

ADL Plc

# Morton Close

## Inspection report

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Date of inspection visit:  
17 February 2016

Date of publication:  
15 April 2016

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We inspected this service on 17 February. The inspection was unannounced.

We last inspected this service in January 2014 and found it was meeting all of the regulations inspected at that time.

Morton Close Care Home is a large detached property situated approximately two miles from Bingley town centre. The home is registered to provide residential care for up to 40 people. Most of the people who use the service are older people, some of whom live with dementia. On the day of our inspection 25 people lived at Morton Close. Accommodation is on three floors with single and some double rooms available. The communal lounges and dining areas are all situated on the top floor. The home is well served by public transport. There is level access into the home and one passenger lift to all floors.

There was a registered manager who had been in post for a number of years. 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.

We reviewed the medicines management systems in place and although we saw some good practice we also identified areas where improvements were needed to ensure medicines were managed in a safe and proper way.

We saw mealtimes were a positive and relaxed experience. Overall we found people were provided with appropriate encouragement and assistance to eat. People told us the food was good and plentiful.

We found care records did not always contain accurate and complete information. We also found a lack of information within care records to demonstrate that risks were being appropriately assessed, monitored and mitigated.

People told us they felt safe and we saw robust procedures were in place to protect people from the risk of abuse.

Staff received appropriate training and development to enable them to deliver effective care. Staff sought consent at the point of care delivery and worked in line with the requirements of relevant legislation such as the Deprivation of Liberty Safeguards (DoLS).

The majority of people we spoke with told us staff provided them with timely support. Our observations during the inspection confirmed this. However, we concluded minor improvements were needed to ensure staffing levels were consistently sufficient.

People told us staff were kind and caring and treated them with respect. Despite the limited information within people's care records we saw staff knew people well and used this knowledge to deliver person centred care. Staff adapted the running of the service to respond to people's changing needs and preferences.

People who used the service and their relatives were asked for their views and were listened to. Where people raised concerns or complaints these were promptly investigated and resolved. Where quality assurance systems were in place these were not sufficiently robust and did not always prompt improvements to be made. There were some areas where comprehensive audits were not in place but were required to ensure appropriate action was taken to monitor and improve the service. Despite this, people spoke positively about how the service was run and told us the registered manager provided good leadership and generated positive staff morale.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

The systems for managing medicines needed to be improved.

Improvements were needed to ensure care records were accurate and complete. Although we saw evidence staff took action to manage risks, care records did not always provide evidence that risks were being appropriately managed.

We concluded some improvements were needed to ensure staffing levels were consistently sufficient.

People told us they felt safe and robust procedures were in place to protect people from the risk of abuse.

### Is the service effective?

**Good** ●

The service was effective.

People were supported to eat a varied and balanced diet and had their healthcare needs met.

Staff sought consent before providing support and worked in line with the requirements of relevant legislation such as the Deprivation of Liberty Safeguards (DoLS).

Staff received effective training and development.

### Is the service caring?

**Good** ●

The service was caring.

Staff had a good understanding of people's individual needs and used their knowledge to deliver person centred care.

People were treated with respect and dignity.

Staff involved people in making decisions about their care.

### Is the service responsive?

**Good** ●

The service was responsive.

Staff used their knowledge of people to deliver person centred care.

The service was adapted to respond to people's changing needs and preferences.

Staff listened to people and where they concerns or complaints these were promptly investigated and resolved.

**Is the service well-led?**

The service was not always well-led.

Where quality assurance systems were in place these were not sufficiently robust and did not always prompt improvements to be made.

People spoke positively about how the service was run and the registered manager. People's feedback was sought and acted upon to make improvements.

**Requires Improvement** 

# Morton Close

## 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.

The inspection took place on 17 February 2016 and was unannounced.

The inspection team consisted of three inspectors.

Before the inspection, we reviewed the information we held about the provider such as notifications and any information people had shared with us. We also spoke with the local authority commissioning and safeguarding teams and a health professional who visited the home to ask them for their views on the service and whether they had any concerns. We reviewed the information on the 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.

