HICA

Wilton Lodge - Care Home

Inspection report

402 Holderness Road
Hull
Humberside
HU9 3DW

Tel: 01482788033
Website: www.hica-uk.com

Date of inspection visit:
24 October 2016

Date of publication:
22 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Wilton Lodge is registered to provide personal care and accommodation for a maximum of 48 people, including those living with dementia. Communal accommodation is provided in a variety of lounge and dining areas and bedroom accommodation is provided in single rooms, some with en suite facilities. The home is situated in a residential area on a main road and close to local amenities and bus routes into the city of Hull.

We undertook this unannounced inspection on the 24 October 2016. At the time of the inspection there were 44 people living in Wilton Lodge. At the last inspection on 2 and 3 September 2015, we had concerns about staffing levels and how the lack of a registered manager had impacted on how the service was run; the quality monitoring had fallen behind schedule.

During this inspection, we found there had been improvements in both these areas. The service now had a registered manager in post as required by a condition of registration. 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 registered manager was carrying out more audits and checks on the quality of the service although we saw some areas required review to continue the improvement achieved so far, especially in relation to records. We have made a recommendation about this in the well-led section. People were asked their views in surveys and meetings. The registered manager was approachable and people who used the service and their relatives were listened to and their views taken seriously so practice could be improved.

The staffing levels had been increased since the last inspection, which meant staff had more time to meet people's needs safely.

We found people had not always received their medicines as prescribed. You can see what action we have asked the registered provider to take at the back of the full version of this report.

Although people had access to a range of health care professionals, we had concerns that at times staff did not always follow their instructions and work together with them to ensure the optimum level of care was delivered to people. There was also an instance when a person's health care needs had increased beyond the skills of the care staff team and this had not been recognised in a sufficiently timely way. The registered manager told us they would seek another meeting with health care professionals to ensure issues could be addressed. You can see what action we have asked the registered provider to take at the back of the full version of this report.

People's nutritional needs were met. People told us they liked the meals and there were choices available for them and alternatives if they didn't like what was on the menu. Nutritional risk was assessed and people

were weighed in accordance with risk and their diet adjusted when required.

Staff knew how to keep people safe from the risk of harm and abuse. They had received safeguarding training and followed procedures in notifying other agencies when required. Care plans were updated to reflect risk and how this was to be managed safely.

People's needs were assessed prior to admission and after admission at intervals to make sure any changes in need were updated. Staff produced care plans to help them support people in the ways they preferred.

Staff approach was kind and caring. Staff knew how to respect people's privacy and dignity and gave examples of how they did this. We saw confidentiality was maintained and personal data protected and stored securely. People told us they liked the staff and they felt safe living at Wilton Lodge.

We saw staff enabled people to make their own choices and decisions when they were able to. When people lacked capacity for this, staff acted within the principles of the Mental Capacity Act 2005 and ensured important decisions were made within best interest meetings with relevant people attending.

Staff had access to training which helped them to feel skilled and confident when supporting people who used the service. The training was monitored and refresher courses made available. Staff received supervision, appraisal and support.

We found the environment was clean and tidy. There were some minor issues that were addressed on the day.

There was a complaints procedure on display and people felt able to complain.

At the last inspection in September 2015, staff had been recruited safely and all employment checks had been carried out before they started work in the service. The recruitment process had not changed in the interim so we did not feel it necessary to check this again. Recruitment processes will be checked at the next inspection to ensure the robust processes continue to be maintained.

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 consistently safe.

Some people had not received their medicines as prescribed due to various reasons such as stock issues and a lack of clear guidance.

The service was generally clean and tidy and some issues found on the day were addressed straight away.

There were sufficient staff on duty to support the needs of people who used the service.

Staff knew how to keep people safe from the risk of abuse or harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We had concerns that staff were not working as effectively as possible with health professionals who were also involved with the care of people who used the service.

People's nutritional needs were met and they told us they enjoyed the meals.

People were supported to make their own choices where possible. When people were assessed as lacking capacity, the registered provider acted within mental capacity legislation and good practice principles by ensuring best interest decisions were held in consultation with others and these were recorded.

Staff had access to training, support, supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff approach was caring and people were treated with dignity and respect.

