Care Quality Commission

Minchinhampton Centre For The Elderly Limited

Minchinhampton Centre for the Elderly - Horsfall House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days – 8 and 9 February 2017. The inspection was unannounced. When we last inspected in August 2014 there were no breaches of the legal requirements.

Horsfall House is registered to provide residential and nursing care for up to 44 older people. The home had two units, one for people with dementia on the ground floor and a general nursing unit. Both units were 22 bedded. All bedrooms were single and had en-suite facilities. The home was purpose built and set within large landscaped gardens. One place was used to provide free respite care for people who needed support on a short term basis. This could be on either unit. At the time of our inspection there were 43 people in residence.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The service was partly effective because they were not working within the principles of the Mental Capacity Act 2005 (MCA). For those people who were unable to provide consent to live at Horsfall House, deprivation of liberty safeguards applications had not been made to the local authority. This meant people were being unlawfully detained.

Improvements were required with people's care records. Core care planning documents were used but the staff added little detail regarding the person's specific needs. Some plans did not record the intervention required by the staff team. Some daily records were not recorded in date order. These shortfalls had not been highlighted during the services auditing procedures.

The registered manager and staff team understood their role and responsibilities to protect people from harm. No safeguarding concerns have been raised in the last year. Risks to people's health and welfare were assessed and appropriate management plans were in place to reduce or eliminate the risk. Staffing numbers on each shift were sufficient to ensure people were kept safe.

The management of medicines was safe and there were good infection control and prevention measures in place to safeguard people.

Staff were well trained and able to carry out their roles effectively. New staff to the service had an induction training programme to complete and regular refresher training was arranged for the whole team. People were provided with sufficient food and drink and staff monitored those people who were at risk of malnutrition or dehydration. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

People were looked after by a staff team who were kind and caring. There were positive and caring

relationships between staff and people who lived in the home and this extended to relatives and other visitors. Where possible, people were involved in making decisions about how they were looked after. People's privacy and dignity were maintained at all times. The service aspires to the principles of the Gold Standard Framework for end of life care and has enrolled on this training programme commencing May 2017.

People received care and support that met their individual specific needs. They were encouraged to express their views and opinions, the staff listened to them and acted upon any concerns to improve the service.

Although the registered manager provided strong leadership and was well respected by staff, relatives and the people who lived in Horsfall House, improvements were required in two areas. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

The service remains safe.

Is the service effective?

The service was not fully effective.

People were not looked after in accordance with the Mental Capacity Act 2005. Those who lacked the capacity to consent to live at Horsfall House for the care and treatment they needed did not have authorised deprivation of liberty safeguards in place.

Staff were well trained and had the necessary knowledge and skills to do their jobs effectively. The staff were well supported by the registered manager.

People were supported to have enough to eat and drink. Where a person was at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

The staff ensured that people's health care needs were met and worked with the GPs and other healthcare professionals to access relevant services.

Is the service caring?

The service was caring.

People were looked after in the way that they wanted and the staff took account of their personal choices and preferences. People were involved in making day to day decisions about their care.

People were treated with dignity, kindness and respect. The staff team provided the support they needed but encouraged people to be as independent as possible.

Is the service responsive?

The service remains responsive.

Is the service well-led?

The service was partly well-led.

The monitoring systems in place had not been effective in ensuring that care records were accurate, complete and contemporaneous. Other audits had identified shortfalls and gaps and remedial actions had been taken

The registered manager used any comments or complaints people made about the service to drive forward any improvements.

A programme of improvements to the premises ensured people were looked in comfortable and pleasant surroundings.

Care Quality Commission

Minchinhampton Centre for the Elderly - Horsfall House

Detailed findings

Background to this inspection

The last inspection of Horsfall House was completed in August 2014. At that time we did not find any concerns about the service and there were no breaches of legal requirements.

The inspection team consisted on one inspector 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. Their area of expertise included dementia care as well as care of the older person.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. The PIR was very well completed and provided us with a lot of information about how the service ensured it was safe, effective, caring, responsive and well-led.