During our inspection we used a number of different methods to help us understand the experiences of people who lived at Morton Close. This included reviewing three people's care records and medication administration records. We also reviewed a number of other records relating to the running of the service, such as policies, procedures, audits and staff files. We spent time observing the care and support provided to people and spoke with nine people who used the service. We also spoke with the registered manager, cook and five members of care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

# Is the service safe?

## Our findings

We reviewed the medicines management systems in place and although we saw some good practice we also identified areas where improvements were needed.

People told us they received their medicines when they needed them. We found medicines were stored safely and securely. We observed the morning medicines round and spoke with the staff member responsible for administering medicines on the day of the inspection. We saw the staff member was patient and kind with people, giving them a drink with their medicines and staying with them until the medicine had been taken. We saw people were offered pain relief and, where people had pain-relieving patches, staff checked these were still in place. They told us no one currently received their medicines covertly (hidden in their food or drink) or self-medicated.

However, we saw the staff member did not always check the prescriber's instructions on the medicine administration record (MAR) before administering the medicine. For example, four people were prescribed a medicine which the MAR stated should be administered before food, however we saw this was given after people had eaten their breakfast. When we raised this with the staff member they said they were not aware of these instructions.

One person was prescribed a medicine which thins the blood. The dose of this medicine varies according to blood test results. The dosage was handwritten on a piece of paper with the MAR. There was no information to show who had authorised this dosage or when. When we asked the staff member administering the medicine about this they were not sure. The registered manager showed us an entry in the person's care file which showed the dosage was correct and had been prescribed by the doctor. However, the registered manager agreed this information should be kept with the MAR so staff had clear and accessible information when administering medicines.

We saw some people were prescribed medicines to be given on an 'as required' basis. We found protocols were not in place to guide staff as to when and how often to administer these medicines. For example, one person was prescribed a medicine to manage their agitation. The instructions on the MAR read 'half a tablet three times a day as required'. Although the staff member could describe to us when they would give this medicine, the lack of a formal protocol meant the person may not consistently receive their medicine when they required it. The provider's medicine policy stated, 'PRN protocols will be available in the medicine file showing when to give, what symptoms may be present, what to do if the medicine is ineffective and when a further dose can be given'. This showed that this procedure was not always being followed.

The staff member told us topical medicines, creams and lotions were kept in people's rooms and applied by care staff. There were no signatures on the MARs to show these had been applied and no protocols or body maps in place to show what to apply, where, when or to sign when done. The provider's medicine policy stated body maps and treatment records should be completed for prescribed creams. Similarly the MARs showed two people were prescribed a thickening agent to be added to their drinks but there were no records to show when this had been given.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw these medicines were stored securely and stock levels we checked were correct. However, we observed staff administering a controlled drug and found correct procedures were not always being followed. Two staff checked the controlled drug together and counted the stock, both signed the controlled drug register to say the drug had been given and the administration witnessed, however this was done before the drug had been administered. The controlled drug was then administered by one staff member and not witnessed by the second. We found the dose given the previous evening was recorded in the controlled drug register but had not been signed as given on the MAR.

The registered manager told us all the senior staff received medicines training which was updated annually and this was reflected on the training matrix. They also told us they checked staff competencies but these were not recorded, although they said they would put this in place.

Overall we found improvements were required to ensure medicines were managed in a safe and proper way. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found action had been taken to mitigate risks to people, although this was not always fully reflected in the records we reviewed. For example, staff knew one person had fallen several times and were able to tell us of the actions they had taken and checks they carried out to keep the person safe. This included making sure the person sat in a specific chair, the use of a sensor mat and crash mat at night and regular checks throughout the day and night. The person's care records made reference to these safeguards, yet there was a lack of detail due to the format of the documents which comprised predominantly of tick boxes. For example, in the support plan for safety and mobility dated 22 August 2014 the 'risk of falling out of bed' box had been ticked. Handwritten next to this was 'crash mat 19 January 2016'. Similarly 'risk of tripping/falls' had been ticked and handwritten next to it was 'try to supervise at all times'. However there was no detail to explain to staff why these measures were needed and how they should implement them. There was no detail about the person needing to sit in a specific chair to reduce the risk of falls.

