

Kirklees Metropolitan Council

Ings Grove House

Inspection report

Doctor Lane
Mirfield
West Yorkshire
WF14 8DP

Tel: 01924326475
Website: www.kirklees.gov.uk

Date of inspection visit:
11 June 2017
16 June 2017

Date of publication:
08 August 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 11 and 16 June 2017. The service had previously been inspected in December 2014 and was meeting the regulations in place at that time.

Ings Grove House is registered to provide accommodation and personal care for up to 40 people. The home has 28 beds allocated for intermediate care. The remaining places were available for people requiring respite care and people transitioning from hospital and waiting for adaptations and care packages in their own homes. There is a multi-disciplinary team based at the home to support people receiving intermediate care. The accommodation is based over two floors linked by a passenger lift. Accommodation is in single rooms with each room having en-suite facilities. Lounge and dining facilities are situated on two floors.

There was a registered manager in place who has been registered since March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the home. Staff we spoke with were knowledgeable about safeguarding people. They were able to explain the procedures to follow should an allegation of abuse be made.

There were some systems and processes in place to protect people from the risk of harm. Assessments identified risks to people and management plans were in place to reduce the risks and ensure people's safety but these had not always been updated when people's needs had changed. Not everyone at the service had a Personal Emergency Evacuation plan.

Medicines were stored safely and procedures were in place to ensure medicines were administered safely with the exception of prescribed creams. We saw people received their medicines in a timely way from staff who had been trained to carry out this role although their competencies had not been assessed in line with good practice.

The registered provider had not fully met their responsibility to ensure staff received periodic supervision, appraisal and training to ensure their competencies were maintained and to keep up to date with best practice to enable them to perform in their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager had complied with their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They had a good understanding of when a person might be deprived of their liberty.

People we spoke with said they were very happy with the meals provided and were involved in choosing what they wanted to eat and where they wanted to eat their meals. Mealtimes were a relaxed and enjoyable experience for people at the home and staff supported people with dignity and respect.

Staff interacted with people with warmth and respect and we saw the atmosphere in the home was friendly and supportive. Staff were able to spend time chatting and laughing with people. People spoke highly of the staff who cared for them and felt able to raise any concerns with staff.

Care files were person centred and evidenced people were involved in their care planning when appropriate. Due to the nature of the service, people's needs changed frequently and the care plans were not always updated to reflect this. However, the registered manager had devised a written handover sheet which contained essential information to guide staff. Families had also been consulted with to ensure people's preferences and views were considered when devising support plans.

There was a positive atmosphere in the home and people all told us how much they liked staying there. Staff were friendly, helpful and were all positive about their experiences working at Ings Grove House. The registered manager had only been in post a short time when we inspected but demonstrated she was changing systems and processes to improve the service delivered to ensure they met their regulatory obligations. We found not all the existing systems, processes and audits had been robust and did not identify all issues.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, the training and supervision of staff, and in good governance. 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?

The service was not always safe.

People and their relatives told us they were safe and there were enough staff to respond promptly to people's needs.

Risks to people were assessed on admission but had not been updated when people's needs had changed. Accident and incident analysis required a more detailed analysis to ensure lessons were learnt.

Medication was managed well apart from the administration of creams.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff had not always received appropriate induction, training, support and supervision to enable them to provide effective care and support to people. Although the registered manager had identified this and plans were in place to improve this.

Assessments of people's mental capacity was in accordance with the principles of the Mental Capacity Act 2005.

People received support to access health care services and to meet their nutrition and hydration needs.

Requires Improvement ●

Is the service caring?

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

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

People's privacy and dignity were respected.

Good ●

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans reflected people's, preferences, choices and personal histories but were not always up to date in relation to their care needs.

We observed people making choices in their everyday lives and staff supported people to make choices when required.

Complaints were well managed and were used to improve the service. The home received frequent compliments in relation to the service they had provided.

Is the service well-led?

The service was not always well-led.

Staff told us they were supported by the registered manager. However, due to a gap in management, the registered manager was still in the process of establishing the quality of the service, and putting in systems and processes to drive improvements.

The registered provider held regular meetings with staff and people who lived at the home to gain feedback and input into service developments.

Regular audits and quality checks took place and most of these resulted in improvements to service provision although some audits had lacked robustness.

