

Mencap in Kirklees

Castle Hall Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 13 February 2017 and was unannounced. This meant they did not know we were coming. The service was last inspected on 15 June 2015. At that time the service was not meeting the regulations related to person centred care, safe care and treatment, and suitable premises.

After the last inspection the registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this inspection we checked to see if improvements had been made.

Castle Hall Residential Care Home provides personal care and support for up to 16 adults who have a learning disability. At the time of our inspection there were 15 people who used the service, thirteen on a long term basis and two on a short term basis. Castle Hall is set over two floors with bedrooms on both floors. The service has three lounges which are open to the people who live at the service. There is a large garden with a patio area which leads from the lounge, and large lawned areas. There is a dining room with an open plan kitchen where people who use the service come together to have their meals, as well as an activity room.

The service did not have a registered manager. 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 manager had applied to register with CQC, however they were on leave during this inspection and did not return to their position..

People we spoke with told us they felt safe and relatives we spoke with told us they were confident their relative was safe at Castle Hall Residential Care Home.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

At our last inspection we found creams were not always stored at the correct temperature. At this inspection we found improvements had been made and administration of medicines was well managed, although improved storage of some medicines was still required.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence. The registered provider had safe recruitment and selection procedures in place.

At our last inspection we found people were not always protected against the risk of unsafe or unsuitable premises because window restrictors were not in place on all upper floor windows. At this inspection we found these had been installed.

People's consent to care and treatment was not always sought in line with legislation and guidance, however people were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were enough staff on duty to meet people's assessed needs and provide a good level of interaction.

Staff had received an induction, supervision, appraisal and specialist training to enable them to provide support to the people who used the service.

Meals were planned to meet people's dietary needs and people were supported to eat a balanced diet. A range of healthcare professionals were involved in people's care.

Staff were caring and supported people in a way that maintained their dignity, privacy and human rights. People were supported to be as independent as possible throughout their daily lives.

We found evidence of people's access to activities in line with their care plans.

People were able to make choices about their care. People's care plans detailed the care and support they required and included information about people's likes and dislikes. Individual needs were met through the development of detailed personalised care plans.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The culture of the organisation was open and transparent. People, their representatives, and staff were asked for their views about the service and they were acted on.

The registered provider had an overview of the service and took action to improve the quality and safety of the service provided, however this system had not identified and addressed some of the problems we found on the inspection.

The management team were open and honest throughout the inspection and took immediate action to address any issues that arose.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff had a good understanding of how to safeguard people from abuse.

Risk assessments were up to date and reflected people's changing needs.

There were enough staff on duty to meet people's assessed needs.

Medicines were managed in a safe way for people.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's consent to care was not always sought in line with legislation and guidance.

Staff were provided with training to ensure they were able to meet people's needs effectively.

People told us they enjoyed the meals and people had access to external health professionals as the need arose

Is the service caring?

Good ●

The service was caring.

People told us and we saw the staff who supported people were caring.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good ●

The service was responsive.

People and representatives were involved in the development and the review of their support plans.

People were supported to participate in activities which were person centred.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

The service was not always well led.

The culture was positive, person centred, open and inclusive.

There were systems in place to regularly seek feedback from people who used the service.

The registered provider's quality monitoring system had not been fully effective in identifying the problems we found.

Requires Improvement 

Castle Hall Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 13 February 2017 and was unannounced. The inspection was conducted by two adult social care inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. Before the inspection, the provider 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. We used this information to help plan the inspection.

Some people who used the service were unable to communicate verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time in the living areas observing the support people received. We spoke with five people who used the service. We spoke with two members of support staff, two senior care workers, the cook, the chief executive officer (CEO) and one community professional. We looked in the bedrooms of eight people who used the service with permission. After the inspection we received feedback from two relatives.

During our inspection we spent time looking at four people's care and support records. We also looked at four records relating to staff recruitment, training records, maintenance records, medicine administration records and a selection of the service's audits.

Is the service safe?