Staff provided explanations and information to people to help them make their own choices and decisions.

People's information was held securely and confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and information was included in plans of care. The information enabled staff to provide care that was person-centred and in line with people's preferences.

There were activities for people to participate in, to provide them with stimulation and interest.

The service had a complaints procedure that was on display. People felt able to make complaints and had confidence these would be addressed.

Is the service well-led?

Requires Improvement

Although there had been improvements in this area, the service was not consistently well-led.

There were quality monitoring systems in place which included audits, checks and surveying people's views through meetings and questionnaires. Some audits required closer attention to ensure they identified shortfalls, and concerns with recording, in a timely way so that swift action could be taken to rectify them. We have made a recommendation about this.

The registered manager was available and approachable when people wanted to raise concerns with them.

The culture of the organisation was open and inclusive.

Wilton Lodge - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 24 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We checked our systems for any notifications that had been sent in as these tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with local authority contracts and commissioning teams and safeguarding team about their views of the service. We also spoke with three health care professionals and a community psychiatric nurse during the inspection.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with five people who used the service and six people who were visiting their relatives. We spoke with the registered manager, two senior care workers, three care workers, two housekeeping staff and the cook.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 12 medication administration records (MARs) and monitoring charts for food and fluid intake, weights, pressure relief and behaviour which could cause anxiety. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota and how numbers are calculated based on people's dependency levels, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Requires Improvement

Is the service safe?

Our findings

We found there were times when people had not received their medicines as prescribed. One person had not been given their pain relief medicine every 12 hours, which was a controlled drug and required stricter monitoring. In the last four weeks there were several occasions when the time between doses was shorter or longer than 12 hours, for example, 10 hours, 11 hours, 14 hours, 16 hours and 18 hours between doses. They had not been given it at all on the morning of the inspection and staff had recorded the reason why as the person being 'sleepy'. However, staff had recorded the person was given a 'when required' medicine and three other medicines at the morning dose time. The person had a pressure ulcer that was being dressed by the community nursing team and the pain relief helped with this process. Whilst there was no record in the person's daily notes to evidence they had experienced an impact from not having the pain relief, the potential was there for this to occur.

When we checked the person's record of 'when required' medicine, which was prescribed twice a day when necessary to relieve anxiety, we found there was no protocol to guide staff in when to give this to them. When we asked one member of staff why they had given it to the person on the morning of the inspection, they said, "Because it was there." When we checked the person's medication administration records (MARs) for the previous 15 days, we saw there were 10 occasions when the medicine had been given to them but, when cross-referenced with their daily notes, only on one occasion was it recorded the person was distressed or anxious. We also found the medicine was recorded as 'G' which meant 'not available' on 12 October 2016 with no reason why. The same person had missed 24 doses of a specific medicine in one month due to stock issues. A senior care worker told us medicines were often missing from the delivery and they had to contact GPs again to chase up prescriptions. On the day of inspection, one person had not received any of their medicines as stock had not arrived; the senior care worker contacted the pharmacy to address this.

We found there was a discrepancy in the controlled drugs register for another person's pain relief medicine when the total remaining was recorded as 23 but we found 24 tablets in the stock cupboard. The registered manager told us they would investigate this.

Not ensuring medicines were managed properly and people received them as prescribed was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

Medicines were stored appropriately and securely. We observed staff giving out medicines to people and noted they were patient and responsive to people's needs. They checked the medicine with the person's medication administration record, dispensed them into pots to give to people, provided a drink of water and stayed with them until they were sure they had taken them.

People who used the service told us they felt safe living there and there was sufficient staff to support them. Comments included, "Yes, I do feel safe", "They come and check I'm alright during the night", "I have a gate on my room to stop other residents coming in and that makes me feel safe", "There seems to be enough

staff on duty", "They always seem to be busy but they do stop and talk" and "I press my buzzer and they come; sometimes I have to wait but they come in good time."

Comments from relatives included, "I think my mum is safe; they seem to be kind", "I trust everybody, I trust the staff", "I feel my relative is safe here", "Yes, there is enough staff", "There is always staff about" and "I can always find and member of staff when I need them."

