Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
Normanton
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West Yorkshire
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Tel: 01924891144

Date of inspection visit:
17 August 2016

Date of publication:
30 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Attlee Court took place on 17 August 2016 and was unannounced.

Attlee Court provides accommodation and nursing care for up to 68 people. The service has two floors and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were 23 people living at the home as only a small number of people at a time were being admitted due to previous concerns. This inspection was to consider whether improvements we had seen at our previous inspection had been sustained.

The service did not have a registered manager in post at the time of our inspection although there was a home manager who had been in post since August 2015 and had applied for registration. The home manager was on annual leave on the day we visited; however the area and deputy managers were present. We spoke with the home manager on their return from leave.

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.

People were safe and this view was supported by relatives. People felt confident in staff's abilities and staff were able to explain what action they would take if they found anything of concern. We saw the manager had taken appropriate action in regards to recent concerns.

We found risk assessments were person-specific and contained risk reduction measures to limit the likelihood of harm. Staff received guidance from these assessments as to how best care for people with differing needs, whether this was due to physical or mental health needs. We did highlight to the area and deputy managers that moving and handling risk assessments needed further detail in regards to the method of transferring someone so that staff had specific instructions. They agreed to remedy this promptly.

Staffing levels were sufficient on the day we inspected and we saw staff had time to spend talking to people and the atmosphere was relaxed. It was evident staff were focused on the needs of people in the home at all times.

We observed medicine administration and found concerns around this practice. One person was receiving covert medicine without the necessary authorisation and in addition this medication was crushed without direct medical guidance. We discussed this with the area manager who immediately took action by speaking to the member of staff. The area manager acknowledged our concerns and arranged for the staff member to receive further training and support for this role. The area manager also changed the processes for covert medicine on our guidance.

People were supported with nutrition and hydration, and were able to access health and social care services as required. Care records showed regular visits from chiropodists, social workers and GPs.

We saw that people had Deprivation of Liberty Safeguards in place where their freedom was restricted due to a lack of mental capacity to assess risk, and that decision-specific mental capacity assessments had been competed for all aspects of people's care needs.

Staff displayed confidence in their role and had access to regular training which was supported by regular supervision. We saw staff had a good rapport with people; they spent time listening to them and displayed a sound knowledge of people's preferences and routines. Consent was sought each time they supported someone and privacy and dignity were respected.

People were occupied throughout the day with a variety of things to do such as sitting in the garden, playing games and chatting to each other and staff. We observed high levels of interaction during the afternoon bingo game where it was evident there were positive relationships between people.

Care records reflected individual needs and were based on people's wishes. They were regularly reviewed and any changes implemented as a result. Complaints were handled sensitively and investigated thoroughly.

The home and area managers had scrutinised the previous inspection report in depth and developed a robust action plan. This had resulted in a detailed action plan which had been followed and was evident in all aspects of the home. The home had shown evidence of sustainability and persistence, and through its new processes would be able to identify any concerns much earlier and take action quicker.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People and relatives told us they felt safe as staff were confident in their role. Staff could explain what may constitute a safeguarding concern and knew how to report such matters.

Risk assessments reflected individual needs and reduction strategies were in place, although moving and handling methods needed recording.

Staffing levels were appropriate for the needs of the people in the home.

Medicines were stored and stock levels checked correctly but there was an issue with administration as tablets were given covertly and crushed without appropriate authorisation.

Is the service effective?

Good

The service was effective.

People had access to regular food and drinks, and were supported as required to eat and drink.

There was a rigorous pressure relief programme in place and people accessed external health and social care services as required.

Staff had received regular training and supervision.

The home followed the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards by requesting appropriate authorisations for people being deprived of their liberty.

Is the service caring?

Good

The service was caring.

We observed staff to be empathetic, understanding and patient.

Consent was obtained at every opportunity before care intervention and explanations given during such times.

People's dignity was promoted as everyone was acknowledged and spoken to as an individual.

Is the service responsive?

Good

The service was responsive.

Care records were very person-centred and focused on how to meet specific needs in the manner the person preferred.

People had access to a range of activities and we saw lots of positive interaction between people in the home and staff during the day.

Complaints were dealt with in a timely manner.

Is the service well-led?

Good

The service was well led.

