

Brampton Meadow Limited

# Moorleigh Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We inspected Moorleigh Nursing Home on 07 and 19 July 2016. The inspection was unannounced on the first day and we told the registered provider we would be visiting on the second day. The service was last inspected in August 2014 and was found to be meeting the regulations inspected at that time.

Moorleigh Nursing Home is a large property which consists of a Victorian main building with modern extensions. People have access to extensive gardens which are accessible to people with mobility difficulties. The service provides care and support for up to 36 older people and is accommodation for people who require personal care and nursing. The service is close to all local amenities.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had not completed works to the property where risks to people and the property had been identified during safety checks carried out by appropriate specialists. The provider told us this work would be completed following the inspection. We saw not all known risks had systems in place to check for safety. For example, no checks were completed to check bed rails were safe to use.

Risks to people's safety had been assessed by staff and records of these assessments had been reviewed. The documents did not always reflect accurately the risks to people, either because staff had incorrectly completed the document or records within the care plan had conflicting information.

Systems were in place for the management of medicines. The service did not record robustly the information needed to ensure people received 'as and when required' medicines and creams and lotions as prescribed. Medication discrepancies or errors were not fully investigated.

Staff understood the practicalities of using the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards to provide support for people in the least restrictive way. However, they did not formally assess people's capacity or record best interest decisions made for people who lacked capacity.

Staff training was not up to date and this meant staff may not have the skills and knowledge to provide support to the people they cared for. We saw most staff had received supervision on a regular basis however; staff had not received an annual appraisal.

There were systems in place to monitor and improve the quality of the service provided. We saw the range of checks carried out both by the registered manager and registered provider did not cover all known risks or analyse robustly the patterns trends and root cause of issues identified. Actions identified were not always completed.

The registered provider had a system in place for responding to people's concerns and complaints. People said they knew how to raise concerns. A system to capture day to day concerns raised was not in place.

People told us there were enough staff on duty to meet people's needs. A tool was not in place to use information about people's dependency to understand safe staffing levels. We found safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Staff were able to tell us about different types of abuse and were aware of action they should take if abuse was suspected.

There were positive interactions between people and staff. We saw staff treated people with dignity and respect. Observation of the staff showed they knew the people very well and could anticipate their needs. People told us they were happy and felt very well cared for.

We saw people were provided with a choice of healthy food and drinks which helped to ensure their nutritional needs were met. People were supported to maintain good health and had access to healthcare professionals and services.

We saw people's care plans were person centred and written in a way to describe their care needs. We saw evidence to demonstrate people and their families were involved in all aspects of their care plans. At times information held in the care plan did not match information reflected in risk assessment records.

People's independence was encouraged and their hobbies and leisure interests were individually assessed. We saw there was a good and varied range of activities which people told us they enjoyed. People told us they would like outings into the community as this did not happen.

Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found during this inspection. You can see what action we told the provider to take at the end 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 was not always safe.

The registered provider had not ensured works identified by appropriate specialists were completed which posed a risk to people and property. Not all areas of risk were properly assessed and relevant checks completed.

Not all information staff needed to administer medicines safely was recorded and medicines discrepancies were not investigated robustly.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. People told us there was enough staff to meet their needs and we saw safe recruitment checks were carried out.

**Requires Improvement** 

### Is the service effective?

The service was not always effective.

Staff training was not up to date to ensure people were cared for by knowledgeable and competent staff. Most staff had received regular supervision but no staff had received an annual appraisal.

The service was not assessing people's capacity where needed or recording decisions made in peoples' best interests in line with the Mental Capacity Act 2005.

People were supported to make choices in relation to their food and drink and to maintain good health.

**Requires Improvement** 

### Is the service caring?

The service was caring.

People were supported by caring staff who respected their privacy and dignity.

Staff were able to describe the likes, dislikes and preferences of people who used the service and care and support was

**Good** 

individualised to meet people's needs.

### **Is the service responsive?**

The service was not always responsive.

People who used the service and relatives were involved in decisions about their care and support needs. Care plans contained person centred detail on how people wanted to be supported but information on different records did not always match.

People had opportunities to take part in activities of their choice inside the service. People told us they would like opportunities to access the community.