At the last inspection in September 2015, we had concerns there was insufficient staff to meet people's needs. We found that staffing levels had not kept pace with the admission of new people to the service. Since that inspection, there has been an increase in staffing levels confirmed in rotas and in discussions with staff and we were satisfied there were sufficient staff to meet people's needs. There were 26 people residing on the first floor with four staff on duty to support them and 20 people on the ground floor with three members of staff. There was an additional member of staff who worked between both floors supporting where needed the most. There were four staff on duty at night. There was a registered manager and deputy manager on duty during the week and a range of ancillary staff such as catering, housekeeping, domestic, administration and activity coordinators. Comments from staff regarding increases in staffing levels included, "It's much better now, we don't seem as rushed", "The staffing levels have increased and we have someone who works between the two floors" and "They seem to be recruiting the right calibre of staff now." One health professional said, "There always appears to be a lot of staff around."

There were policies and procedures to guide staff in how to keep people safe from the risk of abuse and harm. Staff had received safeguarding training and in discussions were able to describe the different types of abuse and how to respond to allegations, concerns or incidents between people who used the service. People had risks identified in their care files for areas such as nutritional intake, falls, moving and handling, skin integrity and behaviours which could cause them anxiety or distress. In one person's care file, we saw the moving and handling risk assessment had been updated following an incident when they fell and sustained an injury. Each person had a personal evacuation plan to provide staff with information about how they should be evacuated from the building in emergencies.

We found thought had been given to making the environment safe for people, whilst still enabling them to have freedom of movement in their bedrooms and communal rooms. For example, the kitchenettes off both dining rooms had a hot water boiler for staff to make hot drinks; these were placed in locked cupboards which made them safe but didn't stop people who used the service from entering the area if they wanted to open cupboards or wash up pots. Equipment used in the service was maintained and checked regularly to make sure it was safe to use. There were checks on hot water outlets, window restrictors, bed rails, wheelchairs, hoists and slings, the lift and gas and electrical appliances.

Relatives told us the service was always clean and tidy and we saw there were plentiful supplies of cleaning products and personal, protective, equipment for staff such as gloves, hand gel, paper towels and soap. We found there were some areas of the service that required attention and cleaning, for example, bedrails protectors stored on the floor under beds which harboured dust, a wheelchair required cleaning, a person's chair in their bedroom was sticky, a wardrobe needed securing to the wall, a toilet was leaking and two toilet seats were loose. These and other minor issues were addressed on the day and the registered manager told us they would ensure staff checked areas more thoroughly and reported concerns to domestic or maintenance staff straight away.

At the last inspection in September 2015, we found the registered provider's recruitment practices were robust and staff only started work when all employment checks had been carried out. The system remained the same, as confirmed in a discussion with a new member of staff during this inspection. As such we did not

need to check recruitment records again at this inspection.

Requires Improvement

Is the service effective?

Our findings

We found people had not always received care which had been consistently effective in meeting their health needs. Health professionals raised concerns about how people's pressure areas and food and fluid intake was monitored and recorded. One also told us they had witnessed staff move and handle a person in a way that did not respond to their specific needs and raised this with the registered manager to address with them. A health professional expressed a view that staff may need to be more responsive and identify sooner when people's health needs could no longer be met within the service. The registered manager told us that one specific person was to move to an alternative placement at the end of a respite period but this had not occurred as the service was unable to meet their needs. Health professionals stated staff contacted them when they had concerns about people, and although the registered manager was responsive to concerns, they felt care staff did not always comply with nurse's instructions. For example, the management of one person's diabetes, including the timing of breakfast in line with professional advice for insulin injection treatment so as to prevent anxiety. The registered manager told us staff were aware of instructions from district nurses regarding the timing of breakfast but on some occasions the person who used the service became distressed so staff served them the meal. On one occasion, staff had been asked to obtain a urine sample but they had forgotten, which delayed antibiotic treatment for one person. On the day of the inspection, a health care professional was concerned about one person's low blood sugar levels and the colour and consistency of their urine. This led them to question the accuracy of their recorded food and fluid intake.