Our findings

People we spoke with told us they felt safe and relatives we spoke with were confident that their family member was safe at Castle Hall Residential Care Home. One person said, "I'm never worried about 'owt." One relative said, "Yes, (relative) is definitely safe." Another said, "Yes. (Person) seems happy when we go."

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One member of staff said, "If I was concerned I would speak to the manager. If I was concerned about the manager I would speak to the group manager or go to the police or safeguarding." This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and Care Quality Commission had been notified. This showed the manager was aware of their responsibility in relation to safeguarding the people they cared for.

The members of support staff we spoke with understood people's individual abilities and how to ensure risks to them were minimised whilst promoting people's independence. People's care records contained comprehensive risk assessments for aspects such as managing money, accessing the community, use of bed rails, keeping a room key, medication, choking and falls. Risk assessments were detailed and included measures to mitigate risks to people and clear guidance for staff, for example instructions on how to use the hoist and the correct sling to use for one person.

We saw in one person's care records their eating and drinking care plan had been updated on 24 January 2017, however the associated risk assessment had not been updated to reflect this. The CEO told us they would address this.

Staff told us they recorded and reported all incidents and accidents and people's individual care records were updated as necessary. We saw in the incident and accident log that these had been recorded and an incident report completed for each one. Accidents and incidents were recorded in detail and staff had taken appropriate action. For example, following a fall one person was referred to the GP and physiotherapist for a review, as well as being accompanied by staff within the building as required to reduce the risk of falls. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety in the service.

People told us there were enough staff on duty. The staff we spoke with told us there were enough staff on duty most of the time, but they would like to see improvements to enable people using the service to access more activities outside the home.

The senior support worker on duty told us there were usually five staff members on duty in the morning and

four staff in the afternoons including the senior on duty. Two staff members were on duty at night. Three domestics were deployed as well as a cook and a kitchen assistant throughout the week. Care staff completed laundry tasks and a small number of people were supported to do their own laundry. A laundry assistant had been recruited and they were awaiting pre-employment checks. Senior carers and the managers were on call 24 hours a day. The group manager and CEO were based in an office at the service at the time of this inspection.

People had dependency level assessments in their care records and we found there were enough staff on duty to meet people's individual needs and keep them safe. The group manager told us they were recruiting for additional night staff due to the increasing dependency of people, as well as two staff members to cover maternity leave.

We saw sufficient numbers of staff were deployed at the service. We saw regular agency and bank staff were used to cover for staff absence and ensure the service to people could be maintained.

At our last inspection we found medicines were not always managed in a safe way for people because some creams were not stored at the correct temperature medicines were stored in safe way for people. At this inspection we found creams were stored appropriately and the date of opening was recorded in order to ensure they remained effective and were used as prescribed. Body charts were in place to direct staff with the application of topical creams.

Blister packs were used for most medicines at the home, as well as some medicines in bottles and boxes. We looked at people's medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and are used to record when they have been administered. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. We saw a count of medicines was completed every week to check the stock was correct and no errors had occurred in administration. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

We saw the senior carer asked people for consent before giving medicines and anticipated one person's need for pain relief from their demeanour and knowledge of the person and offered pain relief to them. Some people were prescribed PRN 'as required' pain relief. For the person we observed the staff member told us the person was able to ask for pain relief when it was required and staff would offer pain relief if the person also showed sign of pain, as they had on this occasion. We saw each person had an individual medication profile including a section entitled, "How you will know if I am in pain", which included information about the signs of pain where people lacked capacity or had communication impairments. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. The registered manager told us all staff at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw the competence of staff to administer medicines was usually assessed annually. This meant people received their medicines from people who had the appropriate knowledge and skills. Some prescription medicines contain drugs (Controlled Drugs) that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. The secure box containing the controlled medicines was kept locked in the medicines trolley in the locked medicines room and only appropriately trained senior staff had access to it. The service had not supported any people who used controlled drugs

until September 2016, when a person who was prescribed a controlled drug moved to the service. Following the inspection the CEO took immediate action to ensure the medicines were stored in line with the requirements for storage of controlled medicines to ensure they complied with legislation.