The area and home managers had responded positively to the previous inspection's findings and developed a detailed action plan which had been followed.

It was evident the quality assurance processes were more robust and showed accountability for specific actions.

There was decisive leadership in evidence which was reflected by high levels of staff morale and a positive atmosphere within the home.

Attlee Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we checked information held by the local authority safeguarding and commissioning teams in conjunction with any statutory notifications received.

We spoke with three people using the service and three of their relatives. In addition we spoke with six staff including one care worker, one senior care worker, a nurse, the deputy and home managers, and the area manager.

We looked at four care records including risk assessments, three staff records including all training records, minutes of meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

One person said in response to ringing their buzzer, "Yes, I feel safe. Staff come after a few minutes to see what I need." One relative we spoke with told us, "Oh yes. Everything is safe. My relative uses a wheelchair, has a pressure relieving mattress and no pressure sores." They continued, "I am here quite a lot and have never seen anything of concern. If anything has gone wrong, they have contacted me immediately." Another relative said, "All the doors are locked. I can't walk straight in. I have to press the buzzer." They also said, "The staff have all had training. They've even had training on the inflatable sheet to come downstairs (in the event of a fire). I've seen them doing it."

Staff told us there had been no significant accidents or incidents in the home since the previous inspection. We checked accident and incident records and found basic information was recorded regarding the incident; any trends were analysed by the home manager where there were a significant number. In June 2016 one person had seven falls; records showed this person had been seen by the GP and falls team to try and reduce the risk of further falls. All appropriate equipment was in situ such as a low bed, crash mat and sensor mat showing the service had responded to the risks as much as possible at that time.

We looked at risk assessments the service had in place. We found if people were unable to use the call bell, regular checks were made which were recorded to ensure their safety and comfort. There were also risk assessments for falls, maintaining a safe environment, nutrition, moving and handling, bed rails and pressure care. We pointed out to the area manager that although risk assessments were in place for transferring people via the use of the hoist, they only indicated the equipment and staffing ratios and did not include the actual method. They agreed to address this with further guidance. Equally people did not have specific seating assessments which meant they may not have been sitting in the best chair for their particular pressure needs. However, we did not find any evidence of pressure sores which showed the home followed a rigorous pressure care programme.

Information within the risk assessments was person-specific. In one care record we noted "[Name] can become verbally and physically aggressive towards staff when being mobilised….Staff should engage [name] in conversation regarding their relative and past interests to distract them. Staff are always to keep [name] informed about their care interventions." This showed that the service had considered the wider implications of supporting someone safely with the minimum of distress. We later spoke with this person's relative who told us, "Staff always say what they are going to do before doing anything. They explain things." This showed staff were following guidance.

We asked staff how they would support someone if they fell. One staff member said, "I would leave them on the floor and ask the nurse to check them over. If we can't get them up then I would ring 999. We have used the hoist if they can't physically get up. Each situation is different." The falls risk assessment identified the likelihood of falls by assessing a person's falls history, gait, medical conditions and vision, amongst other factors. A specific falls reduction plan was then created with clear guidance for staff on what to do in the event of such an occurrence.

Staff were able to explain the fire evacuation procedure. One staff member said, "Someone stays upstairs and watches all the doors if the fire alarm goes off as all the door locks de-activate. We get people to the safest place. The person in charge makes the decision." The area manager confirmed all personal emergency evacuation plans had been amended following the previous inspection to include the equipment a person may need to be moved into a safe area quickly. We saw this had been completed with details of specific needs such as how a person may respond to hearing an alarm and what measures staff should utilise to support someone.

Staff told us they had received medicine training in-house. Some had also done external training provided by a local pharmacy. One staff member told us, "If there are two boxes of paracetamol one goes in the over stock cupboard to make sure two boxes aren't in the medication trolley. We check for signs of pain and the dosage as prescribed by the GP. This could be twice daily or four times daily. We would check the medicine administration record." We saw in care records that there were clear PRN (as required) medicine protocols in place which included signs to observe after receipt of such medicine; "[Name] is prescribed lorazepam. To monitor every 30 minutes after administration as this increases sleepiness and therefore the risk of falls."