Comments from the community nursing team included, "The staff are ok but it depends who's on, sometimes you can't find them", "Staff can be very difficult and do not comply with nurses instructions", "Pressure area turns have been neglected", "Often things have deteriorated to a large degree by the time we have been informed", "We had a meeting with the manager and asked for patient's charts to be kept in the rooms instead of the office [so they were accessible for nursing staff to check]. It worked for a while but now it's slipped back again" and "Sometimes advice given by nurses is not handed over to staff on the next shift." The registered manager told us they always contacted the district nursing service as soon as possible and gave examples of when they had worked well with health professionals. However, they also acknowledged that the relationship between staff and health professionals could be improved especially in relation to communication and documentation.

The registered manager was described by health professionals as very responsive and always tried to address issues. However, not working effectively with other health care providers who shared care and treatment of people was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

One health care professional had more positive comments, "They monitor the residents and tell us if there are any changes so that's good" and "I have raised concerns in the past about the quality of the documentation and this seems to have improved." Care records indicated people had access to health professionals such as GPs, hospital consultants, district nurses (D/Ns), community psychiatric nurses (CPNs),

dieticians, speech and language therapists (SaLT), emergency care practitioners, opticians and chiropodists. A CPN stated, "Staff have sought support from mental health services when needed and acted upon advice."

People who used the service told us staff looked after them well and they liked the meals provided to them. Comments included, "They seem to know what they are doing", "They look after me really well", "They get plenty of training; my key worker tells me about it", "I like the food, there's a good choice", "The food is ok; I usually get what I want", "We can have want we want for breakfast", "The food is good and we get plenty" and "This new system is ok but it's not like home cooking." The new system the person referred to was 'Appetito meals', which were delivered to the service rather than cooked on the premises.

Relatives made the following comments about the food, "They are aware of mum's nutritional needs and give her choices and help if needed", "The food always looks ok to me", "My mum quite likes the food, she eats it all", "It always smells good and there plenty of choice" and "Yes, the food is good; he said they could offer more fresh fruit."

There was a summary of each person's nutritional needs available for care and catering staff which was comprehensive. It detailed any food allergies, the date people had been seen by a SaLT, special dietary needs such as sugar-free, halal or vegetarian, the required textured of food and fluids, how people preferred their tea or coffee, if food supplements were prescribed and how much support was required from staff. The care files had nutritional risk assessments and care plans detailing people's needs and preferences and their weight was monitored in line with the assessment. The monitoring for one person had days when fluid intake was recorded as low and other days when they drank larger amounts. However, there were no instructions for staff in what was the optimum level of fluid intake for the person to aim for and staff to encourage. The running total was blank which made it difficult to establish, at a glance, whether the person was on track to meet their fluid intake needs and there was no consistent approach to senior staff monitoring this and addressing with care staff at intervals during the day. We spoke with the registered manager about monitoring people's needs more effectively and they told us they would address this with staff.

The cook was fully aware of who required a special diet and showed us gluten-free meals that were obtained for one person. The meals provided had the number of calories in each portion which, the cook said, made it easier to monitor people's daily calorie intake. The cook told us 11 people had a cooked breakfast each day as their choice and they had information about people's birthdays so they could make a cake or special treat. We observed the lunchtime experience was relaxed and no-one was hurried with their meals. Support given by staff met people's needs and was completed in a sensitive and encouraging way. Staff offered people a choice by presenting the food on a tray and people chose the one they wanted; the meals served to people looked well-presented and hot. People were provided with plenty of cold drinks during the meal and offered a warm drink following lunch. We observed one person didn't want any of the food on offer so staff tried different items such as sandwiches and in the end the person had a plate of biscuits and a cup of tea.

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 so that they can 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 found the registered manager and registered provider was working within the principles of the MCA. The registered manager was knowledgeable about the criteria for DoLS, staff had received training and appropriate applications had been made for people. There was a log of when people's capacity had been assessed, when a best interest meeting had been held, when the DoLS application had been made and when they had been authorised. The information enabled the registered manager to follow up with the Supervising Authority, which was the local authority safeguarding team, and check progress of the applications. In discussions, staff demonstrated awareness of the need to gain consent prior to carrying out care tasks.