We saw from staff files recruitment was robust and appropriate vetting had been carried out prior to staff working with people. This meant staff had been properly checked to make sure they were suitable and safe to work with vulnerable people.

At our inspection on 15 June 2015 the registered provider was not meeting the regulations related to premises safety because window restrictors were not in place on all windows on the upper floor. At this inspection we found restrictors were in place on all windows.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). A series of risk assessments were in place relating to health and safety.

The staff we spoke with knew what action to take in the event of a fire. People who used the service had a personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. We saw staff training in fire safety was up to date and fire drills and fire safety practices and scenarios were used to ensure staff knew what to do in the event of a fire. Fire evacuation procedures and fire safety was also discussed at residents meetings. This showed the service had plans in place in the event of an emergency situation.

Appropriate equipment was in place to meet the needs of people who used the service, for example mobile electric hoists, ceiling tracking hoists and profiling beds. Records showed equipment had been properly maintained and serviced.

The service was clean and personal protective equipment (PPE), such as disposable aprons gloves, was available to promote infection prevention and control. There was no odour at the service except in one person's bedroom. The senior carer we spoke with told us a supportive continence care management programme was in place and the bedding and mattress were cleaned every day. We saw the room and mattress were clean and the staff team were considering ways to reduce odour by considering suitable flooring to further promote the person's dignity.

Is the service effective?

Our findings

Relatives we spoke with told us they were confident the staff team could meet their relation's needs.

The registered provider had policies in place in relation to the Mental Capacity Act 2005 (MCA). 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.

Staff at the service had completed training and had a good understanding of the MCA. We asked staff about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. One staff member said, "If someone lacks capacity and they need to make a big decision we get others involved in their best interests such as their advocate, social worker or family members."

We observed people were asked for their consent before they received any support and the service acted in accordance with their wishes or in their best interests.

We saw mental capacity assessments had been completed in all the records we sampled regarding use of a door sensor and where the person had the capacity to consent they had signed the consent form themselves. However, in one person's records, we saw a mental capacity assessment had been completed in March 2016 regarding the use of a door sensor to alert staff when the door was opened. The person was assessed as lacking capacity to consent and a best interest form had been signed by a member of staff in November 2016. There was no evidence of any best interest discussion with the person's relatives regarding the restriction.

We also found the person's consent to photographs form was signed by a member of staff, with no evidence of a best interest process involving the relevant person. We discussed this with the CEO and they arranged to hold a review with the person and their family to address the above issues. This meant there was no evidence the service had consulted the relevant person when making a decision on behalf of a person who lacked capacity.

The CEO told us DoLS authorisations had been requested for all the people who used the service and six of these had been authorised. Three of the applications had been declined as the person was assessed as having the mental capacity to make the decision. One of these people had a mental capacity assessment in

their records prior to the DoLS application indicating they had the capacity to consent to day to day decisions. There was no evidence to indicate the person lacked the capacity to decide to live at the home prior to the application. The DoLS code of practice (2008) states care homes should be satisfied the person meets the requirements for a DoLS authorisation before applying to the local authority and so in this instance the application had been inappropriate.

We found in one of the four records we sampled conditions were placed on the persons DoLS authorisation. The senior staff we spoke with were not aware of the conditions, and there was no evidence in the person's care records the conditions were being met. The service was required to seek day time activities, as the person was unable to go into the community without support. The CEO told us day services had been explored, however this had not been recorded. We saw from activity records the person had been out in the community to the shops or the park approximately twice a week and engaged in activities within the home on other days. Following the inspection the CEO and group manager asked the service to explore further options, arranged a review meeting with the person and their family and requested a local authority review for the person.