Requires Improvement 

Ings Grove House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 11 and 16 June 2017 and was unannounced. The membership of the inspection team included two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, the fire service, infection control teams and reviewed all the safeguarding information regarding the service.

Before the inspection, we asked the provider to complete 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 observed the lunch time meal experience in two of the communal dining areas and observed care interventions throughout the inspection process. We reviewed six care files and daily records for people living there. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development. We spoke with 10 people who lived at Ings Grove House and three relatives who were visiting during our inspection. We spoke with the registered manager, the area manager, and four members of staff.

Is the service safe?

Our findings

People who lived at Ings Grove House told us they were safe and there were enough staff to care for them. One person said, "Yes, I feel safe." Another told us, "My things are safe in my room." A further person said, "I leave my door open all the time, no problem." One of the relatives we spoke with told us, "I think they are all safe in here". In relation to staffing levels we received the following comments, "Yes, there are enough staff all of the time", "They are real team workers" and "They come to the call bell fairly quickly."

We checked how the service was managing risk to people living at Ings Grove House. The registered provider used standardised risk assessments such as the Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished, and at risk of malnutrition.

The registered provider utilised a moving and handling risk assessment and care plan to identify and promote the safe handling of people. However, we found the information in the risk assessment and the care plan lacked detail. This included the recording of the method staff were required to follow to safely move people and not all the equipment needed to do this had been identified in the plan. Where the need for equipment had been identified, we found the equipment in use was not the same as that listed in people's care plans and it was not clear who had assessed for the assistive equipment. As there was a range of equipment in use at this service and a range of assessors, this meant there was no audit trail to confirm that people had been assessed for the assistive equipment they were using and although we did not have any concerns to suggest the equipment in place was not safe the registered manager could not provide the evidence in relation to the assessment.

Our review of care records found one person required the use of a Zimmer frame or a wheelchair to mobilise however it was not recorded in which circumstances it was safe to use one piece of equipment or the other. On speaking with staff they knew how to support this person in a safe way in order to improve independence and prevent falls but this information is required to be recorded to ensure care is both safe and responsive.

All the moving and handling we observed during our inspection demonstrated staff utilised safe moving and handling practice and our conclusions were the issue was with recording. However, the recording of moving and handling risk assessment and care plans are an essential requirement in ensuring staff follow safe practice

Where people had been identified as at high risk of falls, the care plans did not record any control measures therefore a focus on preventing falls was not evidenced although staff could tell us what measures had been tried and the equipment in place to prevent falls.

Accidents and incidents had been recorded by staff in a log book kept in the staff office. On review of this information, we found there had not been an analysis of the information. For example, when a person had fallen, there had been no evaluation where the staff had been located at the time, to indicate whether staff

deployment had been a contributing factor. Our conversations with staff and a review of people's care files confirmed preventative measures had been considered and put in place when appropriate. This lack of deeper analysis of information and a record of actions taken meant the service was unable to evidence how they had learnt lessons from incidents and how this was disseminated to ensure incidents did not happen in the future.

We checked whether each person had a Personal Emergency Evacuation Plan (PEEP) to enable staff to assist people to evacuate the building if necessary. We found this was not the case and although there was a small section on the back page of the summary of care needs for this information, this had not been completed for most people. We raised this with the registered manager, as although the home operated a 'stay put' policy in the event of a fire; they were required to have the information in place to assist an evacuation if people did need to be supported to leave the building. The home had a sprinkler system and had two fire escape staircases at either end of the building although no evacuation equipment. The registered manager and the service manager told us the registered provider was in the process of arranging meetings with key personnel to discuss emergency evacuation in the event of both a fire but also other emergency events which might require evacuation.

As part of our inspection process we checked to see whether medicines were ordered, stored and administered safely. We found that medicines were ordered in line with good practice and there was no evidence of under or overstocking. The medication trolleys, clinical rooms and fridges where medication was stored were well organised and clean. Temperatures were regularly checked and remained within the required range. We looked at people's medicines administration record (MAR) and we saw that each one had a medication profile containing a photograph of the person, information relating to any allergies, preferred method of taking medicines, any contra-indications and specific requirements, as appropriate. This helped ensure that the right medicine was being administered to the right person and any risks minimised.