We contacted the adult social care commissioning team in Gloucestershire County Council prior to the inspection and they provided us with feedback. The comments we received have been included in the main body of the report.

During the inspection we spoke with 13 people who lived in the home, six relatives or friends who were visiting and 14 members of the staff team. This included the registered manager, qualified nurses and care staff, the receptionist, housekeeping, catering and maintenance staff.

Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework for Inspection session (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

We looked at the care records of six people (three from each unit), five staff recruitment files and training records, staff duty rotas and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People were safe and happy at Horsfall House. They made the following comments, "I have a button, look – I just press it and they come quickly", "The staff are always about, never far away", "I walk around with my frame if I need it but there are rails along each side of the corridors" and "The staff know what they are doing and look after me". Relatives and other visitors we spoke with said, "My wife has had one fall since being here but this was discussed with me", "To me this is five star" and "My wife is safe. I would not want her anywhere else".

The service had a safeguarding adults policy and this had last been reviewed in November 2016. Staff were aware what constituted safeguarding and of their responsibility to report any concerns they had. They would report to the registered manager or the nurse in charge but knew they could report directly to Gloucestershire County Council, the Police or the Care Quality Commission if need be. All staff had to complete an on-line safeguarding training module and this was refreshed on a three yearly basis. No safeguarding alerts have been raised by the service or by other services since the last inspection.

Staff files evidenced that safe recruitment procedures were followed before new staff were employed to work in the service. Appropriate pre-employment checks had been undertaken. Each file contained an application form, two written references and evidence of the person's identity. Disclosure and Barring Service (DBS) checks had been carried out for all staff. This helped to ensure that only suitable staff were employed. The majority of staff we spoke with had worked at the service for a long period of time and staff turnover was low.

The service had measures in place to ensure that any risks to people's health and welfare were identified and then managed to reduce or eliminate the risk. Risks assessments were completed for each person in respect of nutrition, the likelihood of developing pressure ulcers, falls, use of bed rails and moving and handling procedures. Where the staff were required to move people from one place to another, a moving and handling personal profile had been devised. Where assessments had shown that the use of bed rails was not appropriate because they posed a greater risk of injury, beds were used that could be lowered to the floor and soft mats were placed by the side of the bed. Procedures for the use of bed rails were the same in both the nursing and dementia care units but the other alternative was more prevalent in the dementia care unit.

The fire risk assessment for the service was last reviewed in July 2016. The fire procedure was last updated following a visit by the Fire and Rescue Service in March 2014 and there was a 'horizontal evacuation' process in place. Regular fire practice sessions were arranged, the most recent one having been the week prior to the inspection.

The service had a business continuity plan. This included information about alternative accommodation and what to do in the event of an emergency such as severe weather conditions, staff shortages and loss of power. Personal emergency evacuation plans had been prepared for each person: these detailed what support the person would require in the event of a fire.

There was a programme of maintenance checks in place to ensure the premises were safe. These included checks of the fire alarm systems, fire fighting equipment, fire doors, and the hot and cold water temperatures. Regular servicing contracts were in place of all hoisting equipment and the call bell system. Records evidenced that all checks has been completed. Catering staff had checks to complete of fridge and freezer temperatures, hot food temperatures, food storage and cleaning schedules. The environmental health officer had recently visited and the service retained their five star hygiene certificate.

Staffing levels for each unit were adjusted according to people's needs and increased when people were unwell or there were activities planned to take place. Shifts were covered with a mix of management, ancillary and care staff (nurses and care staff). Nurses were on duty for every shift including weekends and overnight. Staff were employed to work on either the general nursing or dementia unit but would cover shifts on the other unit if needed. Staff told us staffing levels were appropriate and the registered manager listened to their feedback if the staffing numbers needed adjusting. There was little turnover of staff, with many having worked at the service for years. There was minimal use of agency staff. One long term vacancy for a qualified nurse had been covered by an agency nurse for over a year. People were therefore looked after by staff who were familiar with their needs and preferences.