We saw from records one person's DoLS authorisation had expired in December 2016 and the service had not applied for renewal although they felt the conditions for authorisation were still being met. The CEO told us this was an oversight and immediately applied for the DoLS to be re-assessed. They also completed a log of DoLS applications, authorisations or reasons for declining the authorisation, dates of expiry and any conditions applied to ensure the above issues did not happen again.

The above issues meant the service was not always acting in accordance with the MCA (2005) and guidance. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. We asked three staff members what support new employees received. They told us they completed induction training and then shadowed a more experienced staff member for around two weeks before they were counted in the staffing numbers.

The shadowing focused on getting to know people's individual needs and preferences. Induction training was followed by completion of the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. This demonstrated that new employees were supported in their role.

We saw evidence in staff files and training records that staff regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. Training was a mixture of computer based and face to face learning and included topics such as safeguarding adults from abuse, infection control, behaviour and de-escalation techniques and first aid.

Staff we spoke with told us they felt supported by the manager and they said they received six weekly supervision, an annual appraisal and regular staff meetings. Staff supervision records covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. This showed staff were receiving management supervision to monitor their performance and development needs.

People were supported to eat a balanced diet. People made choices in what they wanted to eat and meals were planned using knowledge of people's tastes and preferences. Care files contained details of people's preferences and dietary requirements. We saw one person was offered a choice of breakfast using a menu

book containing photographs of food options to support them with making a choice. They chose sugar puffs and a cup of tea and added, "It's my favourite."

At lunch time people were offered a choice of main meal and dessert. Some staff ate with people in the dining room to promote a homely atmosphere. We observed people appeared to enjoy their meals. We saw some people used specialist plates, cups and cutlery to support their independence at meal times and that staff gave appropriate support for them to achieve this.

We saw the individual dietary requirements of people were catered for and the cook was knowledgeable about these. They told us two people were borderline diabetic, and some people required support with the consistency of their meals to reduce the risk of choking, for example a blended diet.

A record was kept of the food and fluids consumed by people. People were weighed weekly to keep an overview of any changes in their weight. This showed the service ensured people's nutritional needs were monitored and action taken if required.

People had access to external health professionals as the need arose. We saw systems were in place to make sure people's healthcare needs were met. We saw staff advocated for people when they were experiencing ill health to ensure they received the required support and treatment. People had a hospital passport and up to date health action plan in their care records. Staff told us people attended healthcare appointments and we saw from people's records they were seen by a range of health professionals. This had included general practitioners, consultants, community nurses, physiotherapists, speech and language therapist, chiropodists and dentists. A physiotherapist was visiting the service on the day of our inspection. This showed people who used the service received additional support when required for meeting their care and treatment needs.

The service is in a large two storey building, which was in need of some modernisation. We found, however, the home was in good decorative condition and many rooms had been decorated since our last inspection. The CEO told us plans to refurbish the building and add en-suite facilities were on hold awaiting authorisation from the local authority, who owned the building.

People had access to a sink in their bedrooms. On the upper floor there were three bathrooms and one additional toilet. One bathroom was temporarily not being used due to a water leak the night before, in case water affected the use of the overhead hoist. This had been reported to building services as a priority to ensure adequate bathing facilities were available for people.

During our visit we saw people had freedom to access the lounges and dining rooms as well as their own rooms. One person was a cigarette smoker; they had free access to their cigarettes and the garden. The atmosphere of the service was comfortable and homely. Corridors were designed for ease of access for wheelchair users and picture signage was used throughout the building to support orientation. Art works and photographs were hung in the communal areas giving a homely atmosphere. This meant the design and layout of the building was conducive to providing a safe and practical environment for people who used the service.

Is the service caring?

Our findings

When asked if the staff were caring one person said, "They are yes." They said the best thing about living at the home was, "Having company."

A relative said, "Brilliant. Our (relative) loves it down there. They are very, very good." One community professional told us the staff were, "Very caring." Another said, "Yes they are caring."

We saw there were good relationships between staff and the people who used the service. Staff told us they enjoyed working at the service and providing support to people who lived there. One staff member said, "I like being here amongst the service users." Another said, "It's a really nice place, a homely environment. All the residents get on with each other."