Some people at the home self-administered their medicines. As per good practice, it is encouraged that people remain as independent as possible with managing their own care, including medicines. However, the service retains the responsibility with offering on-going monitoring and support. During our inspection, we observed risk assessment forms in use for people taking their own medicines and this was discussed with the person and signed on admission. Support offered included people's medicines stocks being checked by staff on admission and then at regular intervals during their stay. This demonstrated the registered provider was monitoring compliance and reviewing arrangements for people self-administering their medication.

We observed staff administering medicines and saw they were focused on the task in hand whilst keeping a positive interaction with the person they were supporting. Time specific medicines were given as prescribed and there was a note on the white board in the office to remind staff who required time crucial medicines. One person that was using the service told us, "They give me my pills at the right times every day".

Body maps were not always used to direct staff to where to apply creams and we noted three people's MARS sheets showed they had prescribed creams but there was no record this had been applied, and all three people told us they had not been supported with their creams. This meant the registered provider was not managing this aspect of medicines support robustly.

We saw 'as and when required' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. One person confirmed staff supported them to manage their pain and said, "They ask if I want pain killers."

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found medicines were accurately recorded and administered in accordance with good practice

The lack of PEEPS, administration of prescribed creams and out of date risk assessments demonstrated a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They were able to describe the signs to look out for which would indicate a person was being abused. They told us they knew about whistleblowing and would report a colleague if they were concerned about their practice. This meant people were protected from harm because staff had knowledge of appropriate action to take if they had concerns people were at risk of abuse or harm.

Our observations during our inspection confirmed there were sufficient staff to meet the needs of the people at the home. We asked the registered manager how they determined staffing levels and they advised us they utilised a dependency tool. We reviewed the tool which included time for staff to complete ancillary tasks in addition to hands on care. This meant the registered manager was measuring and reviewing the number of staff hours required according to the dependency levels and needs of the people at the home.

We looked at three staff files for staff that had been recruited since our last inspection. We found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, a review of people's employment history and two references received for each person. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

We saw evidence which showed the premises were well maintained and we reviewed the checks undertaken by the maintenance officer. We saw safety records and maintenance certificates, such as gas safety, legionella and portable appliance tests (PAT) were up-to-date. The registered manager had recently updated the fire risk assessment for the home. Equipment such as hoists and the lifts had been maintained and had a recent Lifting Operations and Lifting Equipment Regulations (LOLER) certification. The latest sling certificate was not included with the hoist and lift certification and was only just out of date. The registered manager arranged a date for these to be checked whilst we were at the home. Wheelchairs and beds were regularly checked but there was no asset log for all the assistive equipment at the home to ensure each piece of equipment had been accounted for and was checked in line with the manufacturer's instructions.

Cleaning schedules and records showed regular cleaning took place and this aspect of service delivery had been regularly audited. We observed staff using personal protective equipment, such as gloves and aprons, throughout our inspection. This helped to prevent and control the risk of the spread of infection.

Is the service effective?

Our findings

We looked at staff induction and training records to determine whether staff had been supported to carry out their duties. The registered manager told us the service had not been utilising the Care Certificate although this was planned for future new recruits. 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. We found staff had received a basic induction into their role, which included shadowing more experienced members of staff.

The training matrix showed us staff were offered opportunities to train and develop knowledge and skills in the following areas; safeguarding adults, fire safety, alarm and drill; health and safety, the movement and handling of people and hoist training, infection control, emergency life support, basic food hygiene and MCA and DoLS. Training was required to be refreshed at intervals set by their training department. Those staff who administered medicines were offered training in this area although annual competency checks were not all up to date.

The matrix showed most staff were up to date with mandatory training but we could see that not all staff had received training in safeguarding adults from abuse or health and safety training. We also looked at staff training in supporting people in an event of a fire and saw that a number of day and night staff fire safety alarm/drill training was out of date. Not all moving and handling was up to date although most staff had been booked onto this training. The registered manager told us moving and handling training was dependent on the availability on the local authority training course. One member of staff we spoke with told us they had waited several months to secure a place on the course, although they did not undertake any moving and handling without an experienced carer taking the lead. However, learning from other staff who have not been assessed as competent to deliver this training, is not considered to be good practice and priority should be given to provide accredited training to staff whose main role involves the handling of people.