The measures in place for the management of medicines were safe. Prescribed medicines were stored, administered and disposed of in line with current regulations and guidance. Those medicines that must have additional security were and the drug register was completed each time medicine was administered. A monthly stock check was undertaken. All qualified nurses who administered medicines were trained and assessed to ensure they fulfilled their role safely and people received their medicines as prescribed. One of the nurses told us the GP regularly reviewed the medicines people were prescribed.

People were cared for in a well maintained, clean and hygienic environment. Staff received infection control training and one of the nurses had taken a lead role in infection control and prevention. They had established contact with the local NHS Infection Control Link Nurse and attended control group meetings. The nurse monitored and audited the effectiveness and adherence to the policies and procedures of the service. This included checks of the mattresses and air mattresses, pillows, commodes and the sluice rooms. We found that the equipment used to assist people was fit for purpose, regularly maintained, serviced and kept clean.

Requires Improvement

Is the service effective?

Our findings

People said their needs were met by staff who knew what they were doing and their agreement and consent was sought before personal care was provided. They said, "If I want something done, they will help", "The staff are exceptionally good although some are take-it-or-leave-it" and "Just ask and they'll help". Relatives told us "(named person) gets on very well with the staff" and "The staff seem to think she is settling in ok". Relatives were confident their loved one was looked after by staff who had received the right training.

Staff we spoke with were knowledgeable about the people they were looking after and were able to talk about their individual preferences and daily routines. Staff turnover was low and many of the staff team had worked at the service for many years. People were looked after by staff who were familiar with their needs.

However, we found that the service was not working within the principles of the Mental Capacity Act 2005 (MCA). 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. 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).

Some of the care plans we saw included specific forms which assessed whether the person had, or lacked, the mental capacity to make a particular decision. The assessment for one person, completed in June 2015 determined they lacked the capacity to make decisions, about washing/showering, feeding/nutrition, continence and dressing. A review of this assessment in October 2015 stated "to carry on making decisions". This person's full MCA assessment had not been reviewed in over 18 months. For another person their care plan stated they did not have capacity however there was no evidence of an MCA assessment having been carried out. This person's care plan stated they were resistive to being supported with personal care and would become aggressive and physically abusive.

Information provided by the registered manager prior to the inspection reported there were no DoLS authorisations in place and this was confirmed during the inspection visit. When we visited in August 2014, the registered manager had been in the process of submitting the relevant applications to the local authority. The registered manager was unable to provide an explanation as to why the service was not working within the principles of the MCA and those nursing staff we spoke with had little or no understanding of the DoLS legislation.

The service looked after 22 people in the Cotswold unit – the dementia nursing unit. This was a secure area of the home which could only be entered or exited using a fob key. The registered manager, nurses and care staff told us people were able to access a courtyard garden or the gardens to the rear of the property however would generally do this under supervision (from staff or family). There was no evidence of any mental capacity assessments having taken place to determine whether the person was able to consent to

reside at Horsfall House for the care and treatment they needed. People were therefore not safeguarded against the risk of receiving improper treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. This meant that these people were being deprived of their liberty without a DoLS authorisation in place.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

During the course of the inspection we heard people being offered 'day to day' choices by the care staff. We heard people being asked, "Would anyone like a bit of music on", "We are doing some flower arranging in the dining room would you like to come and join us" and "Would you like a nice cup of tea and some biscuits". Staff told us they would always ask for people's consent before providing assistance with personal care.

Staff were well supported. They had a regular supervision meeting with the registered manager, the unit leaders or a qualified nurse. Supervisions were arranged on a two to three monthly basis and records evidenced these arrangements. Staff said the registered manager and the unit managers were always available and they could talk to them at any time about concerns or training requirements.