All the staff we spoke with told us they would be happy for a relative of theirs to live at Castle Hall Care Home.

Staff told us they spoke to people or their family members about their likes or dislikes and spent time getting to know them during their induction to the home. We saw care files contained detailed information about the tastes and preferences of people who used the service, including their personal histories. Staff told us they had opportunities to read these records before commencing work with the people. This gave staff a rounded picture of individuals and their life and personal history.

People were supported to make choices and decisions about their daily lives. We saw staff took an interest in people's well-being and were skilful in their communications with people, both verbally and non-verbally, to help interpret their needs. They used gestures, facial expressions, appropriate touch, sign language and photographs to support people to make choices according to their communication needs. One staff member told us a person would touch the choice of drink they preferred when presented with options. We saw the activity board in the foyer displayed pictures of activities. One staff member said, "We always try to incorporate a lot of pictures on notices as some people struggle with reading."

Staff worked in a supportive way with people and we saw examples of kind and caring interactions that were respectful of people's rights and needs. We heard staff asking people what they would like to do and explaining what was happening, for example one person who was asleep in a wheelchair was gently supported to wake up and offered a choice of more comfortable chairs to sit in. The carer bent down to speak with them and replaced their slipper which had fallen off. We heard staff chatting with people whilst supporting them with transfers or with their meals. We saw one person being constantly reassured in a gentle manner by staff during a transfer using the hoist and the person's name was used frequently to provide reassurance. One person chose not to move from the table after lunch to a more comfortable chair, so the staff member brought them some building blocks to use at the table, which they were clearly very happy with.

People's individual rooms were personalised to their taste. Personalising bedrooms helps staff to get to know a person; it can also create a sense of familiarity and make a person feel more comfortable. Staff were

respectful of people's privacy; they knocked on people's doors and asked permission to enter. Staff told us they kept people covered during personal care and closed curtains and doors. One staff member said, "I talk quietly and discreetly to people in communal areas if talking about personal care. There are new slide indicators on the bathrooms to indicate when they are engaged." We saw privacy was promoted on risk assessments and support plans related to support with personal care. One staff member said, "I speak to people as I would want to be spoken to. We try to make it like a family atmosphere. It is people's home." A dignity notice board was present in the foyer setting out the registered provider's dignity policy.

People using the service appeared well groomed and looked cared for. People wore jewellery and clothing they had chosen in keeping with their personal style.

People were encouraged to do things for themselves in their daily life. Staff told us some people liked to put their laundry into the machine and helped to take it out. Care plans told staff what people could do themselves and where support was needed to promote independence. For example, "I can brush my own teeth but I do need staff to put toothpaste on my toothbrush for me." This showed people using the service were encouraged to maintain their independence and daily living skills.

Staff were aware of how to access advocacy services for people if the need arose and four people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People using the service had person centred and detailed end of life care plans in place and people and their representatives had been consulted regarding end of life plans and wishes; for example one recorded, "I would like music and flowers at my funeral."

Is the service responsive?

Our findings

One person said, "There is enough to do. I play pool or watch TV. I go out to the park." Another person said, "Yes we have reviews. Complaints-I don't have any."

One relative said, "They have reviews but we can't always get there now. They tell me if (relative) has a fall or anything."

At our last inspection the registered provider was not meeting the regulations related to person centred care because activities were not planned to meet people's assessed needs. At this inspection we checked to see if improvements had been made.

An activity coordinator had recently commenced employment at the service for 30 hours who we observed engaging people in Valentine's Day craft activities on the day of our visit. A new administrative and housekeeping assistant had also been appointed for 25 hours, who would enable care staff to have more time to participate in activities with people.

We saw from activity records people had engaged in activities in line with their tastes and interests. Staff told us people engaged in activities outside and inside the home but felt it would benefit people who used the service if there were enough staff on duty to take people out into the community more often. We saw from records some people had been on shopping trips or for a coffee in a local café over the last week. Staff told us and we saw from records how they enabled people to see their families as often as they wished. This meant people's social needs were being met.