Staff had access to a range of training to enable them to complete their roles. This was monitored and updates arranged at intervals. We spoke to a new member of staff who confirmed their induction had consisted of three days of training in areas such as fire safety, moving and handling, safeguarding, first aid, infection prevention and control, and respect and dignity. Following this they completed shifts shadowing more experienced staff and observed how personal care and supporting people to eat their meals was carried out. They told us they were supported by senior staff until they felt able to complete tasks alone. They said, "The induction was very helpful; the staff all helped." Staff had regular supervision meetings and annual appraisal. The registered manager also completed additional supervision and competency checks as a result of incidents or observations of practice.

Good

Is the service caring?

Our findings

People who used the service told us staff were caring. Comments included, "The staff are kind; they see that I'm looked after properly", "They [the staff] are always nice and cheerful, we have laugh with each other" and "They [the staff] come to see if want anything and they help get dressed and go to the toilet. I don't go out of my room much but they come and see me."

Relatives said, "The staff are lovely, they just can't do enough for my mum. She can be a bit awkward at times but they are really patient with her", "She always looks clean and tidy with her hair and nails done", "Staff are friendly, caring and approachable", "Staff are very caring", "It's brilliant here and the staff are great", "The chef is very friendly and says hello and mingles with families" and "All the staff seem to care, no-one shouts or loses their temper; they are really good."

Visiting health professionals said some staff were excellent and provided their names. They said if they were on duty, things got done. They said staff were approachable, friendly and helpful.

The interaction we saw between staff and people who used the service was positive. Staff had a caring and kindly approach and took their time with people to make sure they had understood what they had said to them.

We observed staff were attentive to people's needs, for example, during lunch when explanations of the food available was provided to people. Staff explained actions when they transferred someone from an easy chair to a wheelchair for transporting them to another room. Staff gently guided people away from any confrontational situations and made sure they were safe. Staff knew the needs of the people who used the service and could describe these to us. We saw some people did not have socks or tights on when they wore their slippers and asked the registered manager to address this with staff and establish if this was choice, a lack of appropriate clothing or a time issue. The registered manager told us they would address this with staff.

Staff understood the importance of respecting people's dignity and choices. They told us, "I always knock on people's doors and make sure they are covered over if I'm doing any personal care" and "I think it important to respect people's dignity and choices; we have to make sure they don't feel as though they are not important." Staff also understood the importance of maintaining people's independence and told us, "I like to help the resident keep as independent as possible so they feel good about themselves", "I make sure they do things for themselves if they are capable" and "We try and keep people's independence and help them when we can."

People had individual bedrooms, some of which had en suite facilities; the bedrooms afforded people privacy. There was a lockable facility for people to store valuables in each bedroom and privacy locks to bedroom, bathroom and toilet doors. We saw people's bedrooms were personalised to varying degrees and some people had their own phone, ornaments, pictures on the walls and small items of furniture to make it more homely. We observed one person's bedroom was sparse but after discussion with them, they

confirmed it was their choice to have the room this way and they did not want to change it. They said, "I make my own choices; I like it here and I'm comfortable. I like to watch TV and I go to the dining room for meals."

People were provided with information. There were notice boards reminding people of the day and date, what activities were on offer, what the menu was that day, messages for relatives about unidentified laundry, minutes of meetings and dates for the next residents and relatives meetings. There was also the opportunity for visitors to comment on whether any member of staff has made a difference to their relative.

Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the offices. Health professionals could see people in their own bedrooms. Staff files were held securely and care files were in lockable cupboards but were accessible to staff. People's medication administration records were held with the medicines trolleys in the treatment rooms. The registered manager confirmed the computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held.

Good

Is the service responsive?

Our findings

People told us they knew they could raise concerns or complaints. Comments included, "I would see the new manager she's really nice" and "I would tell the staff but I don't have any right now."

Relatives told us staff were responsive to people's needs and there were activities for them to participate in. Comments included, "She seems settled some days. She doesn't need a lot of help but she looks well", "We're invited to reviews to discuss the care", "They are never left in any pain", "There are different activities every day and she is not forced to join in if she doesn't want to; she has been taken out for a walk and to a show", "There are lots of different things to do" and "Yes, there are things to do and trips out sometimes. She can get a bit fed up of doing the same ones [activities] as she likes to go out all the time."