Staff received the training they needed to do their job effectively. New staff completed an induction training programme when they first started working in the service. Any 'new-to-care' care staff also completed the Care Certificate training. The Care Certificate was introduced in April 2015 as the new minimum standard for induction for those commencing a career as an adult social care worker. The Care Certificate comprises of 15 Standards aimed at ensuring that these new workers are suitably trained and assessed to deliver safe, effective, responsive care. These can be achieved by a mixture of knowledge learning, practical training and workplace assessment.
A new member of staff told us they were working through the Care Certificate and was being supported by a mentor during the process.

Staff had a programme of mandatory training to complete with refresher training arranged on a yearly basis. Training was delivered in a number of ways – online training courses and face to face training. Key staff had taken lead roles in delivering some of the training, for example moving and handling, food hygiene and health & safety. All staff who worked on the dementia care unit had completed dementia care training, with a knowledge based assessment test at the end. Training was arranged regarding specific clinical conditions for example, catheter care, syringe driver training for nurses, palliative care and diabetes management. All but a few care staff had achieved a diploma in health and social care at level two or three. One of the qualified nurses had taken a lead role in staff training and monitored that all staff received the training and update training they needed.

People were provided with sufficient food and drink. They were given a wide choice of meals and different types of food were served each day. At midday there were at least two hot meal options with vegetarian options. The kitchen catered for people who needed a gluten free or diabetic diet and also those who needed a pureed of soft diet. The kitchen staff were informed about people's allergies and likes/dislikes and told about those who had lost weight. They provided fortified meals and milk shakes for those who needed extra calories.

Where people were at risk of poor dietary and fluid intake, records were kept of how much they had eaten and drunk. Body weights were checked monthly and more often if needed. The GP was consulted about any

significant weight loss and supplement drinks prescribed or a referral to a dietician was made. People were offered regular refreshment of hot and cold drinks with biscuits and home made cakes. People made the following comments about the food: "The food is quite good. If there is a choice you get what you want", "They have really good food here. There is always a vegetarian option and a second choice, an alternative".

People were encouraged to eat their meals independently but were provided with support where this was needed. Some people required regular prompting to "eat a little bit more" throughout the meal. The staff sat with those who required help to eat their meals and supported them sensitively. Where people were provided with assistance from the staff to eat their meals we noted this was provided in the lounge area adjacent to the dining room or in their bedrooms.

People were each registered with a local GP practice. One of the GPs visited on a weekly basis and did a "ward round" of those people who needed to be seen. Home visits were requested whenever people were unwell or when people needed to see the doctor. Arrangements were also in place for people to receive support from visiting opticians, dentists and chiropodists. The service worked alongside community and hospital social workers, therapists, the community mental health care services in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People were looked after in a caring way and it was evident they were treated with respect and their privacy was maintained when needed. They told us, "The staff are very friendly", "They will sit and chat with you if you want", "There is no one I don't want to see on duty" and "The staff are kind and compassionate". Relatives said, "I am as happy as can be expected. The care here is excellent", "The staff are wonderful and the food is quite good", "(named person) initially came her for respite but they need full time care now. It was fortunate they could come here" and "What better view (pointing to the window). And the staff are wonderful".

People looked smart and well cared for. Their clothes were well laundered and each person was encouraged to wear the style of clothing they were used to. One person told me she liked to wear a skirt and matching jumper and had "never worn a pair of trousers in their life". Staff treated people with dignity and respect. Staff knocked on bedroom doors before entering and hesitated for a while before entering if there was no response.

We looked through a sample of the many thank you cards, sent to the home from families. The cards were full of positive comments for example, "Thank you all so much for the excellent care you gave to (named person)", "The compassion, respect and dignity you gave her in her final days will stay with me forever", "I will be forever grateful for Horsfall House offering a room for (named person) when I was unwell. It helped the family enormously" and Wonderful care and kindness".