The registered provider's policy indicated staff would have supervision a minimum of six times each year and for supervisors with over 20 staff, this could include group supervision with at least two one-to-one sessions each year. We could see from the supervision matrix that supervision had not been delivered in line with the registered provider's policy and some staff had not had supervision in the last 12 months. The registered manager was aware of this and had initiated supervision sessions. We also noted that recent team meetings had been counted as staff group supervision and when we discussed this with the registered manager and the service manager they told us this counted as a supervision session as the topics discussed were the same as would happen at group supervision such as policy discussions, change management, and safeguarding.

We found staff to be knowledgeable and skilled during our observations and through our discussions with staff during the inspection. Staff we spoke with told us they were given the opportunity to develop skills to enable them to progress in the caring field. They told us they felt supported in their roles and would feel able

to request further support or training if they felt this was required. However, the registered provider had a responsibility to ensure staff received periodic supervision, appraisal and training to ensure their competencies were maintained and to keep up to date with best practice to enable them to perform in their role. This had not been met and therefore demonstrated a breach in regulation 18(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing

We observed the lunchtime experience in both dining rooms. The dining rooms were clean, bright, well decorated and welcoming. All the tables had a cloth runner, place settings with mats, napkins, glasses, a centrepiece and condiments. There was a handwritten daily menu on the wall in the dining room. The first-floor dining room had background music playing. People had a choice whether to eat in their bedrooms or in the communal areas. People told us, and we could see for ourselves, that they could choose what to eat from a choice of freshly prepared food. One person told us, "It's very good, good choices, plenty to eat." and another said, "The food is excellent, home cooking, fresh ingredients."

Staff were able to tell us about people's special dietary needs such as if they were on a diabetic diet, or needed their food fortifying. Catering staff recorded what people had eaten and the senior member of staff on duty ensured each person had received a meal, which was necessary as some people ate in their bedrooms and breakfast was served to people at different times depending on what time they got up.

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 authorisation 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. On the first date of inspection one person on a temporary stay was subject to a DoLS authorisation but they had left the home by the second day. The registered manager understood their responsibility in relation to the MCA and DoLS.

The registered provider had trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. Most people using this type of service had the capacity to consent to their care and treatment. We checked to see whether staff understood the principles of the Mental Capacity Act and how they put these into practice. One member of staff told us they supported decision making when dressing by taking two items of clothes out of the wardrobe, depending on the weather and supporting the person to choose. To support with choosing what to eat, they told us they might use picture cards to help with choosing from the menu. Staff were aware that people could make unwise decisions if they had capacity to do so and they were required to support people's rights to do so.

We saw written consent to care had been sought and people signed their care plans and for specific areas such as the use of photographs. Throughout our inspection we saw staff asked for consent before undertaking any interventions. This was recorded in people's daily records to evidence consent which demonstrated staff were aware of the requirements in relation to people consenting to their care and treatment.

People receiving intermediate care had access to a multi-disciplinary team of professionals and people told us this access was excellent to ensure they achieved their set goals. People staying on respite or whilst awaiting services to be put in place to enable them to return home had access to district nursing services and other community based services and we could see from records, that staff had facilitated these services when required.

Is the service caring?

Our findings

We spent time in the communal areas on both floors of the home and the atmosphere in the home was warm and welcoming. We could see people were comfortable and relaxed around staff and we observed people were laughing, smiling and joking with staff during our inspection. We found the interactions between people and staff were positive and people we spoke with told us the staff were caring. One person told us staff, "Very, very understanding. They will do anything for you". Another said, "They know what we like. They know us well".

Staff told us "People tell us they are appreciative of what we do for them. They are happy." People confirmed this and some told us they would be happy to stay at the home although they were aware their stay would only be short term.

We observed staff knock on people's doors before entering and spoke respectfully with people. . We saw people were appropriately supported with their lunch when required and this was done in a caring and dignified way such as discreetly asking if they wanted their food cutting up. One person told us, "They treat me with respect and talk to me properly like a person" and their privacy was respected, "They respect my privacy by shutting the door."

Staff told us they encouraged and supported people to be independent. One said, "It's rehabilitation and people are going home so you need to encourage them. You're not here to do if for them. It's not about quickness, it's about their dignity." Another staff member said, "I try to encourage people to do their own personal care. Go as far as they can go. We encourage people to mobilise as it's a rehab' setting. We walk with them." One person we spoke with during our inspection told us, "They let me do things for myself, as much as possible". It was evident from our conversations with people using the service and with care staff that people were achieving their set outcomes in relation to independence with mobility and activities of daily living to enable them to return to their own home environment.

