manager and staff. Appropriate referral and liaison had taken place with the local authority over safeguarding alerts and concerns which gave us assurance the correct processes were being followed and measures had been put in place to keep people safe.

Risks to people's health, safety and welfare were assessed and risk assessment documentation put in place. These covered areas such as skin integrity, manual handling and nutrition. Where risks were identified, care plans were put in place detailing how these risks were to be controlled. Staff we spoke with had a good understanding of the risks each person was exposed to and how to adequately control them. People and relatives we spoke with said when they had observed moving and handling of people at the service they thought it was done safely and carefully by staff.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had made appropriate DoLS referrals for four people who used the service. One DoLS authorisations was in place with the other three applications awaiting assessment by the supervisory body. One DoLS authorisation had a condition attached and we saw it had been met by the service. However staff we spoke with were not aware of who had a DoLS in place and did not have a proper understanding of DoLS. This meant there was a risk people's rights were not protected. Where DoLS had not been applied for, we were unclear of the decision making process detailing why these applications were not required, with a lack of assessment taking place of the restrictions placed on residents lacking capacity to determine whether further applications were appropriate.

We saw care was provided in the least restrictive way possible with people encouraged to move around the home, use the outside areas and remain as independent as possible.

There was a culture within the home of asking people's consent and respecting their choices. For example people were continuously asked what they wanted to do, what they wanted to eat and where they wanted to sit within the home. People we spoke with told us their choices were respected and they were able to voice their opinions with staff. Staff sought consent before undertaking care tasks such as hoisting.

We found in some instances the service was acting correctly within the legal framework of the Mental Capacity Act but this was not consistently the case. In some people's care records, we saw appropriate best interest decisions had been held where people lacked capacity to consent to their care and treatment. For example, we saw a person had previously been having their medicines covertly, which meant the medicines were hidden or disguised in their food. We saw the correct process had been followed, with a best interest process held and authorisation received from the GP and pharmacist. However, when we looked at another person's MAR it showed a medicine was to be given 'crushed in a small amount of water'. We saw it had been administered recently. A mental capacity assessment dated 16 June 2016 stated the person lacked capacity to make a decision about medication. However, there was no best interest meeting recorded to show how the decision to give a covert medicine had been made or who had been involved in the decision making. On speaking with the manager they told us that there wasn't a need to give this person their medicines covertly and it had only been one staff member administering it in this way. However they recognised that it was unacceptable for medicines to be administered in this way without appropriate

authorisation and told us they would take action to address and also clarify the prescription with the GP.

In another person's care records, records were unclear whether a relative had a Lasting Power of Attorney for health and welfare and when we asked the manager she was also unclear and had to seek clarification from the relative. However this information should have been present as it is crucial to the development of appropriate care plans that uphold the person's rights.

In another case, we saw another person had a sensor device in place in their bedroom which was connected to the call bell system. This device triggered the alarm when the person got out of bed which alerted staff as the person was assessed to be at high risk of falling. The care records showed this person had dementia, yet there was no mental capacity assessment for this decision or best interest meeting recorded.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Some people's care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions held of the healthcare professional completing the form.

People and relatives we spoke with told us staff were competent and had the right skills and knowledge to do the role.

Induction training was in place for new staff. New staff received an induction to the home, the equipment, policies and procedures. New staff without previous care experience were also supported to achieve the Care Certificate. The Care Certificate is a nationally recognised standard of induction training for new care staff. Staff received periodic training updates in subjects such as manual handling, safeguarding, fire and dementia. This was a mixture of face to face and e-learning. We saw most staff were up-to-date with mandatory training with an overall compliance level of 93%. Compliance with mandatory training was monitored by the registered manager, although records demonstrating when people required updates in safely related training such as fire and manual handling training undertaken by the maintenance man were not as clear.

Specialist training had also been provided by external health and social care professionals such as pressure area care. Plans were in place to provide further training in the coming months for example end of life training for care staff. Staff we spoke with told us they had received a range of training and said it was fit for purpose and met their needs. Staff received periodic supervisions and an annual appraisal to help meet their developmental needs. This was a mixture of group supervisions on specific topics and individual supervisions based on assessing their performance against a set of defined criteria.