The staff had excellent relationships with people and their relatives who visited. Relatives received a welcome in to the service and one told us they were always offered refreshments when they arrived. We saw moments of tender loving care when were there. One example was an interaction between a person and a member of care staff – the person was arranging flowers in a vase and the staff member sensitively suggested the vase be turned round so that the other side of the arrangement was filled up. This was a very positive comment and did not draw the attention to the fact the display was lob-sided. One relative commented that it had always been important for their mother that she wore her beads every day, and the staff ensured this was carried on. Staff told us about another person who liked to make up their face each day and they helped her do this. These are very good examples of the person centred care each person will receive at Horsfall House. All staff we spoke with confirmed they would recommend the service to family and friends and were proud to work at Horsfall House.

Staff knew the people they were looking after well and we heard them addressing them in an appropriate manner. The majority of people were called by their first name. In the care plan for one person their preference to be called by their full first name and not a shortened version was recorded.

Each person was allocated a name nurse and a keyworker. A keyworker is a member of the team who has been allocated to a person; their function is to take a social interest in that person, developing a good knowledge of them and building up a trusting relationship and in conjunction with the rest of the staff team ensure the person's care plan remains relevant.

The service recognised that an important part of people's well-being was ensuring their social and emotional needs were met. Relatives and friends were able to visit without any undue restrictions. Social events were arranged including garden parties, celebrations of significant events such as the Queen's birthday in April 2016 and a Christmas bazaar. All birthdays were celebrated with a cake and a sing-song. The day centre adjoining the care home was used for an Over 60's club and people from the service and the local community were able to attend these 'social functions'. The club ran on a monthly basis and guest speakers were arranged – the most recent speaker had talked about the Land Girls. The registered manager explained the importance of people being able to "go out" to a social function rather than everything happening in Horsfall House. This also meant people were able to maintain links with the local community.

People were encouraged to make choices about their daytime activities, what they would like to eat and where they would like to spend their time. One person told us, "I always like to sit in this chair and watch what is going on – everybody knows that". Even though this person did not have the capacity to make bigger decisions the staff respected this person's views and preferences. It was evident from speaking with the registered manager, the nurses and care staff that feedback from people and their relatives/friends was always listened to and acted upon where necessary.

The service has one bed for 'free respite stays' available to be used by people from the local community who were in need. This was paid for by the fundraising team (the charity was founded to provide care to older people in the local area). The registered manager said there was strong take-up for the service. People had written to the registered manager after their relatives had a respite stay at Horsfall House. They said, "A huge thank you – we feel really confident when (named person) stays with you", "The whole experience was extremely good" and "(named person) came home contented and smiling – obviously a successful stay".

In addition to this, the catering staff cook lunchtime meals for people living in the local community and they were delivered to them in their own homes. This was further evidence that the service not only supports people living at Horsfall House but also people in the community.

The service looked after people who had palliative care needs or were at the end of their life. Wishes and preferences were clearly documented in the care plans and acted upon. The home had sufficient specialist equipment to aid people's comfort, worked closely with the local hospice staff and were embarking upon the training programme for Gold Standards Framework for end of life care. The registered manager explained the person's relatives were also supported during this difficult time and the person's comfort, dignity and privacy were maintained to support a dignified death. One person told us, "When my time comes I don't want to go into hospital I want to be looked after in my own home – that's here".

Good

Is the service responsive?

Our findings

People told us the way they were looked after was responsive to their needs, was focused on them as an individual and they were involved in reviewing their care on a constant basis. One person said, "There is always something that can be improved, but I don't go around with my chin on my chest. I think this is a marvellous place". When we asked people and relatives if they felt they were listened to, they made the following comments – "The manager is very nice - she would listen. All the staff are very good", "I would see the nursing manager. We have a good relationship, she's very good" and "I would expect staff to address any concerns, if I had any". Relatives said their views were regularly sought and notice was taken of any comments made. Relatives said they were able to discuss things with the staff whenever necessary and the registered manager was "always available to see".