People told us if they were unhappy they would tell the registered manager and staff. A system to capture information about day to day concerns was not in place.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

A quality assurance system was in place but it was not robust enough to ensure the quality and safety of the service.

The service had a registered manager who understood the responsibilities of their role. The registered manager knew the environment caused a barrier to them being visible in the service and worked hard to overcome this.

People were regularly asked for their views and their suggestions were acted upon.

**Requires Improvement** ●

# Moorleigh Nursing 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 checked 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.

We inspected the service on 07 and 19 July 2016. This was an unannounced inspection on day one of the inspection. We told the registered provider we would be visiting on day two. The inspection team consisted of an adult social care inspector on both days and an expert by experience on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all of the information we held about the service. This included information we received from safeguarding and statutory notifications since the last inspection. We also sought feedback from the commissioners of the service prior to our visit. All the information we received was used to plan the inspection.

The registered provider also completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection there were 34 people who used the service. We spent time with 12 people and eight of their family members. We spent time in the communal areas and observed how staff interacted with people and some people showed us their bedrooms.

During and following the inspection we spoke with the registered manager, registered provider, training manager and clinical lead nurse and 13 staff members.

During the inspection we reviewed a range of records. This included five people's care records, including care planning documentation and medication records. We also looked at three staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies

and procedures developed and implemented by the registered provider.

# Is the service safe?

## Our findings

We saw in November 2015 the gas safety was checked by appropriate specialists who issued warning notices because they felt life and property were at risk. At the time of our inspection works to remove the known risks had not been completed. We spoke with the registered provider who told us following the inspection work would be completed as soon as possible to remove the risks to people and the property.

We saw documentation and certificates to show relevant checks had been carried out on the fire alarm and fire extinguishers. We saw a weekly fire check was completed and a safety issue was identified in April 2016 which meant a fire door closure needed repair or replacement. On the July 2016 fire check this issue was still present and had not been repaired or replaced. This meant people may be at risk if a fire started.

Personal emergency evacuation plans (PEEPS) were in place for each of the people who used the service. PEEPS provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. Records showed evacuation practices had been undertaken. Test of the fire alarm were undertaken to make sure it was in safe working order.

We looked at the risk assessments the registered provider had in place to manage health and safety. We saw all known risks were not identified and therefore control measures were not always identified to manage risks. For example; window checks did not happen to ensure people could not fall out of them and bed rails were not checked to ensure they were safe.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw documentation was appropriate and the registered manager and registered provider reviewed each month's patterns and trends for individuals. However, they did not use this information to record what they felt the root cause was and what actions they would take to prevent any accident or incident happening again.

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

We looked at the arrangements in place for the safe management, storage, recording and administration of medicines.

We saw where people were prescribed creams the service used topical medication administration charts (TMAR's). We saw gaps in records of administration on the TMAR's. Staff told us they were confused about when to sign these charts. They did not know whether to sign when they had administered a cream or lotion or to sign each time the cream or lotion was offered. We spoke with the registered manager and clinical lead nurse who told us they would clarify when staff should sign the TMAR's. The TMAR's did not always contain enough detail about where to administer the cream or lotion on the person's body and for what symptoms.

The registered provider had ensured the prescription detail for 'as and when required' (PRN) medicines and



the reason why a person was prescribed the medicine were in people's care plans. However, they did not have protocols in place to describe to staff the full details for example; when it would be appropriate to administer it. The clinical lead nurse had sought guidance from the pharmacy before the inspection on what should be included in a PRN protocol and told us they would be introduced in the service.

We saw people's care plans contained information about the help they needed with their medicines and the medicines they were prescribed. The service had a medication policy in place, which staff understood and followed. We checked people's Medication and Administration Record (MAR). We found these were mostly fully completed, contained required entries and were signed.

The registered provider had recorded discrepancies they found on the MAR or in medicines stocks, however, they had not recorded their investigation into the discrepancy so they could evidence whether a person had received their medicine as prescribed. The information was not used to map trends and patterns in medicines incidents.

Staff responsible for administering medication had received medication training. We observed staff administering medicines and saw they followed procedure and they were patient and caring towards people who needed more support to understand what their medicines were for.

We spoke with people who used the service and their families; they told us they received their medications on time. One family member said, "I visit at different times of the day; they always get their medications on time and can ask for extra painkillers if they need them. Staff always ask if they are in any pain."