People and relatives all praised the food and said it was of high quality and there was sufficient choice. One person told us, "I think it's [the food] really good. I have Weetabix for breakfast and see what's going for lunch. They come and give us a choice each day. They are very nice and helpful like that." Another person said, "The food's very good here. I can recommend it." They told us there was plenty of choice and said, "I usually have bread and butter but if you want a cooked breakfast you can have it. When I've had one it's been eggs, bacon, black pudding, beans, everything – the full English!"

We saw people had breakfast as they got up throughout the morning and were asked what they would like to eat and drink. People were provided with a choice of hot and cold drinks and biscuits throughout the day.

We observed lunch in the dining room and found it was a relaxed and sociable occasion. Tables were laid with tablecloths, napkins, cutlery and condiments. The menu was displayed on each table alongside a small vase of flowers. Music was playing softly in the background which meant people were able to have conversations with one another. We saw the cook asked people in the morning what they would like for lunch. Lunch was served by the cook from a heated food trolley. We saw some people were asked about the meal. For example, if they wanted one sausage or two, but generally food was plated up without people being asked if they wanted all the components of the meal. We raised this with the manager who told us they would review this aspect of the mealtime experience. People were offered a choice of cold drinks with their meal.

We saw where people required assistance with their meals staff sat with them and chatted with the person as they helped them. This was done in a patient and compassionate manner.

Where people were at risk nutritionally, plans of care were put in place. We saw these were largely appropriate, although one of the care plans we looked at did not fully describe the person's current nutritional plan of care now that they were no longer taking nutritional supplements. In addition, although this person was vegetarian they were not always offered a suitable alternative to the meat which others were served. This was a missed opportunity to increase nutrition to this person. However we did see the person was given regular high calorie drinks and fortified food. The manager told us they would investigate this immediately.

Where people were at risk nutritionally, food charts were kept to detail their dietary intake. We saw these were generally well completed and saw people were offered a range of foods and snacks to boost nutrition. However we were made aware of one complaint that some staff did not always fill in charts in a timely manner after people had eaten. The manager was aware of this complaint and from their response we were satisfied that appropriate action was being taken to address this.

A system was in place to make kitchen staff aware of people's individual dietary requirements such as who had a soft diet and any special requests. For example, one person didn't like cheese so this was respected by the kitchen staff. Although we saw from records people were offered a good variety of food, there was no pre-planned menu in place with kitchen staff deciding amongst themselves what to serve on a daily or weekly basis. This increased the risk that a fully balanced and nutritious diet was not provided in the longer term.

Care records we reviewed showed people had access to a range of NHS services and we saw the involvement of GPs, district nurses and opticians. Health related care plans had been developed by the service. People and relatives we spoke with told us healthcare needs were met by the service and action was taken if people's health deteriorated.

Good

Is the service caring?

Our findings

People and relatives all said that the staff and management team were kind and caring and treated them with dignity and respect. One person told us, "I'm happy here and the staff are nice." Another person said, "Couldn't be happier; they couldn't be more helpful here." A third person said, "Always kind and caring , top marks, we have a laugh and a chat." A relative told us, "The staff make the difference, they are genuine, it's like a family, you aren't just a number here, everyone is really nice." Another relative told us, "Staff are brilliant, they put everything in place for [relative]."

We saw the manager had instilled a philosophy of putting people first within the home. The manager was 'hands on' and along with care staff assisted with care and support and checked people were okay on a regular basis. This created a friendly, attentive and inclusive atmosphere. People knew the manager by name and said they were kind and compassionate.

Our observations of care and support supported people's views that staff were warm and friendly towards people. Staff took care to preserve people's dignity, for example closing doors during personal care and ensuring people were appropriately covered during hoisting to maintain their privacy.

We observed that staff knew people well and engaged with them at every opportunity, for example offering reassurance during care and support tasks and engaging in conversation about what was on television. We saw staff listened to what people had to say and were patient and kind. People appeared relaxed and at ease in the company of the staff who supported them. During observations of care and support we saw people looked clean, tidy and well-presented which indicated their personal care needs were being met by the service

Care planning considered people's dignity and privacy and how to ensure it was upheld during care and support interventions. The attitude and nature of staff was monitored through various mechanisms including audits and checks undertaken by the manager, staff supervisions and through people's feedback about the quality of the service.