Care records were prepared for each person. A full care needs assessment was completed to identify where people needed support and used to then develop their care plan. The plans included people's likes and dislikes and what was important to that person. People were asked what time they preferred to get up and retire to bed at night and where they would like to eat their meals. Catering staff were advised about any dietary requirements, likes, dislikes and allergies. One person's care plan included strategies to be followed when the person was resistive to personal care assistance. The information had been provided by the family who had looked after their relative prior to moving in to Horsfall House. It was evident that the person, where appropriate, and their relatives were involved in the care planning process and had a say about how they were looked after.

Care plans provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, any wound care management and their night time requirements. Some of the care plans provided minimal information to instruct staff on what they needed to do and some of the plans for one person in the dementia nursing unit had been written in 2014. Changes in the person's care needs had been identified in the review records but the care plan had not reflected these changes. Care plans were generally reviewed on a monthly basis although we noted some gaps in the review records. When we spoke with the nurses and the care staff about these changes they were all fully aware of the person's current needs. They told us they received a handover report when starting a new shift and were always told about any changes. During the inspection we discussed with one of the nurses and the registered manager the governance issue with regards to the care records.

There was an activity programme in place throughout the week and people were able to participate in a range of different meaningful activities. Since the last inspection there had been an increase in the number of activity co-ordinator hours. Care records included "This is Me" documentation. The activity staff used these to record information about the person's past life, their family and significant events that had happened in their life. This information was used by the staff to help them engage with the person and find out how they could best meet their needs.

The activity programme for the week of the inspection included flower arranging, an arts and craft sessions (making poppies), pamper sessions, singing for the brain, exercise and quizzes. The activity coordinators

spent some of their time with individuals who were either unable to or did not wish to participate in group activities.

In the dementia care unit one of the bathrooms was being refurbished with a specialist dementia friendly bath with key features including an air spa, a blue tooth sound system and chromatherapy lighting. This provided a sensory experience for people living with dementia. The decorations in the dementia unit made use of bright colours in order to provide a stimulating environment for people.

There were opportunities for the people who lived in Horsfall House and their families to have a say about the service provided. The registered manager explained that the last 'resident and relative' meeting was in April 2016 and the next was planned for May 2017, deferred from October 2016. However the registered manager and board members of the trust met relatives at fund raising and social activities and encouraged feedback to be provided. People were encouraged to express their views and opinions about the way they were looked after in the monthly reviews and on a day to day basis when they were asked if everything was alright.

The service's complaints procedure was displayed in the main hallway and was also included in the written information packs kept in each person's bedroom. People told us that they felt able to raise any concerns they had with the staff and that they were listened to. People said, "I have no reason to complain", "To me this is five star", "I am happy with everything" and "I am certain I would be listened to if something was wrong. All the staff are very conscientious". The service had not received any formal written complaints in the previous 12 months and no concerns had been raised with CQC.

Requires Improvement

Is the service well-led?

Our findings

Because of two breaches in regulations, we have found the service to be not well led. The arrangements in place to check on the quality and safety of the service had not identified the shortfalls identified within care records. The checks had not identified where DoLS applications needed to be made for people who lacked capacity to consent to living at Horsfall House (a breach of regulation 11 – referred to in the effective section).

The registered manager told us care documents were regularly audited. However, some of those care records we looked at were not accurate, complete or contemporaneous. The service used a set of core care plans which the staff were expected to add detail to, regarding the person. The communication care plan for one person, written in February 2017 stated in the last three months their ability to communicate had gone. The intervention required by the care team was stated as, 'his ability to understand and be coherent has gone'. There was no guidance in the care plan for the staff to follow. The mobility plan for one person written in 2014 referred to them being able to use a three-wheeled walking frame, yet their recent care plan review on 26 January 2017 stated they were unable to mobilise independently. The care plan had not been updated. This had the potential to increase the risk that the person would receive incorrect and unsafe care. The daily notes for one person were not in date order. We noted in several people's notes that reference had been made to cot sides rather than the correct term of bed rails. The arrangements in place to audit care documentation was not effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

The other audits we looked at however were effective and had identified some shortfalls and gaps. Audits were completed in respect of tissue viability, infection control, COSHH, the first aid box and the management of medicines. As a result of the last infection control audit one of the sluices had been upgraded and commodes had been replaced. The records of the other audits evidenced that remedial actions had been taken where concerns had been identified. The maintenance staff had a programme of safety checks to ensure the premises and the gardens were kept safe. The registered manager monitored that these checks were completed as scheduled.

