Milewood Healthcare Ltd

Holgate House

Inspection report

139 Holgate Road
York
North Yorkshire
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection took place on 9 May 2017 and was unannounced. At the last comprehensive inspection of the service on 25 October 2016 we rated the home as Requires Improvement due to a breach in Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance. This was because, although the registered provider had implemented improvements since an inspection in June 2016, there was a lack of management oversight to ensure the measures had been sustained and were consistent across all areas.

At this inspection we found that governance had improved, quality audits had taken place to identify any shortfalls and action had been taken to address the shortfalls. Recording in care plans and risk assessments was consistent, including records of people's nutritional needs.

The home is registered to provide accommodation and care for up to 30 older people and younger adults with varying needs that include learning disabilities, autistic spectrum disorder and / or mental health. On the day of the inspection there were 19 people living at the home. The home is situated close to the centre of York. the main house has two floors; there is no passenger lift so people who are accommodated on the first or second floors have to be able to manage the stairs. There are also some ground floor flats to the rear of the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed on 13 March 2017 and they had commenced the registration process with CQC.

Care plans included information to guide staff on how to meet people's assessed care and support needs. There were some minor anomalies in care plans but this had not affected people's well-being or the support people had received.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No-one living at the home had a DoLS authorisation in place but the registered manager had submitted applications that were being considered by the local authority.

There were recruitment and selection policies in place and these had been followed to ensure that only

people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Staff told us that they were well supported by senior managers. They also told us they received the training they needed to carry out their roles effectively, including training on the administration of medicines. This was confirmed in the records we saw.

We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home told us that staff were caring and that staff respected people's privacy and dignity. We saw that there were positive relationships between staff and people who lived at the home, and that staff had a good understanding of people's individual care and support needs.

Activities were provided and people were encouraged to take part, although some people told us they preferred the trips out to the activities provided within the home.

We saw that people's nutritional needs had been assessed and individual food and drink requirements were met. People told us that they were happy with the food provided and we observed that there was a choice at mealtimes. There were facilities for people to make themselves a drink throughout the day.

The premises were undergoing an extensive refurbishment programme. We noticed unpleasant odours in two people's bedrooms but we were assured that these bedrooms were next to be refurbished. The areas of the home that had been refurbished had been completed to a high standard.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been thoroughly investigated and appropriate action had been taken to make any required improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff adhered to the home's policies and procedures on the administration of medicines, and this meant people who lived at the home received the right medicines at the right time.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and people told us they were happy with the meals provided at the home.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed.

People's physical and mental health care needs were being met.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs and how these should be met by staff and other people involved in their care. Care and support provided was person-centred.

Activities were provided both within the home and in the local community.

There was a complaints procedure in place and we saw that any complaints people had made had been thoroughly investigated. There were also opportunities for people who lived at the home to give feedback about the service provided.

Is the service well-led?

Good

The service was well-led.

A new manager had been appointed and they had commenced the registration process. In the interim period, the home was being managed by senior managers within the organisation.

Audits were being carried out to monitor the effectiveness of the service.

Staff told us that they were well supported by managers.

There were opportunities for people who lived at the home and other people involved in their care to give feedback about the service provided.

Holgate House

Detailed findings

Background to this inspection

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

The inspection took place on 9 May 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an inspector from the CQC hospital team who specialised in mental health.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we received some information of concern about the service, and we looked at the issues raised as part of our inspection.

On the day of the inspection we spoke with seven people who lived at the home, four members of staff, the manager, the commercial director and the nominated individual. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe living at Holgate House. One person said, "It's safe here – there's no dangers." Staff described how they kept people safe. They told us, "We keep the environment safe and check for hazards. We have training that alerts us to safety issues. We observe interactions between people to make sure they are safe" and "We report any safeguarding concerns to the local authority and CQC."

There was a policy in place on safeguarding adults from abuse and staff told us that they completed training on this topic. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. They told us they would report any concerns to a member of the management team and that they were confident appropriate action would be taken. One staff member told us, "Managers would definitely act on this information." Staff also told us they would not hesitate to use the home's whistle blowing policy if they had cause to. They said they were confident the issues they raised would be addressed. When poor practice by staff had been identified, we saw that appropriate disciplinary action had been taken.

We saw that staff had been reminded of the importance of accurate recording in respect of managing people's monies. There was also information in each person's care plan to advise staff what action to take should someone go missing from the home.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. We saw that interview questions and responses were recorded and held for future reference. These checks meant that only people considered suitable to work with people who may be vulnerable had been employed at the home.