People's care records contained personalised information about people's likes, dislikes and personal preferences. This included information about people's life histories. This showed the service had taken time to understand people and what was important to them. Through discussion with staff and observation of care and support, it was clear staff understood people well and their individual preferences.

People were given choices as to how they spent their daily lives. For example, staff supported people to make choices about what areas of the home they wanted to sit in. Two people who were sitting in the conservatory told us they liked it in there as it was quiet and they could see outside. People's comments and views were listened to and acted on both informally through regular interaction with staff and also in a more formal manner through mechanisms such as care plan review, resident meetings and quality questionnaires.

Requires Improvement

Is the service responsive?

Our findings

People and relatives spoke positively about the care and support provided. For example, one relative told us how they had seen a positive change in their relative since they moved into the home. They told us staff were attentive and met their relative's individual needs.

Overall, people's needs were assessed prior to admission and appropriate plans of care put in place. Care plans were in place in areas such as mobility, nutrition, continence and pain and these were largely appropriate, well completed and regularly updated. People and/or their relative were involved in care plan reviews. People and relatives we spoke with told us they felt fully involved in their care and treatment. However, we identified some instances where the service was not fully responsive. In one case we found moving and handling needs were not always considering the full range of aids available to support the person in transferring. We saw the person being assisted by staff to transfer from a wheelchair to an armchair. The person was struggling to get out of the wheelchair and we saw staff were holding onto the back of the person's trousers in an attempt to help them stand. This was not successful and was possibly uncomfortable for the person. We mentioned to the staff that a handling belt may be more appropriate. The care records showed there had been a gradually deterioration in this person's mobility over recent months and stated they were only partially able to weight bear. However, there was no mention of aids which could be used to assist other than a hoist which the record advised staff to use when the person's mobility was 'very bad'. We discussed this with the manager and operations manager at the inspection feedback session and they said they would arrange for this person's mobility to be reassessed.

We also identified a lack of robust 'End of Life' care plans in place where people were approaching the end of their life. Although we did not identify that 'End of Life' care was inappropriate, the lack of well-defined care plans meant there was a risk of inconsistent care and support being provided.

Daily records were in place for each person which provided evidence of the care and support offered to people each day. Handover records were in place to aid in updating staff at the start of each shift of any changes in people's condition.

Some people required regular pressure relief to reduce the risk of skin breakdown. We looked at charts which indicated that people had received pressure relief at the required frequency. Staff we spoke with were clear about who needed this relief and how often it was provided.

People told us there were activities taking place which they could participate in if they wanted. One relative told us, "Every time we come there are activities going on here, for example they had a party for the Queen's birthday." We spoke with the activity co-ordinator who also worked as a care assistant. They told us they worked on activities from 10am until 3pm three days a week and in the afternoon on the other two days. They spoke enthusiastically about their role and told us of the activities they had organised. We saw they were in the process of completing individual booklets with people entitled 'My Choices' which included information about people's interests, preferences, relationships and life history. They also included what was important to people and detailed activities they had participated in. We looked at a booklet for one

person which showed in recent weeks they had enjoyed a shopping trip to Ilkley, a party to celebrate the Queen's birthday, a bingo session and reminiscence. Another person's record showed they had enjoyed a game of balloon volleyball and a sing-a-long. We saw a bright poster showed the events planned for the month which included dominoes, bingo, music and films.

People told us they knew how to make a complaint. We saw the complaints procedure was displayed in the home. We looked at the complaints file which showed two complaints had been received. We saw both complaints had been acknowledged and responded to in writing. One of these complaints was ongoing. We spoke with one relative about a complaint they had recently made. Although it was early in the complaints process, they said it was being dealt with appropriately by the manager.