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

We looked at the arrangements in place to manage risk so people were protected and their freedom supported and respected. Risks to people's safety had been assessed and personalised to each individual and covered areas such as nutrition, pressure care and moving and handling.

We saw the outcome of a person's risk assessment to complete monitoring tasks were not always understood or followed up by staff. For example; we saw one person had their weight monitored monthly by staff even though their care plan said this should be carried out fortnightly.

The review score this person had on the nutrition assessment indicated the person was stable, however, the weights recorded showed fluctuations and this should have been referred to the GP for advice as stated on the assessment tool guidance. We spoke with staff and they told us there were three different records for this person's weight and we found no accurate record which accounted for all of the weights taken. This meant deterioration in the person's health and wellbeing could be missed by the service.

For another person we saw their falls risk assessment indicated they were at low risk of falling; however, their care plan indicated a medium risk of falling due to recent history of falls which had not been taken into account when completing the falls risk assessment.

We spoke with the clinical lead nurse who told us they would work with the nursing team to ensure assessments and reviews were completed robustly.

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

We looked at three staff files and saw the recruitment process included completion of an application form, a formal interview, previous employer reference where possible and a Disclosure and Barring Service check (DBS) which in most cases was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults.

Employers receive an initial check alerting them whether a candidate's name is held on the barring list. On two occasions we saw staff members had commenced duty following a barring check being received as clear but before the criminal records check had been completed. The registered provider assessed the situation and made the decision it was safe for the staff member to commence their induction under supervision.

We saw some references were handwritten and not always dated. The registered manager understood the importance of verifying the source of references to ensure the service were confident of the source to evidence candidates were of good character. The registered manager told us they would build this into their process during recruitment.

We asked people who used the service and their family members if they felt safe. People told us they felt safe. A family member told us, "When I go home from here, I know that they are safe." Another family member said, "I can rest on my pillow at night knowing they are safe and well cared for."

We spoke with the registered manager about safeguarding adults and action they would take if they witnessed or suspected abuse. The registered manager told us all incidences were recorded and the service investigated concerns. Records we saw confirmed this.

All the staff we spoke with said they would have no hesitation in reporting safeguarding concerns and they describe the process to follow. They told us they had been trained to recognise and understand all types of abuse. We saw from training records 77% of the staff had up to date training in safeguarding.

We looked at the arrangements in place to ensure safe staffing levels. During our visit we saw the staff rota and the tool used to map the dependency of people who used the service, which was not used to determine safe staffing levels at the time of the inspection.

During our visit we observed there were enough staff available to respond to people's needs. We saw at mealtimes people needed support to eat their meals in the dining room and in their own rooms. We saw people's family members were there to support a few people whilst they happened to be visiting. We spoke with people and their families and some told us they felt staff did struggle to support everyone at mealtimes. One family member said, "Sometimes I don't think there are enough staff, the staff struggle at mealtimes to help everyone."

Staff told us staffing levels were appropriate to the needs of the people using the service. However, staff were conscious they could not provide what they called 'over and above' to people. They told us this included doing activities with people or being able to respond quicker when people asked for support.

We were told two staff worked on each floor to support people with personal care. Many of the people needed two staff to support them; this led to delays if two people asked for support at the same time. We saw one staff was always present in the lounge areas to support people spending time there. The registered manager and staff told us how an additional staff was available at peak times and they worked between the floors. The staff told us this did relieve the pressure a little for them.

People we spoke with did not say they had to wait for very long for support. One person said, "The staff give me good attention, I don't have to wait long for anything." Another person said, "The night staff go around at night to make sure we are alright, they just pop their head in my door and ask if I am ok." And a family member said, "Whenever I ask the staff for assistance with my relative they are there straight away."

Staff told us the staff team worked well and there were appropriate arrangements for cover if needed in the event of sickness or emergency.

The registered manager told us they looked at staffing levels regularly and the registered provider was involved. We saw minutes from a residents and relatives meeting where staffing levels were discussed. The registered manager told us they would source a tool to use dependency information to evidence staffing levels were safe.