No one at the home utilised advocacy services at the time of this inspection but the registered manager was aware of who to refer to if this service was required. An advocate helps people express their wishes and feelings, supports them in weighing up their options, and assists people to make decisions.

Care plans we looked at showed people were involved in decisions about their care and treatment. People we spoke with confirmed this and we also saw people had signed their care plans to show they had been consulted about the care and treatment provided. One person said, "Yes I do discuss my care with them". We saw DNAR forms that were completed appropriately for people who would not benefit from resuscitation. No one at the service was supported with end of life care and this service only supported people with short term care. Where a person required this, they would be directed to a service offering this type of care prior to any pre-admission assessment.

Is the service responsive?

Our findings

Relatives all spoke positively about the care their relations were receiving at Ings Grove House. They told us they were kept informed of any changes in their relative's condition and care needed. One said, "Yes and they phone up to let us know about any changes in [relative's] condition". They reported there were no restrictions on visiting and one said, "Yes, we can visit any time".

We observed staff were responsive to people's individual needs and care plans reflected people's preferences and choices. Staff told us how they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care. People using the service told us they were actively involved in their care plans and were motivated by staff to improve to achieve their goal to return home. Relatives we spoke with told us care was responsive to people's needs and they were involved in their relatives care planning. One said, "We have made an active plan to get [relative] home. We talk all the time about [relatives] abilities and rehabilitation."

Daily records were detailed and provided an accurate record of a person's daily life whilst at the home. They detailed whether people had been offered a shower and also how the person had been supported to transfer and mobilise. They also recorded which part of an activity of daily living such as dressing the person was able to do independently. In addition there was a record to show whether the person had taken part in any activities.

In addition to the daily records, each person had a summary of care which detailed the level of support required day and night including bathing and showering preferences, and assistance required, mobility and equipment required, social information regarding interests and hobbies, oral health, dietary requirements, skin condition and continence. This gave a brief overview of people's care needs. We found not all important information had been recorded. For example, one record detailed a person was an insulin dependent diabetic but did not record they managed their own insulin or that they were on a diabetic diet. Their risk assessment and some entries in their daily records confirmed they received a diabetic diet, which meant the issues were around recording rather than practice.

We found the detailed information in the daily records did not match the information in the person's care plan. The lack of detail in some care plans and risk assessments meant that these care plans did not contain all the information to provide a guide to staff. We observed staff had a good knowledge about each person but this had been obtained verbally and at handover rather than from the recorded care plan. Due to the nature of the rehabilitative and reabling service provided people's needs changed on a day to day basis which meant the care plans could be out of date shortly after they had been written. We discussed this with the registered manager who told us the management of the care staff and intermediate care team were working on utilising joint records which would help to alleviate the issues with recording around the assessment and management of risk and would provide up to date risk assessment and care planning information.

However the issue with inaccurate care records was a breach of Regulation 17(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

We found care plans were not always accurate and up to date, for example; one person's risk assessment and care file indicated they required a hoist to transfer, but the daily records evidenced that as a result of the services provided, they had significantly improved and had now progressed to transferring without equipment and were now able to walk with support. Other records showed a person required assistance to transfer onto a commode, however the person told us staff had been proactive in obtaining the same commode they had at home which meant they could transfer on and off the commode during the night without support.

We asked people whether the home supported their mental wellbeing by providing them with meaningful occupation and activities. Those people receiving intermediate care had a rehabilitation programme in place which involved activities of daily living. Other people told us, "There is enough for me, I join in if I can with skittles and things", "Because I need help to get about I don't join in", "There are not many from what I have seen but they are OK" and "There should be more to do."

The home had a team of volunteers who provided some activities at the home. Entertainers also visited the home. A hairdresser provided a service at the home once a week and there was a designated hairdressing room. The home had links with the local school and choir. They had also taken people to a coffee morning at the local library, but this depended on staff numbers. We observed people making cards during our inspection as part of a group activity.

People we spoke with and their relatives knew how to make a complaint and who to go to if they had any concerns. We received the following comments, "We haven't wanted to make a complaint but I know how." Another said, they hadn't made a complaint but said, "I would go to see the manager." The registered provider had a complaints procedure in place and information on how to complain was made available to people at the home. The service recorded all compliments and complaints on the same log and we reviewed this information as part of our inspection. There had been no recent complaints recorded, but a significant amount of compliments.