Another person's 'behaviour and communication plan' had the box ticked to say 'I can get agitated at times'. A note was handwritten next to this to say 'When [the person's name] can't manage things themselves they get very anxious and panic.' There was no further information about what potential trigger points or scenarios for this behaviour may be, what action staff should take or de-escalation techniques. This meant staff did not have appropriate information to manage this risk.

Whilst our observations showed us people were being supported to eat a varied and plentiful diet. We found the information contained within care records did not always demonstrate nutritional risk was being appropriately managed and monitored. One person's care records showed they had low body weight and had lost weight in recent months. The support plan for eating was dated 22 August 2014 and 'low body weight' had been ticked and showed the person had 'poor eating habits', 'staff to supervise and offer assistance when needed' and 'biscuits, chocolate, food between meals'. There was a malnutrition universal screening tool (MUST) form dated 29 April 2014 but no other nutritional risk assessment had been completed. We saw the person was provided with and supported to consume food and drink throughout the day, yet it was not clear how this person's food and fluid intake was being monitored. The lack of a detailed risk assessment and care plan meant this person was at risks of receiving inconsistent or unsafe care.

Another person's care records stated 'I need supervision when taking food'. A handwritten note stated 'staff assist feeds.' There was no information to detail why the person needed supervision when eating or what



specific assistance staff should provide. At the bottom of their eating care plan a note was handwritten on 11 September 2015 to state the person 'now has thick and easy. All meals to be liquidised.' There was no information to detail what the potential risks were to this person to have prompted this change. The eating care plan review for October 2015 stated the person, 'has meat blended and thickener in drinks.' Whereas the care plan review for November 2015 stated the person 'continued to have a soft diet and thickener.' Care staff, the registered manager and cook told us all of this person's meals were blended not just the meat. They could describe what soft snack foods this person could eat and that they had thickener in all fluids, but they could not tell us why this was, other than it was the suggestion of this person's GP. This risked that staff would not have sufficient information to effectively manage this risk.

Staff told us about another person whose weight fluctuated. They had been prescribed nutritional supplements and their care plan detailed staff should 'monitor' their diet due to the risk of weight loss. It was not clear how this person's food intake was being monitored. The only information about this person's dietary preferences was that their favourite food was fish and chips. There was no other information to assist staff in identifying foods they enjoyed. The section in the eating care plan which asked whether this person was at risk of malnutrition was ticked 'no'. The registered manager told us this was a mistake. This person was also identified as being at risk of urinary tract infections (UTI's). An entry in their multi-disciplinary notes from August 2015 stated, 'GP rang to say [person's name] has got a UTI and to push plenty of fluids because they are dehydrated.' There were no records to demonstrate their fluid intake was monitored. Care staff were able to tell us about the importance of encouraging this person to drink fluids and we saw this person was encouraged to drink at regular intervals throughout the day. However, the records did not evidence appropriate action was being consistently taken to reduce this risk.

Whilst most people's care records had been updated if there had been a change we found the information recorded was sometimes confusing. For example, one person's safety and mobility care plan had been completed in October 2014. There were a number of handwritten notes across the top and bottom of the plan which detailed various changes. For example, a handwritten note in the margin at the side of the care plan dated 22 May 2015 stated this person's Nimbus 3 pressure relieving mattress was no longer in use and had been returned to the supplier. However, a handwritten note at the bottom of the care plan document dated 29 June 2015 stated 'Nimbus 3 back in use.' There was no explanation as to why these changes had been made and as the updates were not recorded in a clear sequence it was difficult to quickly establish what this person's current needs were in relation to their pressure care. This risked that staff would not take effective action to manage this risk.

Overall we found care records did not always contain accurate and complete information. We also found a lack of information within care records to demonstrate that risks to people's health, safety and wellbeing were being appropriately assessed, monitored and mitigated. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked round the building with the registered manager and saw a sample of bedrooms, bathrooms and the communal areas. We found the home was clean and there were no odours apart from one room which was empty, which the registered manager told us would be cleaned before it was occupied. We found the carpet in one bedroom had a patch which was threadbare. The registered manager told us this carpet was due to be replaced as part of the home's ongoing refurbishment plan. We observed it was very warm in the home when we visited and some people said it was too warm. One person told us they often found it too warm particularly in the communal areas. The registered manager said they could adjust the temperature if people wanted.