On the day of the inspection we saw that there were sufficient numbers of staff on duty to meet people's needs. This included the new manager, the commercial director and the nominated individual as well as a senior support worker and four support workers. There were two 'waking' support workers on duty overnight. The rotas showed that staffing levels were flexible to meet the individual needs of people who lived at the home so they varied from day to day. Agency staff continued to be used to cover vacant shifts but we saw that the number of shifts covered by agency staff had reduced as new staff had been employed. Any agency staff used were 'regulars' so they knew the people who lived at the home. Staff told us that staffing levels had increased. One member of staff said, "It's brilliant now. We are never left short anymore. We occasionally use agency staff but we get the same ones so they get to know the home."

We noted that there was always a staff presence in communal areas of the home should they be needed by people who lived at the home. There was no longer a cook employed at the home; support staff prepared

meals and this meant people who lived at the home could be involved in preparing their meals with staff.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for accessing the community, conflict with others, slips / trips / falls, relapse of mental health, smoking in the building, verbal aggression, financial abuse and night time care. Risk assessments recorded the risk, any triggers and how the risk could be reduced or eliminated. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

We saw that care plans recorded possible behaviours that might challenge the service or others, and how staff should manage these behaviours to diffuse the situation. Staff told us that they completed Management of Actual or Potential Aggression (MAPA) training which provided them with the knowledge they needed to carry out low-level restraint. This was only used when there was a danger people who lived at the home might hurt themselves or someone else.

There was a contingency plan in place that included advice for staff on how to deal with emergency situations. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

We observed that medicines were appropriately ordered, received, recorded, administered and returned when not used. Medicines were supplied by the pharmacy in a monitored dosage system where tablets were stored in separate compartments for administration at a set time of day. Each person had one or two medicines cabinets in their bedroom; one for medicines to be taken orally and one for topical medicines (medicines that are applied to the skin such as creams). The temperature of the cabinets was checked each day to ensure medicines were stored at the correct temperature.

The medicines room included a controlled drugs (CDs) cabinet and we saw CDs were stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medicine and saw that these balanced. There was a fridge in the medicines room to hold medicines that needed to be stored at a low temperature. The temperature of the medicine fridge and the medicine room were checked to ensure that medicines were stored at the correct temperature. Medicines that needed to be returned to the pharmacy were stored securely and recorded in a returns book. There was an audit trail to ensure that medicines prescribed by the person's GP were the same as the medicines provided by the pharmacy.

We looked at MAR charts and found that they were clear, complete and accurate. We saw there were protocols in place for the administration of 'as and when required' (PRN) medicines. Codes were used correctly to record the reason medicines were not administered. When people were absent from the home there was a separate record of any medicines they took with them. GPs had signed to record homely remedies that were safe for people to take along with their prescribed medicines. Product sheets from the medicine package had been retained for staff to refer to. However, two people were prescribed a medicine that needed to be closely monitored for side effects. The home had retained the product information from the package but had not identified the specific monitoring requirements. The commercial director told us they would make sure all staff were made aware of this straight away.

Staff who had responsibility for the administration of medicines had completed appropriate training, and staff told us their competency was checked by senior staff.

We noted that any accidents or incidents involving people who lived at the home were recorded in their care

plan. We also saw a document that recorded incidents, accidents, serious accidents, safeguarding incidents and complaints. Any trends identified were discussed at staff meetings, including associated identified health and safety risks.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, emergency lighting, portable electrical appliances, gas safety and the electrical installation.

There was a fire risk assessment in place and fire drills had been carried out on a regular basis to ensure that people who lived at the home and staff knew what action to take in the event of a fire. Records showed that in-house checks of the fire alarm system, emergency lighting and fire doors were completed on a regular basis. In addition to this, weekly health and safety checks were carried out, as well as checks of wheelchairs, window opening restrictors and the emergency call system.

We noted a strong odour in one person's bedroom and an odour in another person's bedroom. We were assured that these two bedrooms were next on the list to be refurbished; work was due to start on the room with a strong odour within two weeks. The infection control audit also referred to the refurbishment plan and how the refurbishment would address some of the infection control concerns.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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. A person's capacity to make decisions and consent to their care was recorded in their care plan, and any best interest decisions made on a person's behalf were also recorded. It was clear that the staff who we spoke with understood the principles of this legislation. We saw that information about mental capacity was clearly displayed on the notice board for people who lived at the home.

Staff described to us how they supported people to make decisions, and one member of staff told us they were aware that people could make unwise decisions.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the registered provider had submitted applications to the local authority for consideration and that there was a record of the acknowledgement from the local authority including whether the application was being processed as high, medium or low priority.