Another staff member told us, "Medication errors always need reporting to the manager or deputy. No one in the dementia unit is on covert medication. People all take their medication but not everyone knows why they are taking it. Everyone has a capacity assessment. This shows whether they have capacity, the reason for assessing the capacity and whether they understand. If people lack capacity then it's in their best interests to take medication. We would get in touch with the GP and family if there were concerns."

We observed people receiving their medicines. One person was about to be supported to have a shower and the member of staff said, "[Name], I'm just sitting you up so I can give you your medicine. I just want to get this medicine down you before you go. Are you ready then?" The staff member took their time and ensured the person had received their medicine safely. One relative told us, "My relation was having problems taking some of their tablets. The home spoke to us and they now have it in liquid form."

We checked the storage of medicines and found fridge temperatures were taken and recorded daily, as were the room temperatures. The staff member was aware the room temperature was high at 27°C but explained the fan was left on to bring this down. This higher temperature could impact on the effectiveness of medicines. Items stored in the fridge had the date of opening recorded on them to ensure they were not used past their expiry date. The staff member told us boxed medicines were counted to check that actual stock matched records before administering medicines each day to minimise the risk of errors. Controlled drugs were also checked twice daily at the beginning and end of each shift to ensure stock levels tallied. Staff's competency was checked through observed medicine administration rounds which included preparation, administration, observation and the explanations given to people. This included completing a workbook and a further competency check one month after doing the initial training.

We spoke with the member of staff administering medicines about one person who took their medicine in food. They told us, "Sometimes I cut it in half and sometimes I put it in jam. It's OK to give it covertly." When asked by an inspector if the person knew it was in the jam, the staff member said, "Oh yes." We then saw the staff member talking to the person saying, "It's an antibiotic for your chest. See if you can swallow it. It's quite a big tablet." When it became obvious the person was unable to swallow it the staff member said, "I think I'm going to have to crush it." They told us it was crucial the person had this tablet at 10am. They then proceeded to crush the tablet. We asked the staff member who would be responsible for requesting the medicine in liquid form; they replied it would be them. However, this had not been done and it was not recorded on the medicine administration record that it had been crushed until the inspector asked where this information would be recorded.

There was no evidence in the person's medicine administration record to say the tablet could be crushed as this could have limited its effectiveness. The service had therefore not followed the requirements for the safe administration of medicines. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) 2014 safe care and treatment as we observed one person not receiving their medicine safely and practice did not reflect current guidelines. The area manager took immediate action and spoke with the member of staff concerned. They were asked to reflect on their practice and further training and support was arranged for them.

The staff member had indicated the person knew they were taking the tablet in food. If this had been the case, then it would not be covert administration which demonstrated a misunderstanding on the part of the staff member. However, upon checking this person's care record we found a mental capacity assessment which indicated they did not have capacity. The deputy manager said the person's GP had been consulted about the covert medicine and we saw in the care record and medication audit reference to this. It was recorded '[Name's] GP has given written permission to give medication covertly as this is deemed to be in their best interests. [Name] sometimes spits out tablets but will usually accept in a little jam or chocolate. Staff to monitor the effect of [name's] medication and liaise with the GP regarding any concerns.' However, we stressed to the area manager this was not sufficient as there should have been a best interest meeting held with all interested parties including a pharmacist. They agreed to remedy this with immediate effect and following the inspection we received confirmation this had been actioned.

We looked at staff recruitment records and found the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

There were 23 people in the home on the day we inspected and we saw staffing levels were appropriate to meet their needs. Six care staff were deployed on the nursing and residential units while two care staff were upstairs with seven people ensuring people had plenty of personal attention. One relative also told us, "Staffing is much better – there are more staff and they are recruiting. They are going to be more selective about who they take here so there are the right staff with people."

The home manager used a dependency tool to determine staffing ratios. Each person had an assessment identifying the levels of support they needed for mobility, personal care support, communication, behaviour and social interaction. The combined results helped shape the number of staff needed to support people safely and effectively.

Staff were able to describe possible types of abuse such as physical, emotional or financial. One staff member said, "We look for changes in behaviour, appetite or routines. A person may be low in mood or might become aggressive towards others. They may be withdrawn." This staff member said if they saw any of these signs they would, "Report it to the person in charge. If they don't do anything then I would go to Social Care Direct if needed." This is the local authority referral point for safeguarding concerns. The home manager kept safeguarding records which detailed incidents and any actions taken to remedy a situation. Actions we saw included further training for staff, such as not being distracted while administering medicines as this had led to an error. Another situation had resulted in the dismissal of the staff member for gross misconduct.