We saw different people engaged in craft sessions in the activity room throughout the day of our inspection and some people played pool in a games room, which was styled like a public bar. Some people watched TV or dined in one lounge and chose not to engage in planned activities and another person was engaged in knitting and chatting. We saw staff interacted with people and supported them with activities in the home, such as painting their nails, craft activities, table top games, sensory items, choosing music and watching DVD's. On the day of this inspection four people attended day services.

One staff member told us the registered providers' motivation team visited the service monthly to get people involved in playing instruments or doing quizzes, but some people were reluctant to join in, whilst others enjoyed the activities. They also said an art group came in to the home once a week, as evidenced on the activities board in the foyer and a Valentine's day movie night was also advertised in the 'pub room.' Some people had also been on holidays over the last year, for example to Blackpool.

The service was currently awaiting delivery of its new minibus to enable trips further afield to be completed and a trip to York railway museum was being planned in response to people's requests.

Through speaking with people, relatives and staff we felt confident people's views were taken into account. There was evidence people and their representatives had been involved in discussions about their care and relatives we spoke with told us they were always invited to reviews and involved in their relative's support.

We saw people making choices, for example, by pushing food away when they had had enough or choosing where to eat their lunch. This meant the choices of people who used the service were respected.

People's care files contained detailed person centred support plans covering areas such as personal care, physical health, finances, nutrition, medication and accessing the community. Support plans included photographs and colourful symbols to involve the person in their support. We saw care plans provided information about the individual that would enable them to receive person centred support. For example, "I would like staff to make sure they are using non perfumed shower gel and shampoo." We saw care plans had been reviewed regularly, were signed by the relevant person and up to date.

Detailed specific guidance for staff was present in care plans such as, "How to help me shower", and, "Things that make me upset." Daily records we saw detailed what activities people undertook, wellbeing, personal care, pressure care and nutritional intake.

We saw care was delivered in line with people's care plans, for example one person needed their feet to be raised when seated and we saw they were supported with a footstool. Another person sometimes declined to have a shower, which led to some health and hygiene concerns and the care plan stated after three strip washes this should be flagged up with the senior staff on duty to ensure the person's hygiene needs were met in their best interests by encouraging them to access the shower. We saw from daily records this action had been completed by staff.

Goals the person wished to achieve were set at reviews and progress toward goals was recorded. The senior on duty told us reviews were held annually and care plans were updated regularly and when needs changed. These reviews helped to monitor whether care records were up to date and reflected people's current needs so any necessary actions could be identified at an early stage. We found in one of the care records we sampled the person had not had an annual review for two years and no plans were in place for this to take place. We spoke with the CEO and they said this was an oversight and they would arrange it immediately. Following our inspection they showed us the date had been arranged.

One relative said, "I have no complaints. They are very, very good." The relatives we spoke with told us staff were always approachable and they were able to raise any concerns, but had never needed to complain. We saw there was an easy read complaints procedure on display for people to see and there was another copy in people's care files. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. Compliments were also recorded and available for staff to read.

Is the service well-led?

Our findings

Family members we spoke with told us they were happy with the service and they thought the service was well-led. One said, "(Person) calls it home. (Person) is always ready to go back after a visit. They are happy." When asked about the managers they said, "They keep swapping. They do a good job. I can't complain."

One person told us they were not confident managers would act on their concerns and they wanted to live more independently. We spoke to the senior on duty about this and they spoke with the person who then accepted the concern was being acted on and a social worker was looking into their desire to move to more independent living.

One community professional told us the management of the service had improved in recent months and people's care records were easier to read, for example when looking for a person's medical history.

All the staff we spoke with told us they would be happy for a relative of theirs to live at Castle Hall Care Home. One staff member said, "My mum would get the best possible care and keep her dignity and respect."