We observed that staff checked people were consenting to their care or support before they provided that support. People's care plans recorded their consent to having a photograph taken to be included in their care plan and in medicine records.

During their induction period, staff received a copy of the staff handbook, a job description and a selection of the organisation's policies, such as challenging behaviour, whistle blowing, data protection, use of personal protective equipment (PPE) and professional boundaries. Staff confirmed that they shadowed experienced care workers during their induction period. We discussed how it would be helpful to record these shadowing shifts to provide further evidence of staff induction training. People new to the caring profession were expected to complete the Care Certificate. This ensured that new staff received a standardised induction in line with national standards.

Staff told us they were happy with the training they received. One member of staff told us, "The training is really good. It's thorough and the trainer finds ways to engage us." The training matrix recorded that staff had completed training on moving and handling, first aid, health and safety, fire safety, safeguarding adults from abuse, stigma, care planning and specific mental health conditions. We saw information displayed in the staff room about external training that was available for staff, such as understanding the care and management of diabetes, understanding nutrition and health and principles of team leading, plus a wide variety of distance learning courses.

Staff told us they had supervision meetings with a more senior member of staff and that they felt they were well supported. The supervision matrix showed that staff had a supervision meeting with a manager each month, and an annual appraisal. The 'policy of the month' was also discussed with staff as part of the supervision meeting. Staff were issued with mentoring forms when managers had recognised that they needed reminding about good practice guidelines. We saw that these included information about dealing with bodily fluids, good hand hygiene, food safety, stoma care and angina.

We saw that staff had regular contact with health and social care professionals to discuss any concerns about people's physical or emotional health. These contacts were recorded in people's care plans.

People had hospital passports in place. These are documents that people can take with them to hospital appointments and admissions when they are not able to communicate information about their care and support needs to hospital staff. They provide hospital staff with information about the person to enable them to meet their needs. On the day of the inspection a member of staff had accompanied one person to a hospital appointment, and they had lunch out before they returned to the home.

Referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutrition or swallowing / choking had been identified. Some people had been prescribed nutritional supplements and staff confirmed that people were happy to take these. Any advice received had been incorporated into the person's care plan.

People told us that they liked the meals provided at the home and that the menu was based on their likes and dislikes. There was a four week rotating menu that changed with the seasons, and following suggestions made by people in 'resident' meetings. There was a choice of food at each meal time. At a recent staff meeting staff had been reminded to prepare extra meals in case people changed their mind about the choice they had made. The commercial director told us that they had provided four kitchen areas during the refurbishment to make the dining experience more homely. However, the feedback from people who lived at the home was that they did not like the smaller areas, and most people preferred to eat in the main dining room. A smaller number of people chose to eat in the conservatory and others chose to eat in their own room. There was a record of the meals taken by each person every day.

We observed the serving of lunch in the dining room. The lunchtime meal was a ploughman's lunch; it looked fresh and appetising. The main meal had been moved to the evening at the request of people who lived at the home. There were two areas of the home were people could make a drink during the day and night. There was also a bowl of fresh fruit so people could help themselves.

There was no passenger lift. People who were not able to manage the stairs had bedrooms on the ground floor. Other people had bedrooms on the first or second floors of the home, or in adjacent flats. No-one had difficulty finding their way around the premises although we noted that some people had difficulty negotiating steps within the home along with heavy fire doors. We discussed this with senior managers. They told us there had never been an accident in these areas of the home, but they would monitor this closely to identify the level of risk. One service user with failing sight had been provided with a red toilet seat to make it easier for them to identify the seat in their toilet.

There was an extensive refurbishment programme in place. As rooms were being refurbished, people were moving into completed rooms so work could commence on their own rooms. People could choose whether they wanted a bath or shower in their en-suite facilities, and how they would like their room to be decorated. The rooms that had already been refurbished had been completed to a high standard. Each evening the areas of the home being refurbished were made safe when the builders left the premises.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff cared about them. Their comments included, "Staff really care about me. They are very caring" and "The staff are alright. I get on fine with them. They'll help you with anything you need." One person mentioned a member of staff by name. They said, "[Name of staff member] is an angel." It was clear that people were treated as individuals and that staff knew people's personality traits and likes / dislikes.

We saw positive interactions throughout the day between people who lived at the home and staff. People were comfortable in the presence of staff, and staff were attentive, encouraging and patient. We found there was a sense of community amongst people who lived at the home.

Care plans recorded people's preferred name and we saw that these were used by staff. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. One person told us, "Staff speak nicely to me and they knock on doors before they come in." Staff described to us how they protected people's modesty by closing curtains and making sure people knew they were using the bathroom so they were not disturbed. They added that they respected people's wishes and could not make people take a bath if they did not want one.