One other staff member we spoke with was aware of the importance of their role in reporting any practice they were not happy with and knew how to use the whistleblowing policy. They told us, "It's part of my role to report colleagues if I see something I don't like."

The home manager ensured regular infection prevention and control audits were in place whereby staff were checked in relation to their practice for hand hygiene, the disposal of waste, their use of personal protective equipment and presentation. We saw an external audit completed in June 2016 scored the home at 82%; a comprehensive action plan had been created and was being completed as a result.

Good

Is the service effective?

Our findings

One person said, "The food is champion here." Over lunchtime we heard one person say, "It's lovely", in relation to the soup. One relative told us, "I stay for dinner and tea. I think they are over fed! They can have a cooked breakfast and three courses over dinner. There are also snacks. They have what they want in-between." They also said, "Here they encourage my relation and watch what they eat. Food is always given out. If they want a cup of tea or coffee, it's always available." Another relative told us, "My relation is on a soft diet. They get what they like to eat and they eat well."

We observed mealtimes and saw people were supported to eat and drink at their own pace, with encouragement offered when necessary. People were offered a choice food and drink. If people did not like any of the options then alternatives were offered and given. The dining rooms were laid out nicely with tablecloths, cutlery, cups, napkins, condiments and menus.

During the day people were offered drinks and snacks. One staff member said "[Name] would you like a wafer? Do you want to dunk it to make it softer?" During lunchtime we heard one member of staff say to a person, "Hello [name]. How are you, love?" The staff member then gently guided the person to their seat and supported them to eat. Staff were directed in the downstairs lounge by the deputy manager as to who to support. One person was adamant they did not want anything further to eat but staff tried to encourage them. They left the person and agreed to try again in a little while, which we observed.

People were weighed regularly and this was monitored where necessary. Most people whose records we looked at were putting on weight and staff told us people were offered healthy snacks such as fruit and yoghurt. In one record where the person was reluctant to eat, we saw evidence of a comprehensive care plan which guided staff as to how best support the person. This was supported by a capacity assessment as it was clear the person did not appreciate the consequences of not eating sufficiently.

We saw evidence of regular pressure area care which was recorded on people's individual charts showing what support had been given and at what time. Body maps were also completed if red areas were discovered. In one person's records we found detailed records of wound care.

One relative told us, "The chiropodist comes and the GP." Another relative said, "They will phone for the GP if there is a hint of a chest infection. I am confident staff know what they are doing." We saw from people's care records the GP was called promptly if there were concerns about someone's condition. We also saw external health professionals were requested as needed. In one person's record it was recorded, "Smooth pureed food may help to avoid the person spitting out lumps." We saw this being offered to the person. One staff member had tried to access dental services for people via the local NHS Trust as it was difficult to access this service for people in the home and they were waiting feedback.

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 and hospitals 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. One staff member told us four people had a DoLS in place in the upstairs unit and there were no conditions attached. They were aware of one further application awaiting authorisation.

We spoke with staff to determine their understanding of DoLS. One member of staff said, "It's like their understanding of their own safety going outside. At the end of the day you can stop a resident going out if they don't understand the risk. They can still go out with someone for their own safety." This shows the service was aware of the impact of a DoLS and what authority it gave them to intervene if required.

We found people's consent to care had been sought in line with the MCA. The service had completed a two stage mental capacity assessment and if the conclusion was the person lacked capacity, they had followed the best interests checklist and held meetings with family and other interested parties. The decisions recorded reflected the specific answers each consultee had given, showing how the assessment decision had been reached.

One staff member told us, "We always assume capacity. A person's capacity may change due to infection or medication. If they could not make a decision we would look at their best interests in conjunction with the GP, person and their family."

We looked in staff supervision and training records and found all had received a comprehensive induction and subsequent training in key skill areas. These included health and safety, moving and handling, dementia awareness, equality and diversity, mental capacity, food hygiene, infection control and safeguarding, amongst others. Staff also had three days shadowing a more experienced staff member before working alone with people.