We checked the hot water temperature at one wash hand basin in one person's en-suite and found the

temperature was 48 degrees centigrade. The Health and Safety Executive recommend, where outlets are accessible to vulnerable people, that hot water temperatures should not exceed 44 degrees centigrade. We saw records which showed water temperatures were monitored monthly. Although temperatures above 44 degrees centigrade had been recorded in September 2015, since then temperatures had been below 44 degrees centigrade. The registered manager said they did not currently have mixer valves in place to regulate water temperatures but said they would put control measures in place to ensure water temperatures did not exceed safe levels.

We saw environmental checks, fire safety records and maintenance certificates for the premises were in place. A fire safety check from December 2015 gave an 'unsatisfactory' score and indicated some work was required such as to fix the lounge smoke detector. The registered manager explained this work had been undertaken and a new inspection was booked for the end of February 2016. They said they would send the Commission the updated certificate.

Staff told us they did not feel rushed and had sufficient time to spend with people. The majority of people we spoke with told us staff provided them with timely support. Our observations during the inspection confirmed this. For example we observed a person starting to cough in the large lounge and pressed the buzzer. A staff member came within a minute and was immediately sympathetic offering verbal support and provided them with a drink. However we saw two occasions where no staff were present in communal areas. On both occasions this meant one person identified as being at risk of falling was left unattended. One person told us they thought there were not always enough staff, particularly during mornings and evenings and said they sometimes had to wait up to an hour for assistance. Another person told us, "You sometimes have to wait if they are helping other people, but not for too long, 20 minutes or so. It's not all the time, just some evenings. But on the whole there is enough staff about to help me when I need them."

The registered manager showed us a dependency tool used to calculate the minimum number of staff required to keep people safe. They explained current minimum staffing levels were four care staff during the day and evening and two care staff during the night. A senior was allocated to lead each shift and each staff member was allocated specific duties and responsibilities to complete. We saw a number of ancillary staff were employed such as a cook, laundry assistant, maintenance and domestic staff. The registered manager said they intended to reduce the levels of care staff so that three care staff would be on duty from 5.30pm until the night staff came on duty at 8pm. However, our observations, discussions with people and the layout of the building led us to raise concerns with the registered manager about whether this would be sufficient to keep people safe.

We also found from our review of staffing rotas that the minimum staffing levels identified by the registered manager were not always being met. For example, on some days in January 2016 only three care staff were on duty during the morning and afternoon. The registered manager said where this was the case they were on duty and would provide additional support. Staff confirmed the registered manager was "very hands on." However, we found some occasions where only three care staff were on duty and the registered manager was not rostered to work. On the day of our inspection the registered manager told us there were five people who required two staff to move. The layout of the building was over three floors with bedrooms on the bottom two floors and communal areas on the top floor. Therefore if two staff were required to support someone to move or were assisting in a downstairs bedroom this would leave one staff member to cover all lounges, the dining room and the bedrooms on the other floors.

We concluded some improvements were needed to ensure staffing levels were consistently sufficient. The registered manager said people's needs had changed in recent months and they had not completed their dependency tool since 29 October 2016. They said they would review this as an immediate priority.

Following our inspection they confirmed they had not reduced staffing levels and were due to reassess people's dependency levels in early March 2016.

Staff recruitment files we reviewed showed safe recruitment processes were followed. We saw application forms, interview records and checks such as proof of identity and satisfactory outcomes of Disclosure and Barring Service (DBS) were carried out before staff began work. These checks helped the service to make sure job applicants were suitable to work in the care service and with vulnerable people.

People told us they felt safe. One person said, "I feel safe here. There's no problem with that." Another person said, "I feel safe. Staff always make sure you're taken care of. They're always there for you". The registered manager had a good understanding of safeguarding and we found safeguarding incidents had been dealt with appropriately and reported to the Local Authority safeguarding team and to CQC. The provider's safeguarding policy was up-to-date and available to staff, people who used the service and visitors.

## Is the service effective?

### Our findings

The feedback we received about the food served at the home was consistently positive. One person told us, "The food is good here." Another person told us, "They will change your food if you don't like it". We saw the menus for the week ahead were displayed on the residents' noticeboard and we saw people were involved in planning the menus as part of resident meetings.