There was a form in care plans to record that people had been consulted about who they would like their key workers to be. A key worker's role is to take a particular interest in a person and to provide support with activities, shopping and assisting people to keep in touch with family and friends.

At a recent staff meeting there had been a discussion about the provision of a staff toilet. The response from senior managers was that all toilets should be clean, implying that if they were clean enough for people who lived at the home to use, they should be clean enough for staff to use. This showed a level of respect towards people who lived at the home.

People were encouraged to be as independent as possible. They worked along staff to prepare meals and were able to make their own drinks. Some people did their own laundry. When people needed assistance with laundry, staff ensured they washed each person's laundry separately. One person who lived at the home told us, "I go out on my own. We just tell the staff so they know where we are."

There was a 'room of the day' system in place. One person's care plan was evaluated, their 'infringement of rights' were reviewed, their bedroom was deep cleaned and their wardrobe was tidied. This ensured that each person received 'special' attention on their day.

Information about advocacy was available for people who lived at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. Some people were supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

The training matrix showed that staff had completed training on confidentiality, and a member of staff explained to us that they only shared information with relevant people on a 'need to know' basis. We saw that written and electronic information about people who lived at the home and staff was stored securely.

Care plans evidenced that people had been asked about their wishes for their end of life care. Some people had declined to discuss this, and this had been respected by staff. Other people had discussed this with staff and their wishes had been recorded in their care plan.

Good

Is the service responsive?

Our findings

The care records we saw included pre-admission assessments, risk assessments and care plans. Topics covered in care plans included communication, social skills, personal relationships, use of leisure time, daily living skills, personal care, choice / self image, health, mobility and challenging behaviour. When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. We saw that people had signed a document to show they agreed with the content of their plan of care. One person commented, "You can add to your care plan if you want to."

We saw that care plans included a lot of information and discussed with managers how it might be helpful for new staff and agency staff if a summary of the care plan was produced. They agreed to consider this.

Care plans recorded people's preferred way to communicate. For example, one person used flash cards and staff wrote things down for them and they were able to write responses. They had a light attached to their bedroom door that flashed when someone knocked at the door.

Care plans also recorded how people would express themselves when unhappy, and 'early warning signs' for staff that might indicate a person was becoming unwell. In addition to this, there was an advance directive that recorded how the person would like to be supported during periods of mental ill-health. When people had a specific health diagnosis, there was a description in care plans of that condition. This helped staff to understand each person's physical and emotional support needs.

This showed us that care plans included information that would assist staff to get to know the person and to provide individualised care and support. One person told us, "Staff know what I like and don't like." Because care plans included a lot of information, we discussed with managers how it might be helpful for new staff and agency staff if a summary of the care plan was produced. They agreed to consider this.

Care plans were reviewed and updated by staff each month. More formal reviews were held by commissioners to ensure people's care plans continued to be a true reflection of their current needs. We saw that any concerns expressed in care plan reviews had been explored and appropriate action taken.

Staff told us they had handover meetings at the beginning of each shift. Each person who lived at the home was discussed so that staff on the new shift were aware of everyone's well-being. The handover sheet also recorded medicines administered, any accidents or incidents and people's night time checks.

We saw the weekly activity programme displayed in the home; this included words and pictures to aid people's understanding. Staff told us that they provided a range of different activities and there was an arts and crafts session during the afternoon of the inspection. Staff said that some people were reluctant to take part in activities and they preferred to go out in the home's 7-seater car; these trips out took place three to four times a week. Some people had an annual holiday. One person told us that they kept in touch with family and friends, both by telephone and by them visiting the home.

We saw there was an 'easy read' complaints policy and procedure displayed around the home. The complaints log evidenced that any complaints received had been thoroughly investigated, and the records of the action taken and the outcome were comprehensive. This showed that complaints were being dealt with in line with the home's policy and procedure. Advocates were involved if this was felt to be appropriate. There was also a form on display that invited people to make comments and suggestions and place them in the comments box. This showed that complaints were being dealt with in line with the home's policy and procedure and that people who lived at the home felt empowered to raise concerns. People who lived at the home told us that they would tell staff if they had any concerns. One person said, "I could talk to any of the staff. I tell them straight! They'd sort it out for me."

One person who lived at the home had expressed concerns to another person who lived at the home. They had shared this information with staff, and we saw that staff had made efforts to engage with the person and take steps to improve their quality of life.