Is the service well-led?

Our findings

The registered manager had been in post for three months at the time of the inspection and there had been a short gap between the previous manager leaving their post and the registered manager taking up the post. We asked people using the service whether the home was well-led. One person told us, "It's well run and managed". Staff spoke highly of the new manager and their passion to make positive changes at the service. Staff were kept informed of changes at the service through a monthly staff newsletter.

The registered manager described the culture at the home as, "Very caring. Put the service users' needs first. Staff will cover shifts so we are not struggling. They won't leave a shift if something's happened." They shared their vision for the service, "It's great having intermediate care. We are great at what we're doing. I want to develop better ways of working, develop staff skills around IT, and assistive technology, and improve communication."

It was evident that not all information had been handed over to the manager and they had to compile some of the information we required during the inspection for us into a reportable format. For example, the accident and incident analysis and evidence of staff medication competencies. However, it was clear to us in our discussion with the registered manager; they had the knowledge, skills and abilities to develop the systems and processes required. For example, they had identified the system of handover required improving and had implemented a typed handover sheet to provide staff with a daily update to meet people's changing needs. They had also improved the assistive technology available at the home which improved safety and staff effectiveness. The registered manager was supported by a service manager and also received support and mentorship from a manager of a similar service within the local authority portfolio of homes in the area.

There was a positive culture at the home, and staff all told us how much they enjoyed their roles and many had been at the service for several years. The registered manager could demonstrate the service was working in partnership with health and social care agencies to achieve positive outcomes for people at Ings Grove House. People using the service for respite care told us how much they appreciated the service provided which enabled their carers to have a break from their caring responsibilities.

The registered provider's Quality Assurance Framework (QAF) was completed each month by the registered manager and forwarded to senior management to enable them to monitor the quality of the service provided. This framework consisted of several audits with the responsibility for completion allocated between the registered manager, the deputies and the team leaders. Individual audits were carried out in relation to people's finances, care files, medication observations, activities, medication, nutrition, health and safety and observations around the home. However, the system for observing staff administering medicines focussed on assessing staff undertaking four each month, but we saw evidence some staff had been observed more than once and others not at all over the preceding months. We could see from the audit the home had achieved the registered provider's requirement of 70% training in the following areas, moving and handling, fire training, safeguarding, and health and safety. This did not clarify if this was initial training or a refreshment of training. Staff must be supported to undertake training, learning and

development to enable them to fulfil the requirements of their role and demonstrate competence to carry out their roles unsupervised. We did find some essential training for this type of role to be out of date.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. Records showed meetings were held with different groups of staff, including night staff, team leaders, care staff, senior care staff and domestic staff. A review of the team leader minutes showed the registered manager had found a gap in the audit system around observing staff delivering care to people using the service. They had developed a form to observe staff in relation to their competency in movement and handling, dignity and respect, hand washing, and general personal care delivered. The review of the meetings held at the service demonstrated they were effective at cascading information, encouraging improvements at the service and establishing the quality of the service provision.

Residents meetings were held regularly and one was scheduled on our first day of inspection. The meeting followed the CQC key lines of enquiries around safe, effective, caring, responsive and well-led services and provided a mechanism for people to feedback comments or concerns to management. We saw a "You said, we did" board which showed actions taken to resolve issues raised at the meetings, but it was not evident when this had last been updated as it contained historical information. There was also a suggestions box in the entrance for people to make suggestions for improvements which demonstrated they were listening to people and making improvements based on the views of people at the service.

The previous inspection ratings were displayed on the registered provider's website and at the service. 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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Information in moving and handling risk assessment and the care plan lacked detail and were not always accurate. There was a lack of recorded evidence to indicate people had been assessed for the equipment they were using. People's emergency evacuation plans lacked the detail required to enable them to be supported to evacuate the building.</p> <p>There had been a lack of deep analysis of accident and incident information and a record of actions taken to evidence how lessons had been learnt from incidents and how this was disseminated to ensure incidents did not happen in the future.</p> <p>People had not been supported with the administration of prescribed creams.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Care plan records were not accurate, contemporaneous or adequately detailed to support staff to deliver person centred care.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The registered provider had not ensured staff received periodic supervision, appraisal and training to ensure their competencies were</p>

maintained and kept up to date with best practice.