There was evidence staff received information about specific areas such as bed rails and the importance of regular checks. Other topics included infection control and policy or procedure changes all staff needed to be aware of. Each record we saw was signed by both the employee and the home manager. Staff had also received appraisals and where issues had been identified in their performance these had been discussed and further training provided. One staff member told us they had been supported to obtain further qualifications under the National Vocational Qualification framework. This meant care staff received the training and support they needed to support people safely.

One relative said, "Staff keep me informed. Even the cleaners are great. They get training as well. The kitchen staff are good and they introduced themselves to us." We looked at handover notes and found these were detailed, outlining the main issues for the person that shift such as their level of mobility, their behaviour and mood and ability to make choices. An overview of support tasks was recorded so staff coming onto shift could see what support had been given. During the shift staff were clear with each other about their movements so each knew where they were. This showed their mutual respect for each other.

The environment was clean and free from clutter. People's rooms had their names on the doors with their photograph and a picture of a bed to aid orientation. Window restrictors were in place and all communal bath or shower rooms were clean and decorated with appropriate artwork to make the environment more

homely. In the corners of the building were reading areas with books for people to choose and comfortable chairs to sit on with sparkly cushions.

Good

Is the service caring?

Our findings

One person told us, "Staff are very good. They are all caring." Another person said, "Everyone is nice." One relative we spoke with told us, "Staff are wonderful. There have been problems in the past with agency staff but they no longer work here. It was all dealt with correctly." They described their relative as 'awkward and demanding' but said staff remained very patient with them, "Even when they have pressed their buzzer a thousand times to ask them to pass them something they could reach themselves. Staff do encourage them to be as independent as possible. Whatever independence they have, staff don't want them to lose it. They are very patient."

A second relative told us, "Staff show a lot of empathy, sympathy and understanding. I have peace of mind if I go on holiday. My relation is well dressed and well fed. They are clean, bathed or showered. They washed their hair this morning and will straighten it for them." A third relative said, "They are good staff. They love my relation to bits. They are all lovely and make time for them."

Staff we spoke with said their main aim was to ensure people were happy. One staff member said, "We like to see people sociable, smiling and doing what they want to do. If some residents are reluctant you know you are not doing something right. I supervise and watch staff and they are lovely, caring." During the lunchtime upstairs one person was talking a lot and agitated another person who also became vocal. Staff intervened promptly and discreetly to limit the agitation and divert the first person's attention.

One staff member told us, "We just encourage and prompt people to do things within their own limitations, to do things for themselves, such as getting undressed. If they are capable of taking their top off but it takes fifteen minutes, it's better to let them do it or for people to wash their own hands and face."

We observed staff interactions with people throughout the day in both sections of the home. Just after we had arrived one person left their room, clearly having only just woken up. The staff member said, "Morning [name]. You've just got up. Don't worry. Would you like a cup of tea?" The staff member then went and got the person one. This person was later encouraged to choose some clothes for the day. The staff member said, "Let's go and have a look." Staff engaged in conversation with people and we heard conversations about the Olympics and Usain Bolt who had recently raced.

We asked staff how they would support someone who may refuse to have any assistance with their personal care. One staff member told us, "It depends on the resident. I'd go back every 15 minutes and offer. Sometimes a fresh face may help. We never use restraint." During lunchtime upstairs we observed one person have a continence accident. Staff swiftly supported the person to leave the table without drawing attention to what had happened. The person was gently and discreetly guided to the toilet. The cleaner came in quickly and chatted to people eating their lunch so they did not really get upset by what had just happened.

One relative told us, "I have seen my relative's care plan and signed it. I have power of attorney. We were asked to complete a form about their past life, likes and dislikes, where they worked etc. All this information

has gone into their care plan."

We spoke with people in the home about how their privacy and dignity was respected. One person told us how care staff helped them to maintain their dignity by assisting them to keep a medical device clean and in working order. One relative said, "I suggested that my relation always wears a vest for modesty. They always have a vest on." A staff member said, "We ensure curtains and doors are closed, but the light is on so they can see us and we can see what we are doing."

Good

Is the service responsive?

Our findings

One person said, "The garden is nice. I've never been to the garden at the other side. I go to the club up the road and I go down to the shops in my chair." Another person told us, "Entertainment is between 10am and 4pm. I play bingo." A third person said, "I go to bed between 6.30pm and 6.45pm which is my choice."