## Is the service effective?

### Our findings

We spoke with people who used the service who told us staff provided a good quality of care. A family member told us how their relative was difficult to support at times and they felt confident staff knew how to support them well. Another family member told us, "The staff are well trained in dealing with dementia; they know exactly what they are doing."

The registered manager told us staff new to care were undertaking the Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care expected.

A new staff member who had recently started at the service told us how their induction had involved shadowing experienced staff until they felt confident and competent. Other staff we spoke with told us there was a plentiful supply of training. They told us they had received training in dementia, safeguarding and fire. One staff member said, "I have done various courses and the dementia and safeguarding training was quite in-depth."

The training manager told us all training was refreshed annually and staff completed worksheets to evidence their knowledge in the topic taught.

The training matrix for 2015 and 2016 were provided following the inspection. We saw not all staff training was up to date. For example, of the 43 staff training records we looked at 53.5% of staff had received moving and handling training in the past 12 months and 40% of staff had received health and safety training in the past 12 months. The training manager told us training was booked for staff to attend. We requested information about the clinical training nursing staff had received and competencies completed to ensure they were carrying out clinical interventions to a safe level. The information provided following the inspection showed the nurses did not have up to date training or competencies in all areas of clinical practice they were undertaking. For example, out of the eight nurses employed three had been trained to use venepuncture and syringe drivers. Out of the eight nurses two had training in how to support someone to eat and drink via a percutaneous endoscopic gastronomy tube (PEG).

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

We saw records to confirm 88% of staff had received training in MCA and DoLS and the staff members we

spoke to understood the practicalities around how to make 'best interest' decisions. We did not see appropriate documentation in place for people who lacked capacity to evidence the service had assessed people's capacity or made best interest decisions. We saw people's records did not clearly define their abilities for example; in one person's records the person had signed for their consent to take photographs, but the annual review of the persons care needs was signed by a family member. We were told by staff this person had capacity and could sign for themselves.

We saw professionals had been involved for one person to make a decision whether covert administration of medications was in the person best interests. A GP had provided staff with a letter to authorise this but not the relevant documentation to evidence the MCA process was followed.

Staff we spoke with had a good understanding of DoLS and at the time of our visit 10 people were authorised to be deprived of their liberty. The home was working with the local authority team to ensure applications were processed and 16 applications were pending.

The registered manager told us how they had invited a local advocacy group to come and speak with families and people about DoLS and the process. We saw records of the residents and relatives meeting to confirm this had happened.

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

Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The registered providers policy dated January 2016 stated staff should have supervision at least six times per year if they were a full time employee. It also stated supervision could be completed one to one or as a group and that one of the six sessions would be an annual appraisal.

We looked at six staff members records of supervision during our visit. We saw two of the six staff had received one supervision in a one to one format in the past 12 months. We could not determine from their records if further group sessions had occurred.

The registered manager supplied us with a supervision matrix following the inspection which outlined the dates people had received supervision in the past 12 months. Some of the dates on this document did not match the dates on the documents we had seen. The matrix also did not differentiate whether the date referred to had been group supervision or a one to one meeting. We could therefore not determine a full picture of what support staff had received. Though most staff had at least six dates on the matrix for the last 12 months.

Not all staff had received an appraisal. The registered manager told us they had planned all staff appraisals to happen by the end of 2016. Following the inspection the registered manager told us 30% of staff had already received their appraisal.

The clinical lead nurse had introduced clinical supervisions for the nursing staff and we saw records to confirm regular nurse meetings were held to discuss clinical practice. One nurse told us "Reflective practice has just started in January 2016 and we have had more one to one's recently, I feel more supported now and more appreciated."

People who used the service told us they were involved in making choices about the food they ate. People were asked for feedback frequently at the residents meetings. We saw people had asked their hot pudding

to be moved to the tea time menu from lunch time because they were not always ready for it after their main meal. We saw from menus this had been changed.

We spent time in the dining areas at both breakfast and lunchtime. People were supported to eat in the dining room and in their own room if they chose this. The tables were laid in the dining room to welcome people, the atmosphere was relaxed and people were socialising, and the food looked appetising. We noticed some people were sat in their lounge chair to eat as the dining space did not have enough space to cater for everyone at a dining table. People told us they were happy with this situation.

We saw staff asking people their choices prior to the meal to take to the kitchen staff and asking again once the meal was ready in case people had changed their mind.