Although we found the information within people's care records in relation to nutritional risk needed to be improved, our observations and discussions with people demonstrated people were supported to eat and drink a varied and appropriate diet.

On our arrival at 8am several people were eating breakfast in the dining room. People had been provided with a variety of different foods depending on their choices and preferences. For example, some had poached eggs on toast, others had a full cooked breakfast, whilst other people who told us they preferred a lighter option had various cereals and toast. Tables were set with placemats, cutlery, condiments and serviettes and staff regularly provided people with fresh drinks and offered people extra helpings of food.

At lunch we saw the main meal, a roast pork dinner, looked appetising and people were provided with appropriate portions and appeared to enjoy it. Where people said they did not want the main option we saw alternatives were promptly offered and supplied. Whilst we saw staff provided many people with appropriate and discreet assistance to eat their meal, not all staff sat down so they were at the same level as the person they were supporting. We saw one occasion where a staff member left a person halfway through supporting them to eat their meal to go and perform another task. However, overall we saw staff were kind, patient and caring when supporting people to eat their meal. We both breakfast and lunch during the inspection and found both meals to be a positive, relaxed and person centred experience.

We saw one person was supported to eat a Halal diet. The person with responsibility for cooking on the day of our inspection explained this person had been provided with a different main course for lunch on the day of the inspection as they did not eat pork. The registered manager explained that Halal products were ordered from local suppliers and they often visited a Halal supermarket to bring them Halal produce.

Jugs of juice were available in the communal lounges which we saw some people helped themselves to throughout the day. Staff also regularly encouraged people to drink fluids and offered choices of hot and cold drinks at regular intervals throughout the day. One person told us, "You get drinks all the time". Another person said "You get plenty of drinks, juice and such".

The registered manager had arranged for a local GP to hold a surgery every Monday at the home. People told us they liked this as it enabled them to speak with a familiar doctor if they were concerned about their health. We saw that a variety of healthcare professionals were involved in people's care and staff made referrals in a timely way if they were concerned about people's health and wellbeing. Although we saw evidence that staff followed recommendations made by

healthcare professionals, care records did not always reflect what was happening in practice.

We spoke with a health professional who visited the home on a regular basis. They told us they had no concerns and felt people received a good standard of care. They said they had been able to develop a good working relationship with care staff who they said were always "helpful, attentive, proactive in making referrals and responsive to any changes to people's needs." They said care staff were particularly skilled at ensuring people had a caring and dignified end of life. They said the registered manager was "approachable and on the ball" and they always found the home to be "immaculate." Overall they said that they felt people's healthcare needs were being well met and that Morton Close was "one of the good homes."

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 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.

At the time of our inspection there were no DoLS authorisations in place and the registered manager told us no applications had been made. We did not see any evidence or observations to suggest applications should have been made. Staff had a good understanding and awareness of DoLS and the MCA and how their responsibilities to protect the rights of the people they cared for.

We observed staff consistently asked people for consent before providing any support or care, explained what they were doing and obtained the person's agreement before continuing. Although we saw this happened in practice we found it was not always reflected in the care records we reviewed. We saw no evidence of specific mental capacity assessments although some care plans recorded diagnoses and other indications of reduced mental capacity. For example, one person had a 'Do Not Attempt Resuscitation' (DNAR) form in place which showed they had advanced dementia, yet there was no mental capacity assessment form or best interest decision recorded for the use of a sensor mat. The registered manager told us they would speak with the Local Authority DoLS team and carry out separate capacity assessments where needed. Staff were aware who had DNAR's in place and that they should always accompany people to hospital.

We looked at the training matrix which showed staff were generally up to date with the provider's mandatory training programme, which included safeguarding, moving and handling, fire safety, first aid and infection control. The registered manager told us refresher training was booked for the small number of staff who still required updates. We saw some specialist training had taken place in pressure area care, person centred care planning and challenging behaviour. Recruitment records showed new staff had completed an induction and we saw staff had signed up to completing the Care Certificate. The Care Certificate sets national minimum standards for the key skills, knowledge, values and behaviours required to provide people with safe, effective and high quality care. When we spoke with staff about key topics such as safeguarding and DOLS they were knowledgeable and able to translate this knowledge to their day to day role. This demonstrated that the training staff received was effective.