There was a programme of improvement and refurbishment for the premises. One bathroom on the nursing unit had already been converted in to a wet room and there were plans to redo the bathroom in the dementia unit. There was a rolling programme of upgrade for the en-suites so they were all styled in the same way and were dementia friendly. Bedrooms were assessed when they became vacant and either the paint work was touched-up or fully redecorated. These measures ensured the premises remained fit for purpose and a comfortable place in which to live and work.

A 'resident' and relative survey had not been used during 2016 to gather feedback about the quality of the service. The registered manager said the forms were due to be sent out in March 2017. The survey asked people to rate the quality of care, the meals and activities, the environment and the staff team. Previous

surveys had always resulted in positive comments about the service. A respite evaluation form was always given to those people (and their families) who had used the respite facilities. The completed forms we saw rated the stay as excellent, very good or good in respect of comfort, choice, companionship, the food and general facilities.

Those people who were able to engage in conversation with us said they knew who the registered manager was and confirmed that she was frequently seen in and around Horsfall House. Relatives also confirmed the same. No relatives could remember any formal feedback process about the service although they did say they had regular conversations with the nurses or the registered manager. People and their relatives thought the staff team was well managed and there was a positive atmosphere throughout the whole home.

Staff were of the opinion that the service was well-led. The registered manager was supported by two unit managers, assistant unit managers, nurses, administrators and heads of department. All managers were visible and accessible to people, relatives and the staff team. The registered manager held a range of different staff meeting – unit manager meetings, departmental meetings and general staff meetings. Feedback from staff was actively encouraged and any suggestions they made were acted upon where appropriate. The notes of the meeting held in January 2017 recorded that staff have asked for additional pressure relieving cushions, handling belts, pillow and chair raisers. The registered manager told us the supplies had already been ordered. The date of the next general staff meeting was booked for 8 March 2017. Staff told us they would read a copy of the meeting notes if they were unable to attend any meeting.

The registered manager continued to be an active member of the local authority care home provider forum and the learning exchange. The dementia unit manager had completed a dementia leadership award dementia link workers had completed their training. There were plans to place to increase the number of dementia link workers on the general nursing unit and with those staff who worked at night. These measures ensured the staff in the dementia care unit worked to current best practice. On the general nursing unit the staff linked with the specialist tissue viability nurses in respect of wound care management and the local hospice to ensure best practice was followed for people who had palliative care needs.

The registered manager had to provide formal reports to the board of trustees every two months and informed told them about incidents, health and safety issues, complaints or concerns received, occupancy levels and staffing issues. The registered manager also reported to the general committee on a bi-monthly basis. These measures ensured the registered provider was aware of how the service was being run. The registered manager analysed all falls, accidents and incidents and complaints. They looked for any trends in order to prevent further occurrences. The registered manager told us the board members were regular visitors to the service and also were around during any social and fund raising events.

The manager was aware of when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. In 2016 notifications had been sent in to tell us about expected deaths and one fall where the person sustained an injury. We used this information to monitor the service and to check how any events had been handled.

All policies and procedures were kept under annual review and updated where needed. As new policies were issued staff had to sign to say they read and understood the policy. The key policies we looked at during the inspection had each been dated November 2016. These measures ensured that the staff team worked to the same policies.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured that appropriate applications had been made in respect of the Deprivation of Liberty Safeguards. Regulation 13 (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not accurate, complete and contemporaneous. The records were not fit for purpose. Regulation 17(2)(c).