We did note that more informal or verbal complaints were not always logged as complaints. As such it was difficult to establish the number of these types of issues raised and the action taken to resolve. The manager agreed to ensure all that complaints and actions taken to resolve these were robustly recorded in future.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post. A manager had recently been recruited who was in day to day charge of the service. They told us they were be applying for the post of registered manager in the near future.

The home had reported statutory notifications such as deaths and serious injuries to the Commission. We identified one case where a safeguarding referral had been made but the Commission had not been notified. Due to previous incidents of this nature being correctly reported to us we concluded it was an isolated lapse on the part of the manager rather than a lack of understanding of the correct process to follow. The manager assured us that all notifications would be reported in the future.

It was clear that the manager was very 'hands on' and regularly got involved with care and support. This was confirmed by people and relatives who knew the manager and said they were effective in their role. For example one relative told us, "Manager is a star, [manager] gave out her personal mobile number so we could contact her at home if there were any issues."

The manager told us they felt well supported by the provider and area manager. The manager and staff we spoke with told us there were regular visits by the area manager to support the manager in their new role. Staff we spoke with said they felt well supported by the manager and they were able to contact them at any time, even out of their normal hours.

Staff told us that they were generally happy in their role, although some staff thought that not all staff pulled their weight. On reviewing supervision records, we saw there were a number of negative comments raised about staff through this process. However there was not always a clear and tangible developmental plan setting out how these staff were to be supported to address these shortfalls.

The manager demonstrated a commitment to further improve the service. For example, they identified problems with communication and transfer of information between shifts and had put in place new systems to ensure this was improved. The manager told us they were currently recruiting for a deputy manager which they hoped would further improve communication and cohesion of the staff team as well as allowing greater scrutiny of areas such as medicine management.

Systems to assess and monitor the quality of the service were in place. A range of audits and checks were undertaken. For example, the manager regularly checked the responsiveness of staff to the emergency call bell by testing and evaluating the response. This helped ensure staff acted appropriately in the event of an emergency. A person we spoke with confirmed these checks took place. Daily walkarounds of the service were undertaken by senior staff or the manager which looked at a range of quality areas. Residents care and support was reviewed weekly to ensure it was appropriate. Audits in areas such as infection control, hand hygiene and care plans also took place. Many of these audits were electronic which allowed remote scrutiny by the area manager or central quality team.

However we identified that medicines audits were not sufficiently robust. Regular medicine audits had

taken place within June 2016, and although some areas of concern that we identified had been identified by the audit, this was not consistently the case and there was no evidence recorded of what action was taken to resolve issues that were identified. We concluded the audit process in respect of medicines was not sufficiently robust or effective as the issues we found at our inspection had not been identified or resolved by the provider.

The regional manager also undertook regular audits and provided the manager with an action plan to review. We reviewed the most recent audit which showed a number of actions which the manager was working their way through.

Accidents and incidents were reported on an electronic incident reporting system. These could be analysed and reviewed by senior management at the provider dependant on the risk level. We looked at a number of incidents and saw in most cases there were appropriate preventative measures put in place to help reduce the risk of a re-occurrence. However in one case, we identified the version of events surrounding an incident recorded on the incident form differed from what was recorded in the person's care records. We asked the manager to investigate this as the differing accounts had an impact on the lessons to be learnt from the incident.

The service had systems in place to seek and act on people's feedback. People we spoke with said their opinions were valued by the service. Periodic resident meetings were held where topics such as food and activities were discussed. The manager was in the process of setting up a residents committee to empower people to be further involved in the running of the home. A tablet computer was set up in the reception area to allow people, relatives, health professionals or other visitors to provide feedback on the quality of the service. We saw responses had been received via this method and this feedback was collated by the manager. Feedback we reviewed from this mechanism and the annual quality questionnaire showed people were generally very happy with the level of care and support provided.

A number of staff meetings including care staff and management meetings were periodically held and these were an opportunity for quality issues to be discussed.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent (3) The service was not acting within the legal framework of the Mental Capacity Act (MCA

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)□(2g) Care and treatment was not provided in a safe way because: Medicines were not managed in a proper or safe way.

The enforcement action we took:

We issued the provider with a warning notice requesting them to become compliant with the regulation by 31 August 2016