People who lived at the home told us that they had monthly 'resident' meetings. One person told us, "We have meetings. Staff would listen and try to put things right." We saw a list of the forthcoming monthly meetings displayed on the notice board, and the minutes of the meeting held in April 2017. The minutes of one meeting recorded that there were discussions about people choosing their own key worker, forthcoming themed nights, the home's refurbishment, how to raise concerns, trips out, meal provision and new staff. One person who did not communicate verbally was given the opportunity to express their views in the meetings.

In January 2017 people who lived at the home were given a satisfaction survey. One question included was 'How happy are you with the way staff help you?' Most people responded positively to all of the questions asked. However, one person had responded negatively to most questions and we saw a review had been arranged so these concerns could be discussed. This again showed that people's views were taken seriously.

Good

Is the service well-led?

Our findings

At the last comprehensive inspection of the service on 25 October 2016 we rated the home as Requires Improvement due to a breach in Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance. This was because, although the registered provider had implemented improvements since an inspection in June 2016, there was a lack of management oversight to ensure the measures had been sustained and were consistent across all areas.

At this inspection we found that the improvements we saw in October 2016 had continued and that the registered provider was no longer in breach of Regulation 17; Good governance.

Managers had informed CQC of significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents. In addition to this, the ratings from the last inspection were displayed within the home and on the home's website, as required by regulation.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. Most of these were readily available and others were forwarded to us immediately after the inspection.

We found that care plans, risk assessments and other records relating to people's care were a good reflection of the person's care and support needs. There were some minor anomalies in care plans but this had not affected people's well-being or the support people had received.

There was a checklist in place to remind staff of the audits that needed to be carried out. These included staff training audits, health and safety audits, a six monthly infection control audit and care plan audits. These care plan audits included an overview of each person's care plan and whether any changes had been made that month. An 'operations' audit monitored topics such as the environment and service user finances. We observed that quality audits recorded any shortfalls and the actions that needed to be taken to address them. There was a record of when the required actions had been completed.

Medicines were audited each month and the audit dated 19 January 2017 recorded one required action that had been fed back to staff in the communication book. Following another medicines audit, additional training had been organised for a member of staff. This showed us that action was taken to rectify any identified concerns.

We observed that managers interacted with people who lived at the home throughout the day and that these interactions were positive and friendly. It was clear the managers knew people well. People told us they knew who the managers were. One person told us, "I would talk to the head lass. I know where the office is." Another person named the managers and said they would be happy to speak with them.

We asked staff what they felt about the management and leadership at the home and they responded

positively. Comments included, "I have taken to the new manager. I have also felt supported by [Name of senior managers] and seniors" and "Really good. [Name of new manager] is new and learning but she seems nice. [Name of senior manager] is brilliant. I know I can go to them if I have any concerns."

We asked staff to describe the culture of the home. Their comments included, "We're a great little group – there is good teamwork" and "I enjoy working here." One member of staff added, "I'm proud of how far we've come. It has improved a lot since Milewood took over." The commercial director told us that the home was 'more relaxed and more friendly'. Staff were given specific responsibilities such as gardening with people who lived at the home, activities, nutrition, medication and record keeping. Managers felt that this responsibility gave staff a sense of involvement in how the home was operated.

Care staff told us they attended monthly meetings and that they could ask questions and make suggestions at these meetings. One member of staff said, "We're quite outspoken!" We saw the minutes of a meeting in January 2017. Staff had been reminded they must complete the Care Certificate, that care plan evaluations must be completed every month and about the importance of accurate recording. There was information about the staff who would be taking the lead on activities, and a reminder that activities must be offered every day. Film nights and theme nights were discussed; there were plans for Burns night and Valentine's day celebrations. At the next meeting staff had been asked if they had suggestions for information that could be included in staff induction, as five new staff had been appointed. One person's suggestion was added to the programme. The need for staff to work as a team had also been discussed and at the senior staff meeting in February 2017 staff were asked for suggestions to create team spirit.

There was a staff health and safety committee meeting in January 2017 when safeguarding incidents had been discussed. Although incidents had declined and those that had occurred had been referred to the safeguarding adult's team, staff identified concerns about one person, and a referral was made to the mental health team. This showed that safeguarding information was being analysed to identify any patterns of behaviour that needed to be explored.

Records showed that satisfaction surveys were distributed to relatives, professionals (although no professionals had responded) and staff in January 2017. There had been some negative comments from relatives about the building work and the appearance of the premises in the interim period. A letter was sent to relatives apologising for the untidy appearance of the premises and the action that staff had been asked to take to make improvements.

Staff told us that they learnt from incidents that occurred at the home. They were able to give us examples of incidents that had occurred and how they had put risk assessments in place to reduce the risks of these incidents occurring again.