One relative said, "There are no restrictions on when you can visit. I've been here at 10pm at night. My relative enjoys sitting out in the garden." Another relative told us, "My relation always gets what they need when they need it. I visit daily and am always able to talk to staff. I also ring regularly and someone always answers the phone." We saw people accessing the garden during the day.

We asked one relative what could be done better and they said, "A bus to go out on trips. They do take people to the garden centre but it's on a one-to-one basis. They do have things on such as singers."

We saw people had access to activities in the communal areas such as colouring books and jigsaw puzzles. One staff member said, "There's always something going off every day. The activity co-ordinator is always getting them out somewhere such as Normanton brass band. They take different residents out with a group of staff who volunteer. You don't want to see people sat bored. It's long days for people. We've got cards, chair exercises, nail painting and of course, chatting." During the afternoon we saw people engaged in a game on bingo with people from both upstairs and downstairs playing together. People were happy and settled, and clearly enjoyed their time spent together. Staff were supporting people where necessary.

We saw that prior to people's admission they were assessed by the home manager for the appropriateness of the placement. Where information was brief from the person's previous location staff had sought further information from family members to help formulate the person's care plans. We asked one member of staff what they understood by the term person-centred and they informed us, "It's about them. How they are used to having things done such as getting dressed. It's their choice about what time they want to go to bed and what time they get up."

People's care records reflected their individual needs. They contained a photograph and key details about a person's next of kin, their GP, any allergies and the medicines they were taking at that particular time. There were detailed physical and social assessments for each person which included the environment, communication, nutrition and hydration, personal care needs, mobility and sleep patterns. Information was specific for that person, reflecting their abilities and preferences.

The plans were dated with an identified need, the aim of the provision and how this need was going to be met. If a person lacked the mental capacity to make a decision about how they wished their needs to be met for a particular task, then a best interest decision was recorded in conjunction with all relevant parties to ensure that staff were meeting legislative requirements. Life histories were also completed for people, often by family members and this information helped shape the care plan. There was also a section called 'a day in the life of' which highlighted people's preferred daily routines.

Each record was audited on a monthly basis to see if that need was still pertinent. The reviews included key events and amendments were made to the person's care plan if required. We saw this for one person where it had become apparent from regular nightly checks that they were no longer changing their position in bed, thus placing themselves at greater risk of pressure area damage. This had resulted in a positioning plan for night staff to follow which we saw recorded in detail. In another person's care plan evaluation it was recorded, '[name] has been to a clothes party and picked some clothes for themselves. They continue to like having their nails painted in a colour of their own choice and like to have their hair done.' We observed this person having their nails painted on the day of the inspection and indicating their preferred colour of nail polish.

Each person had daily progress notes which indicated how they had spent their day. One record noted 'Settled in their room listening to music'. Information regarding family and friends visits were also recorded.

One person told us, "If I wasn't happy I would go and tell the boss. I've not had to complain about anything recently." One relative said, "I would go to whoever is in charge at the time if I had a complaint. This could be the manager of any of the senior carers. I am satisfied they would sort it out." Another relative told us, "On every shift they have a senior and I would go to them if I had any concerns. If it wasn't sorted then I would speak to the deputy or the manager." We looked at the complaints log and found that there had been one complaint made since our previous inspection. Records showed it had been addressed in full, with an apology made to the complainant and further training received by the staff members involved.

The home had a display of 'thank you' cards in the reception area along with some photographs of recent activities. The deputy manager said they thanked staff, wherever possible, at the end of each shift for all they had done as they felt it was important to reinforce good practice and the feeling that they done something worthwhile.

Good

Is the service well-led?

Our findings

One relative we spoke with said, "This home is well led. I've never had any concerns with any of the managers. Anything you need to know, the manager knows." They also told us, "The care is excellent. I know there have been issues with the building but it's always been very clean. They always look at the person first." Another relative told us, "Yes the home is well led. The manager is a qualified nurse. I've seen them feeding people or taking them to hospital. This one knows what they are doing." They also told us they had met the owner. A third relative said, "I speak to the manager regularly and they are always happy to listen. They help me with any paperwork. Nothing could be done better."