Records showed staff received regular supervision and appraisals. We saw records of group supervision where topics such as infection control and health and safety were discussed with staff to check their

knowledge and understanding.

# Is the service caring?

## Our findings

During the inspection we spent eight hours in various communal areas of the home observing interactions between staff and people who used the service. We saw staff were kind, caring and attentive to people's needs. We saw a number of good humoured exchanges between staff and people who lived at the home and a relaxed and homely atmosphere. For example, staff spoke with people about whether they had received any Valentines cards which prompted lots of jokes and laughter.

All of the feedback we received about the staff was very positive. When we asked one person if the staff were caring they said, "Oh yes love, the girls are kind here, no doubt about that." Another person told us the best thing about the home was the "Very nice staff". Another person said, "The staff are very good"

Staff clearly knew people well and used this knowledge to deliver individualised care and support. For example, we saw a staff member approach a person who was upset and anxious. The staff member spoke in a calm and reassuring manner, sitting at their side and holding their hand, asking if they would like their hair doing saying "It might make you feel better". The resident declined and the staff member suggested they went for "a nice cup of tea and a chat" which the person agreed to. We saw staff engaged this person in a chat about a relative who was due to visit later that week and we saw this was effective in calming the person.

We saw people were clean and appropriately dressed with hair combed. Male residents were clean shaven and female residents had polished nails. One person showed us their painted nails and said, "Aren't they lovely? The girls here do them for me. It's just the right colour." This showed us staff had taken the time to support people with their personal care. On the day of our inspection the hairdresser visited. We saw this was a focus of many positive interactions between staff and people who used the service. Many staff complimented people about how lovely they looked, in particular when they had been to the hairdresser during the course of the morning, and the residents responded positively to this, with smiles and patting their hair.

Staff told they were always mindful to protect and respect the privacy and dignity of the people they cared for. We saw evidence of this during our observations. On the morning of our inspection we observed a person who used the service remove the top half of their clothing whilst sat in the large lounge. Staff swiftly and discreetly went across to the person and assisted them to put their jumper back. This was done with minimal fuss so as not to embarrass the person or alert others who were sat in the area. Staff suggested this person may be too hot, the person agreed and two staff members assisted the person to their room to change into a lighter top. We also observed staff knocking before entering toilets to assist people and discreetly encouraging people to be supported with personal care. People who used the service told us staff treated them with respect. One person described how, "Staff knock before they come into my room."

We saw people were offered choices in an appropriate way. For example, people were shown the two different cordials which were on offer at lunchtime so they could choose which drink they would prefer. We saw staff did not presume what foods people would prefer, but used the information they had about

people's preferences to help guide people. For example, at breakfast one person said they wanted cereals. Staff asked them which type of cereals they would prefer and listed the various cereal options available. The person said "I don't know." The staff member said, "Well you usually like either Weetabix or porridge. Would you prefer a warm cereal or a cold cereal today?" From this information the person then decided they would prefer a bowl of porridge as they wanted something warm.

Care records showed people and their relatives were invited to care reviews approximately every six months. From the records we saw this provided people with the opportunity to discuss any concerns or changes they wished to make to the care and support they received and identify what was working well. We also saw staff encouraged people to make decisions about aspects of their daily routine whenever they were able to. Such as offering people choice over where and how they spent their time. We saw people's preferences and choices were respected and provided. For example, we saw people came for breakfast at various times between 8am and 10am. One person described how they were "late up because I just fancied a lie in today." This showed us people made decisions about their preferred daily routine and staff provided support to fit in with this.



## Is the service responsive?

### Our findings

Our observations, discussions with staff and people who used the service showed staff knew people well and used this information to deliver person centred care. For example, we saw staff engaging people in conversations about topics that were of interest to them, such as the local area where people had lived and their past professions. During mealtimes we also saw staff had a clear understanding of the foods people enjoyed and used this information to encourage people to make informed choices. However, staff's detailed knowledge about people was not always translated into care records. We saw limited information about people's social history, likes, dislikes and preferences. This was mostly due to the tick box format of the care records which did not encourage the development of a person centred care plan to. Following our discussions with the registered manager about our concerns with the lack of information regarding risk management, they explained that they intended review and revise the format of care records to ensure more comprehensive information was captured.