We saw people had an assessment of their needs prior to admission which was checked again when they were actually admitted to the service and at intervals to ensure it was updated if their needs changed significantly. There was also a range of risk assessments and moving and handling guidance to assist staff in supporting people safely. The assessments were used to assist staff in formulating care plans. Each person had a plan of care which provided staff with guidance in how to support people in the way they preferred. Some of the care plans provided more detailed information about people's preferences than others but generally they provided good guidance for staff. For example, one person's care plan to support their changing behaviour was detailed yet another person's required more information and a third person's risk management plan required an update following an incident. This was mentioned to the registered manager to address and monitor when completing audits.

People received care that was responsive to their needs. For example, one person received one to one support for several hours a day due to behaviours which could be distressing to them and other people. Daily records had information about the person's behaviour throughout the day and night, the staff approach when the person became distressed and how effective this was in minimising their anxiety and calming them or the distraction techniques they used to avoid confrontation.

There was an activity coordinator employed for the service and they devised a weekly plan. Information about the activities was on display. The activities included memory lane/reminiscence, crafts such as knitting, baking and colouring, and games such as jigsaws, puzzles, darts, dominoes, throwing beach balls and bowling. There were karaoke and singing sessions, hand massages and nail care, listening to music, watching films and reading newspapers. There were musical instruments and oomph sessions to assist people with movement to music. There were occasional trips out and walks in the garden.

We observed an activity of 'charades' during the inspection. People who wanted to participate were supported into the upstairs dining/lounge area and the activity coordinator explained what was to happen and gave an example. The activity coordinator asked people to describe their favourite film or song. Some people were struggling with the concept of the game and had difficulty engaging with the activity so the coordinator changed the emphasis of the activity and started talking about Christmas and what songs should be in the Christmas concert. People enjoyed this and started singing Christmas songs and hymns.

The activity lasted for about one and a half hours and people seemed to enjoy the interaction.

We found the environment and equipment used in the service had been designed as a response to people's needs. For example, corridors were wide for people who used wheelchairs, there were grab rails to assist mobility and signs to alert people to the location of toilets and bathrooms. Thought had been given to the colour of toilet doors and toilet seats to make them more visible to people living with dementia and we saw there were tamper-proof fire extinguishers. There were specific wide-grip cutlery and plate guards to assist people with eating their meals independently.

There was a complaints procedure on display in the entrance and this was provided to people in a 'service user guide'. The policy and procedure described timescales for acknowledgement, investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. Relatives knew they could raise concerns or complaints with staff or the registered manager. They said, "I know there's a complaints procedure and I can go to the manager if I want, but I just tell the staff and they sort it out", "I would approach [registered manager's name] directly or ring HICA headquarters" and "Yes, always [can raise complaints and they will be addressed]."

Requires Improvement

Is the service well-led?

Our findings

There was a quality monitoring system in place in the service. This consisted of audits, surveys and meetings to seek people's views. The medication was audited at the end of every shift by the senior care workers on duty; the shortfalls found in medicines management during the inspection evidenced a need to audit this more closely. We saw evidence the registered manager had audited people's monitoring charts and gave staff instructions when shortfalls were found. However, there remained some shortfalls especially in monitoring people's fluid intake and output and behaviour when they were specifically at risk. The checks in place required closer scrutiny and follow up with staff. Care plans were audited and in most instances any shortfalls found were addressed. However, we noted one person's risk assessment required adjustment following an incident of concern. The registered manager told us they would address these shortfalls straight away.

We recommend the audit system is developed further to include robust monitoring of records and follow up when shortfalls identified.

Other audits had been useful in identifying areas to improve. For example, one audit included assessing and reporting on outbreaks of infections and who had pressure ulcers each month. There was a monthly environmental check to look at infection prevention and control, general cleanliness and the need for replacement items. There was a monthly early warning tool completed by the registered manager which covered a range of areas such as health and safety, infection control, staff training and supervision, complaints, staffing levels, recruitment and retention, medication, a selection of care files and nutrition. The registered manager told us the quality monitoring system was under review but the tool was still being used in the interim. We saw senior managers completed visits and reported on their findings. For example, a senior manager visited on 5 October 2016 and scored the service in specific areas. They had checked documentation such as the training matrix, accidents and incidents, maintenance checks, fire safety and bedrooms. The registered manager had made interim notes and an action plan from the visit.