A fourth relative commented, "I raise things at relative meetings which are held four times a year. They've had a lot of major things going on – floors put in, changing furniture etc. I have a copy of the minutes. It's on their website. I suggested the home have laminate flooring and wipe clean chairs in bedrooms as they were cloth." We saw evidence that the home had implemented some of these suggestions as part of their ongoing refurbishment plans.

One staff member told us, "I feel supported by both staff and the manager." Another staff member with supervisory responsibilities said, "I support them (the staff) with things. If there is anything they are unsure about I will support or find out." A third staff member said, "There's been a lot of improvements since [the home manager] came. In paperwork, routine. Everything's improved. There's much more team work. Staff are getting on better." This staff member was keen to share their ideas for improvements to the care records which they were implementing, such as a different order of information to enable easier access for all staff.

A staff member told us, "The manager comes up every time they're on. They might come up once or twice a day. If I ever need the office I will go down." The area manager spoke with us about the daily walkaround they did which identified any obvious issues and sought to address them promptly. They also stressed this was an opportunity to reflect on good practice. The home manager had implemented a staffing task sheet which ensured all essential tasks were completed during a staff member's shift and they knew which areas they were responsible for.

One staff member also said, "The owner is lovely. They walked around and was really friendly. They introduced themselves to visitors." Staff said if they had a magic wand it would be to have 'more residents'. Another member of staff said, "It's hard for the residents. They need some different faces and a more active environment. One resident ate with a spoon but when I sat them with three other residents using a knife and fork, they also started to use a knife and fork." This view was reiterated by the deputy manager as they felt there was a potential for the home to become stagnant if new people did not move in. They said, "Having people in for periods of respite has really motivated staff and residents as these are new people with different experiences and ideas. This helps us all keep fresh."

We saw that the home had displayed its ratings and previous inspection report. The area manager advised us following the last inspection they had gone through the report in great detail and identified every concern. This had generated an action plan which we saw being completed. Staff had received additional

training in areas which were their key responsibility such as the checking of bed rails and all people had been assessed for their ability to make specific decisions. The boiler had been replaced and there were no building issues as all the refurbishments had been completed. The home had managed some new admissions well and the area manager felt they were in a position to move the service forward.

We found the home manager and area manager had undertaken a complete review of the quality assurance processes and identified key areas for regular review. These included infection control, health and safety, medicines, care records, accidents, complaints, people's weight, skin integrity, first aid boxes and equipment checks such as slings, airflow mattresses and bed rails. Each audit had a set frequency and we saw everything had been reviewed as per the schedule. These were in addition to the regular reporting completed by the home manager on the registered provider's electronic system which picked up key issues and alerted the area manager to any possible trends.

Each audit recorded the information, for example a person's weight, and then the action taken if required. This also included details if no action had been taken if a problem had been noted. This was to show the home manager had considered all possible explanations. Medicines audits monitored the staff member's recording, medicines ordering, administration, stock levels, storage, controlled drugs and temperature checks. They were comprehensive. Each one scored a rating with any shortfall resulting in an action to remedy the problem which was then checked for completion on the following month's audit.

We saw records which showed all equipment had been serviced and maintained as required. There were sling check certificates in place along with other lifting equipment such as the hoists and bath lifts. We saw the home had ordered new slings and these had arrived on the day of our inspection to be allocated to people. This showed the home manager was noting any concerns and responding to them promptly. There had also been regular fire safety checks including fire alarm tests and drills.

We saw evidence of bi-monthly resident and relatives' meetings with honest feedback to people following the last inspection and discussion of the ongoing programme of improvements. People's views were sought as to activity provision and it was evident the meeting allowed for a sharing of views and ideas. The general consensus from the meeting held in July 2016 was how much the home had improved. Staff meetings were also held although not as regularly but still presented opportunities for opinions to be obtained and discussion had.

We asked the deputy manager, in the absence of the home manager who was on leave on the day of inspection, what they felt the values of the home were. They said, "For people to have choice and a quality of life. The home was not to be seen as the end choice but to be somewhere where people felt comfortable and happy." The deputy manager told us they felt supported and listened to by the home manager, and the home felt much more robust and secure as there was so much more monitoring in place. This had resulted in a better staff attitude which all helped improve morale and there were resources in place to meet needs as they arose.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We observed one person not receiving their medicine safely and practice did not reflect current guidelines.