People were supported to be as independent as possible to eat their meal. People's preferences were taken into consideration and we saw one person had not been feeling well so staff offered a lighter alternative for them.

People told us the food was good overall, comments from people included; "They always put on a good spread when it is a special occasion." "The cooks know exactly what I like to eat, they ask me every day, even though they know what I will ask for." "The food is just how I like it and there is plenty of it." "Nothing is too much trouble for the cooks, if you don't like something; they offer you something else straight away."

Snack stations had been introduced in each dining area; they included fruit and cakes for people plus drinks. People could take items whenever they were hungry or thirsty in between mealtimes. During the second day of our visit it was a very hot day and we observed staff being mindful of people's temperature and they ensured people had plenty of fluids to prevent dehydration. We saw ice creams and ice lollies being handed around to try to keep people cool.

We spoke with the kitchen staff and they were knowledgeable about people's needs and where people needed specific types of diets or food they knew what was required.

We asked the registered manager what nutritional assessments had been used to identify specific risks with people's nutrition. The registered manager told us they used a nutritional risk assessment and staff at the service closely monitored people and where necessary made referrals to the dietician or speech and language therapist. People were weighed by staff but where the staff recorded those weights was not in one place all of the time. This meant information could have been missed about a person's weight loss.

We saw records to confirm people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. The registered manager said they had good links with the doctors and district nursing service.

One person told us, "I have my own doctor and optician; the staff make sure I get there." A family member said, "If ever my relative sees the GP, they call me with any information I need to know however trivial."

People and their family members told us they were not able to access a bathroom to have a bath. We saw the only bathroom was on the upstairs floor and people living downstairs could not access this if they were unable to access the lift because maybe their wheelchair was too large. Staff told us people were offered an option but most people chose to have a shower; however, the bathroom itself was not accessible for people with complex mobility needs because the equipment was not suitable. This meant people's choice was restricted and their preferences could not always be met.

We discussed this with the registered provider and registered manager and they told us they would make clear to people what facilities were available so people understood when they were choosing to live in the service.

## Is the service caring?

### Our findings

People we spoke with during the inspection told us they were happy and the staff were caring. One person said, "I am so grateful for the kindness the staff show to me" and "The staff are always good for a laugh and they will sit with you and have a good chat." A family member told us, "The staff are so patient with my relative" and "The staff bring a smile to everyone's face." "The staff are angels, they look after me as much as they look after my relative."

During the inspection we spent time with staff and people who used the service and we could see the relationships people had developed. Staff were friendly and they took time to listen and communicate with people, they looked comfortable together, there was friendly banter between people and lots of laughter. There was a calm and relaxed atmosphere.

We saw staff treated people with respect. Staff did not rush people and spoke with people gently. For example, we saw one person who was missing a scarf and staff took the time to support the person to their room to find what they had lost. We later saw the person who told us, "I am so pleased I found it." Another person was talking with staff about the staff member's recent holiday and they reminisced about old music stars together and looked at photographs. The conversation was relaxed and the positive relationship between them demonstrated there was mutual respect.

Staff told us how they worked in a way which protected people's privacy and dignity. For example, they told us about the importance of knocking on people's doors and asking permission to come in before opening the door. We saw staff did this throughout our visit.

We saw in a communal hall a curtain was used for privacy across the toilet door area. We discussed this with the registered manager and clinical nurse lead; because the area was a communal corridor the curtain would not offer privacy around noise and conversations within the toilet area. The registered manager agreed and the curtain was removed immediately.

A person we spoke with told us they could choose whether to be supported by a male or female staff member and this was something they felt was important. The registered manager and staff we spoke with showed concern for people's wellbeing. It was evident from discussion all staff knew people well, including their personal history, preferences, likes and dislikes. Staff we spoke with told us they enjoyed supporting people.

Staff we spoke with said where possible they encouraged people to be independent and make choices such as what they wanted to wear, eat, and drink and how people wanted to spend their day.

We saw people had free movement around the service and could choose where to sit and spend their recreational time. The service was spacious and allowed people to spend time on their own if they wanted to. We saw people were able to go to their rooms at any time during the day to spend time on their own. We saw one person helping to clear the tables after morning coffee and take items to the bin. This was a very



natural activity for the person which told us it was something they did often.