Relatives knew the registered manager's name and told us they were able to meet with them if required. They also said they were asked their views about the service and had meetings at which they could raise issues. Comments included, "[Registered manager's name] is always available. She is very pleasant and we always have a chat" and "The manager is very positive. You can see her; she has an open door policy and you see her on the floor [walking around and visible to people]" and "There are meetings monthly." One relative told us how they had raised the issue of staff not wearing uniforms and the difficulty this posed when wanting to speak to senior staff. This had been listened to and staff now wore different coloured tee shirts dependant on their role, and had name badges.

At the last inspection in September 2015, we had concerns there was insufficient oversight and monitoring of the quality of the service provided to people. The registered manager has been employed since the last inspection and has made improvements in how audits and checks are carried out; staff morale has risen since stable management has been in place. We spoke with the registered manager about the culture of the organisation and their own management style. We found the registered manager was open in her approach

and keen to identify shortfalls and make improvements. The organisation had 'SHINE' philosophy" [expectations of staff behaviour that underpins HICA's values and vision]. There were SHINE awards that staff could achieve through nominations from colleagues or relatives of people who used the service. The Chief Executive Officer and senior management had visited the service and made themselves available to staff should they wish to raise concerns.

Staff told us they felt supported by the registered manager, the deputy manager and senior care workers in charge of shifts. They said, "The seniors are nice and the manager is lovely; I feel I can go to them" and "The manager is approachable and I would not hesitate to go to her with anything."

Accidents and incidents were logged when they occurred and the registered manager had identified whether these had been falls, incidents between people or injuries caused by other issues. The times and location of accidents and injuries were identified to enable an analysis of factors such as time of day and whether people were prone to falls more in the morning or evening, when alone or in communal areas. The notifications received by the Care Quality Commission have this information included in each one and the action taken to try to minimise them.

We saw there was a good exchange of information between the manager and staff and also in interactions and meetings with people who used the service and their relatives. The registered manager held team meetings and also ensured staff saw memos of an urgent nature. She attended handover meetings when required to ensure specific information was passed on to staff.

Staff meetings took place to enable issues to be discussed, information to be shared and for people to express their views. We saw minutes of several meetings such as the health and safety forum; this highlighted areas of work that needed action and the timescale for their completion. We saw most of these action points had been ticked as completed. The minutes of a senior care staff meeting in September 2016 detailed a discussion about how care, communication and systems within the service could be improved; the minutes were comprehensive and evidenced senior care staff were helped to develop their roles as they were asked to chair the meetings and record the minutes. The minutes for the full staff meetings were similarly thorough with the registered manager passing on important information, reminding staff of their roles and responsibilities, holding a quiz about the needs of people who used the service, and providing positive feedback to staff.

There were meetings for people who used the service and also for 'friends and families'. Those for people who used the service provided information about the change in staff uniforms, discussed meal provision, checked if people had any complaints and whether they would like to go on any specific outings or had suggestions for activities. The friend and families meetings discussed areas such as refurbishment plans, complaints and niggles, activities, the amenities fund, staffing levels and changes, surveys and outcomes and the actions taken to keep people who used the service safe. The minutes showed that people were able to express their views and make suggestions.

There had been surveys for people who used the service, their relatives, professionals and staff. There was also evidence the registered manager had held a meeting with health professionals to discuss concerns. In view of some concerns highlighted during the inspection, the registered manager is to arrange another meeting with health professionals to try and address issues.

The registered manager was aware of their registration responsibilities; we received notifications in a timely way about incidents and accidents which affected the safety and welfare of people who used the service. We saw the score awarded from a food safety inspection was displayed for people to see; this was '5', which was

the highest rating possible ['0' being the worst and '5' being the best].

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that service users were protected by the proper and safe management of medicines; some people had not received their medicines as required. Regulation 12 (2) (g) The registered provider had not consistently ensured that staff actively worked with other persons, who shared responsibility for the care and treatment of service users. Regulation 12 (2) (i)