We saw evidence that staff adapted the running of the service to respond to people's changing needs and preferences. For example, the registered manager explained they had arranged for the morning shift to start at 7am, rather than 8am. This was because some people who used the service at that time preferred to get up early. They said the shift had now been changed back to 8am as most people who had asked to get up earlier now no longer used the service.

Staff had a good understanding of people's relatives and family history. Although this knowledge was not always reflected within people's care records. When we spoke with staff they had a clear understanding of the importance of supporting people to maintain relationships with the people who were important to them. We observed staff supported one person to speak with a relative over the telephone during our inspection. We also saw visitors were welcomed and actively encouraged to be part of the home and were invited to participate in activities, events and trips out. Some relatives attended people's care reviews and resident's meetings. The registered manager also told us how staff had supported one person to attend their relative's funeral. The person was themselves quite poorly so this was arranged in a coordinated way in consultation with other health professionals so that the person was able to attend whilst maintaining their own health and wellbeing. Care records showed that staff kept people's relatives informed of changes.

A complaints policy was in place and there was information in the entrance to the home to tell people how they could raise a complaint. We saw two complaints had been made in 2015 and records were kept to show these had been investigated and responded to in line with the provider's policy. We also saw evidence that staff promptly responded to and tried to resolve any informal concerns which people raised. For example, a communication sheet identified that a family member had called staff to say they were worried about an aspect of their relative's health. Records showed that within five hours of them first calling to raise their concerns with staff, their relative had seen their GP and had been called back with the outcome of that appointment.

We also saw a number of compliment cards which people and their relatives had sent which positively recognised the care and support staff had provided. Some of the comments people made included;

"You are all wonderful and I appreciate your help in all of the things you did for me."

"Thank you for all of the love and care you have given to my [relative] while in your care."

"I wish to thank you very sincerely for all of the help, love and kindness."

A programme of activities was advertised on the noticeboard. On the day of our visit we saw people were supported to attend the visiting hairdresser, the local vicar conducted a church service and staff engaged people in a 'higher or lower' card game in the communal lounge. People told us staff often supported them to go out on trips out such as to Ilkley for fish and chips and other local beauty spots. Staff also told us they supported people to attend a local pub for a meal out once a month which people enjoyed. People told us there was usually something going on. One person told us, "There's plenty going on. We get singers and other stuff". Another person told us how they enjoyed that the hairdresser visited each week and that staff painted their nails for them. However, we saw at least two occasions where staff put programmes on the television and radio which were not appropriate to the needs of the people sat in those areas. We raised this with the registered manager. Who said they would ensure all staff were reminded of the importance of ensuring people were offered a clear choice of entertainment.

## Is the service well-led?

### Our findings

During this inspection we identified concerns with regards to how medicines were managed. The registered manager told us the pharmacist had carried out a medicine audit in January 2016 and they were awaiting a copy of their report. The registered manager also completed a medicines audit every three months. We found these audits lacked detail as the focus was mainly on stock level checks with no evidence to show what had been checked or any outcomes recorded. The last audit had been completed in October 2015 and PRN protocols had been recorded as 'not applicable'. This showed us that the current audit format did not provide a comprehensive check of the management of medicines in the home and was therefore not an effective monitoring system.

We found audits of accidents and incidents were carried out monthly and these were up to date. However, we found the analysis was limited and did not fully identify themes and trends or consider lessons learnt to prevent similar accidents occurring. For example, we saw the number of accidents which had occurred each month varied considerably. In October 2015 there had been 17 accidents, in November 26 accidents, December 13 accidents and in January 2016 there had been 16 accidents. There was no evidence to show this had been identified or reviewed by the manager or provider to determine if there was any reason or cause for these fluctuations. We saw some people had repeated accidents yet the analysis did not always capture what action had been taken or consider if there was a pattern. This showed us that the current system for analysing accidents and incidents was not fit for purpose.