During the inspection people showed us their bedrooms. They were very personalised and people told us how they had chosen the wall paper for the feature wall in their room and the colour scheme when they were decorated.

At the time of the inspection people who required an advocate had support to access a service. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. One person who did not have capacity may need a new place to live where they can spend time with younger people and an advocate had been sought to help identify a new place to live in the future.

People and their family members told us how they were fully involved in decisions about their care. One family member said, "They never make a decision about my relatives care without involving me."

## Is the service responsive?

### Our findings

People told us they were involved in a good range of activities. One person said, "There is a lovely church service here from time to time, the priest comes to see me in private." Another person said, "I used to enjoy gardening at home and here I get to do gardening, I have done some of the hanging baskets and a trough", "I love everything they plan" and "We had a fantastic party for the Queen's 90th birthday."

We saw the garden area was fully accessible and a summer house was used to for arts and crafts. We saw people supported from upstairs and downstairs to access the garden area. One person said, "I get out into the gardens every day, no matter what the weather and the staff make sure I am alright outside." We saw the service had won a 'Leeds in Bloom' gold award three years running for the garden and plants.

People told us about people who visited to provide events such as 'Pete and Pam' an interactive music duo. We saw everyone really enjoyed this on the day we visited. People spoke fondly of 'Pets scheme' and the 'Donkey Sanctuary' who visited. One person said, "When the animals come it seems to brighten everyone up."

We saw on the activities board the in-house activity worker supported events such as poetry and creative writing, reading the paper, coffee mornings and gardening. We saw examples of people's poetry on the wall in the home. The activity worker told us they enjoyed their role but felt they could do lots more if more time was allocated to their part time role. A family member told us, "The person that organises the activities deserves a medal; they are so positive and enthusiastic."

We saw people were supported by staff to have their own preferences for activity either alone or with friends. For example, we saw two people be supported to sit together because staff knew they liked dominoes. Another person had their own books on a table to read and their family told us, "They always make sure my relative has reference books that they enjoy reading, natural history books."

Staff told us how they offer all activities to everyone and they said some people wished to remain in their room or not join in. People who were nursed in bed were supported as much as possible one to one by staff to read books or chat and have their nails painted.

People, their families and staff told us in the past outings used to happen where people visited local shopping centres or places of interest. People told us they miss this and now do not have this opportunity. We were told by the activities staff member and registered manager about how the transport for outings had been too expensive. The registered manager told us they would add this as an agenda item to the next resident and relatives meeting to discuss what could be arranged.

During our visit we reviewed the care records of five people. We saw people's needs had been individually assessed and detailed plans of care drawn up. We found care plans were reviewed on a regular basis. However, we saw details in the care plan did not always match risk assessment information. People told us they had been involved in making decisions about care and support and developing their care plans.

The care plans detailed how people wanted to be supported which meant they were person centred. The care plans we looked at included people's personal preferences, likes and dislikes and contained very detailed information on how the person liked to be cared for and their needs. For example, the type of egg a person preferred a person's wish to have their bedroom door open so they didn't feel locked in and a person's dislike of milk type puddings.

During the inspection we spoke with staff who were extremely knowledgeable about the care people received. We saw staff react to people when they knew they needed support; for example, a person who had a sore back was supported to lie down before lunch so they were comfortable and another person was offered a different meal because staff knew they had an upset stomach. Staff were responsive to the needs of people who used the service.

People told us how staff went out of their way to do their best for people. One person said, "The staff know me very well and they help me outside umpteen times a day for a smoke." Another person said, "Staff are great, we are like one big happy family."

Through discussions with staff we learnt how they supported extra on their days off for people; for example, one staff had arranged to meet a family member to help dye a person's hair colour.

We were shown a copy of the complaints procedure. The procedure gave people timescales for action and who to contact. People and their families confirmed with us they knew who to speak with if they had any issues. We were told everyday concerns and requests were logged in people's daily notes rather collated by the registered manager. Issues like this were dealt with immediately and resolved. We discussed with the registered manager how this information could be recorded better so patterns and trends could be looked at by them. They told us they would look to develop this.