There was no registered manager of the service. The registered manager had left the service in April 2016 and an interim manager had been appointed until September 2016 when the new manager came into post and applied to register as manager. They were on leave during this inspection and left the service the following week.

The manager of the service had worked office hours and the group manager and CEO were based in an office at the service whilst the manager was on leave. The CEO was active in the service on the day of our inspection, interacting with people and helping people put up pictures in communal areas.

Staff we spoke with felt supported by the management team and told us the home was well-led. Staff we spoke with told us they were confident the manager would act on any concerns they might have. One said, "The new manager is doing great. I feel positive for the future."

The service promoted a positive culture that was person-centred, open, inclusive and empowering. The senior staff said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this.

People from the local community were invited in to the service for events, such as a summer fete and Christmas fair and the CEO was liaising with a community organisation to support local people into employment with the service, for example with the recently appointed laundry assistant.

The registered provider's vision was displayed in the foyer, "Our vision is a world where people with learning disabilities are valued equally, listened to and included." One staff member said, "There is enthusiasm within Mencap and people are bringing more ideas."

There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Medicine counts were completed weekly by senior staff and we saw from records medicine audits had also been completed every six to eight weeks by the manager. Care plans and documents were also reviewed, updated and audited regularly. This showed staff compliance with the service's procedures was monitored and addressed to improve the quality and safety of the service, although issues with DoLS and best interest processes had not been identified prior to the inspection.

We saw audits were maintained in relation to premises and equipment. Health and safety checks were completed monthly, for example; ensuring the first aid box was fully stocked and water temperatures were safe. Additionally senior carers completed a daily walk round to ensure any immediate concerns were picked up and addressed.

Records indicated some quarterly audits had not been completed recently in line with the registered providers' policy and the registered provider had addressed this with the manager.

The group manager showed us they had been present at the home regularly to support the manager and ensure compliance with the registered provider's policies and procedures prior to the manager deciding to leave the service. They completed a quality monthly audit report covering areas such as people's feedback, activities, safeguarding, quality management and care plans and actions were recorded and followed up. This was then sent to the CEO who shared the information with the management board to monitor progress with the quality of the service. This demonstrated the senior management of the organisation were reviewing information to improve the quality of the service; however this system had not identified and addressed some of the problems we found.

Senior staff told us they felt supported by the registered provider and could call a manager any time. We saw the manager had supervision recorded in December 2016 and February 2017 following their induction to the service, and regular support visits from the registered provider. The manager attended regular managers meetings to share good practice and learning from incidents as well as discussing training, health and safety, service updates and ideas for activities. This meant the manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people using the service.

The group manager told us after the inspection "We want a home we can be proud of. The care the residents get is lovely, but we want to make improvements to the building, ensure staff feel valued and give residents more choice over what they want to do with their days."

Residents' meetings were held monthly and topics discussed included fire safety, food choices, holidays and any complaints people may wish to make.

The registered provider carried out its own quality assessment of the service through stakeholder, relative and service user questionnaires. We saw a pictorial questionnaire had been completed in each person's care records showing their satisfaction with different aspects of the service. One person commented, "I am happy living here. There is nothing I don't like. I do all sorts of activities."

A family forum had been held in November 2016 and we saw feedback had been responded to in writing and any action taken.

One family questionnaire feedback requested improved en-suite facilities and more activities for people. We saw improved activities had been implemented, and the issues with the building were still in the progress of negotiation.

Staff meetings were held every one to two months. Topics discussed included changes to individual care needs, health and safety, equipment, recording, dignity and the Mental Capacity Act. Actions from the last meeting were discussed and goals were set from the meeting. Compliments and praise was shared with staff. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit statutory notifications to the Care Quality Commission (CQC) when certain incidents happen. All notifications had been submitted as required.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Consent was not always sought from the relevant person when decisions needed to be made in line with the Mental Capacity Act (2005) and guidance</p> <p>DoLs applications were not always appropriately applied for and renewed.</p>