We found a lack of sufficient detail within care records which risked staff did not always have the information required to deliver safe and person centred care. We spoke with the registered manager about their checks of care records. They explained the administrator checked care records on a monthly basis to ensure records were up to date. However, they did not have the experience and understanding to check the content of the care records. The registered manager said they did not complete formal care plan audits but said they regularly checked documentation as part of their quality checks, however there was no audit trail to demonstrate this. They said the provider had rolled out a new quality assurance check as part of their quarterly visit to the home which included a review of at least three care plans. We looked at the first visit they had completed in February 2016 and saw evidence they had identified areas for improvement in the records they reviewed which were being addressed by the registered manager. However, only three care records had been reviewed which risked that not all care records would receive a regular check to ensure the content remained fit for purpose. The concerns we identified with the content of care records further demonstrates that robust and comprehensive checks were not taking place.

We looked at the record of daily baths and showers and found gaps in the entries staff had made. Our observations demonstrated that people received support with their personal care. People appeared clean, tidy and well-groomed and no unpleasant smells were identified. However, the records did not demonstrate that people received regular support to wash. This suggested the issue was with staff forgetting to record what support they had provided, rather than people not being provided with the support. We raised this with the registered manager. They explained they had identified this was an issue and showed us the minutes of the September 2015 staff meeting where they had asked staff to address this. However the

registered manager recognised they had not followed this up with a robust system to check staff had taken this action.

We saw the registered manager monitored people's weights on a monthly basis. Most people's weights remained stable. In cases where people had lost weight the registered manager showed us their checks had prompted them to take action such as referring the person to their GP or exploring whether there was an underlying reason for weight loss. However, there was no formal protocol in place to outline staff's responsibilities if they identified any changes in people's weights. In one case we saw it was not clear what action had been taken when someone had lost almost three kilogrammes between November and December 2015. The registered manager explained the staff member with responsibility for weighing people each month had not brought this to their attention and because the registered manager had been away they had been late completing their monthly weight analysis so had not identified it themselves until January, by which time the person had put this weight back on. If there had been a formal protocol in place this would have prompted more timely action to address any potential fluctuations in people's weight. The registered manager recognised this and said they would introduce a protocol as an immediate priority.

During this inspection we identified concerns with regards to how medicines were being managed and found care records did not always contain complete and relevant information to ensure effective and safe care could be provided. These issues had not been identified and addressed prior to our inspection. This demonstrated there were not robust audit systems in place to monitor, assess and improve the quality of service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a variety of methods to seek people's feedback. We saw evidence this feedback was then used to improve the quality of care provided. This included resident and relative meetings, individual care reviews and annual quality questionnaires. The last quality questionnaires had been completed in October 2015 and the analysis of the results was displayed on the noticeboard, along with the actions the provider had taken in response to the comments and suggestions people had made.

We found the registered manager was open and committed to putting right the issues we identified. During our discussions with them it was clear they were passionate about their role and ensuring people who lived at the home received good quality care. There appeared to be good staff morale and teamwork at the home which staff told us was mostly due to the positive and inclusive attitude of the registered manager. One staff member told us, "We work really together, but I wouldn't have it any other way. We're like a little family. We all muck in." Another staff member told us, "I like my job. I enjoy getting up in a morning to get to work." It was clear the registered manager had worked hard to establish an inclusive and positive approach to their leadership. Staff told us they felt comfortable approaching the registered manager about any concerns and that they felt fully supported in their role. One member of staff who had recently started work at the home said, "It's really nice to have someone to talk to and who I can go to for help. I feel much better here. It's really refreshing. They work as a team." This positive feedback was reflected by people who used the service who also told us the registered manager was "approachable" and "kind." The registered manager explained they were in the process of recruiting a deputy manager. They said they expected this would provide them with additional management support to help implement the improvements that were required.

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 did not take formal enforcement action at this stage. 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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way because appropriate arrangements were not in place to ensure the proper and safe management of medicines. Regulation 12(g)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems and processes must be established and operated effectively to ensure;</p> <p>the quality of the service provided is assessed, monitored and improved. Regulation 17(1)(2)(a)</p> <p>risks relating to the health, safety and welfare of service users and others who may be at risk were assessed, monitored and mitigated. Regulation 17 (1)(2)(b).</p> <p>accurate, complete and contemporaneous records were are maintained in relation to each service user. Regulation 17(1)(2)(c).</p>