One person said, "There is nothing to complain about but I would see [name of registered manager] if I had any problems." A family member told us, "I definitely tell the staff if there is a problem and they sort things out immediately" and "One of the owners pops in and asks how things are."

The residents and relatives meeting were an active forum for people to raise concerns. A family member told us, "I always speak my mind and we can discuss things at the residents meetings." Meeting minutes we saw confirmed the meetings were very open and honest and a good forum for people to be listened to.

## Is the service well-led?

### Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems which help providers to assess the safety and quality of their service.

The registered manager was able to show us numerous checks which were carried out to ensure the service was run in the best interest of people. These included checks on health and safety, medicines, infection control, accidents amongst other areas. We saw some checks had resulted in some changes to the service, for example; the mealtime audit had resulted in new crockery being purchased for people living with dementia to support them to eat better.

However, we saw where actions had been identified; these had not always been completed to ensure safety. For example; a fire door had not been repaired for numerous months even though it had been highlighted through safety checks.

We discussed with the registered manager how they could develop the range of checks to cover all areas of risk for example; bed rail safety checks.

The registered provider looked at the checks to see patterns and trends; for example, they analysed the accident and incident data. However, they did not use all the information gathered to look at the root cause. The registered provider was keen to develop the system they had in place to oversee the performance of the service better. For example, looking to see if actions identified had been completed.

The quality assurance system did not include robust processes that were operated effectively enough to ensure safety and quality. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was a registered manager in post at the time of our inspection. People who used the service spoke positively of the registered manager. One person said, "The owners and manager listen to us."

Family members we spoke with told us they felt confident with the management of the service. One family member told us they would not let their relative stay if they did not think it was the right place for them.

The staff we spoke with gave us varying feedback about the management and leadership of the home. Some staff told us they felt well supported by the registered manager, one staff member said, "[Name of registered manager] is a good manager, they listen and they are interested, they give reassurance." Another staff member said, "If you need [name of registered manager] they are there." Other staff told us they felt the registered manager was not accessible because they shared an office with other managers and staff and they felt that made it hard to go and ask for support.

We noticed during the visit the environment did not help people know where staff members were as it had lots of corridors and corners. This was an issue picked up by the registered manager regarding staff contacting the nursing team when on shift. Technology had been put in place for staff to call nurses when

they could not be seen. The registered manager was already aware and understood they had the same issue when they were present on one of the floors for any length of time as staff and people would not have necessarily known of their presence.

We discussed this feedback with the registered manager and they told us how they completed daily workarounds, spend time with people who used the service and their families each day. Staff, people and their families confirmed this. The registered manager told us they would look at how they could build into their working day more time with staff and people in the main support areas so they were more visible more often.

We saw records to confirm staff meetings were held regularly and agenda items such as good practice, privacy and dignity were discussed. The registered manager also met with different departments such as the kitchen team and senior care team. Staff therefore had opportunity to speak up and discuss the service with the registered manager. One staff member said, "We have regular meetings and we have more now since [name of registered manager] was manager."

Residents and relatives meetings were also held regularly and we saw records to confirm this. One family member said, "I go to relatives meetings and they are well attended." Another family member told us, "They (registered manager and registered provider) respond every time we have a relative meeting, they make changes." We saw on display the outcomes from these meetings so people could see changes had been made. The 'You said, We did' display demonstrated peoples' thoughts and ideas were acted upon. For example; people asked for the puddings to be moved to tea time and this happened. One person who used the service told us, "I have made a few changes by going to residents meetings."

We saw a survey had been carried out in 2016 to seek the views of family and people the service supported. The survey results had been analysed and where actions to improve had been identified they had been addressed.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Assessments of people's capacity and records of decisions made in people's best interests were not completed where required.  Regulation 11(1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were not robust enough to ensure quality and safety.  Regulation 17 (1) (2) (a), (b), (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Staff training was not up to date. Clinical training and competencies for nursing staff were not in place for all areas of clinical practice.  Regulation 18 (1) (2) (a)

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medication systems were not robust to ensure safety.  Known risks identified in the property were not mitigated to prevent harm to people.  Risk Assessments did not cover all known risks and where they were completed guidance from assessment was not always followed.  Regulation 12 (1) (2) (a), (b), (d), (g).

### The enforcement action we took:

Warning notice