

Hollybank Trust

Oak House

Inspection report

Darley Cliffe
Upper Sheffield Road
Barnsley
S70 4AG
Tel: 01226 287621
Website: www.hollybanktrust.com

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Good



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on 4 March 2015 and was unannounced. Oak House was last inspected on 8 October 2013 and was meeting the requirements of the regulations that were inspected at that time.

Oak House is a care home registered to care for people who have a learning disability. Oak House can accommodate up to four people. The Acorns is a separate annex that can accommodate two people. At the time of our inspection, four people were living in Oak House and one person was living at The Acorns.

There was a registered manager in place at the service. However, at the time of our inspection the deputy manager was managing the service as the registered manager was undertaking a period of absence which we had previously been informed about.

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.

Summary of findings

Although staff told us they received training there was no management oversight and effective system to monitor that staff were trained to meet the needs of the people they supported. One person's risk assessment required staff trained in a specific technique to intervene at certain times when needed. The staff we spoke with at the time of the inspection were not up to date with this training and the acting manager was not able to say who was currently trained in this. This meant there was a risk that people were supported by staff that did not have the required skills to meet their needs.

The principles of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) were not always being followed. We observed a form of restraint being used with no evidence to show risks had been considered, whether this was in the best interests of the person or that less restrictive options had been considered. Consideration was required as to whether people living at Oak House needed to have any DoLS authorisations in place in accordance with current criteria.

We saw good systems in place to minimise risks of medicines being handled or administered unsafely. People had support with nutritional needs and to maintain good health and we saw evidence of involvement with various health professionals.

Although there were vacancies, staffing levels were managed, maintained and of a suitable level to meet people's needs. Observations showed staff were visible and present to support people where required. An effective recruitment process was in place so that people were assessed as being suitable to work at the service. Staff completed an induction and then worked alongside

another member of staff prior to supporting people on their own at the service. Staff and management spoke positively about how the staff team worked and supported each other.

Care records were reviewed regularly and contained information about people's support needs and preferences, and how these were to be met. People and relatives we spoke with were positive about the care they or their family member received. Observations showed that staff were kind, caring and patient in their interactions with people although we did witness a situation where people's privacy was not maintained

We saw activities take place at the service and people were supported to access various activities in the community. One person told us about a holiday they were planning to go on with staff. Feedback from people living at the service was sought by way of regular meetings. Relatives said they were kept informed about their family members wellbeing and had opportunities to give feedback. There was a complaints procedure in place although there were no complaints at the time of our inspection.

Incidents were logged on a recording system and overseen by management and head office so that themes or trends could be identified.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which correspond to two regulations 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.

Summary of findings

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 safe. Although there were vacancies, staffing levels were maintained and of a suitable level to meet people's needs. An effective recruitment process was in place so that people were assessed as being suitable to work at the service.

Individual risk assessments were in place in order to minimise and manage risks to people. People and their relatives expressed no concerns for their safety. Staff knew how to identify and report abuse and unsafe practice.

Medicines were managed in a safe way which reduced the risks associated with unsafe management of medicines. Each person had their own medicines stored securely and accessible only by staff in their own room.

Good



Is the service effective?

The service was not effective. Although staff told us they received training there was no system in use to effectively monitor that staff were trained to meet the needs of the people they supported.

The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always being followed. We saw that a form of restraint was used with no evidence to show risks had been considered, whether this was in the best interests of the person or that less restrictive options had been considered.

People had support with nutritional needs and to maintain good health and we saw evidence of involvement with various health professionals.

Requires improvement



Is the service caring?

The service was not always caring. We saw an occasion where people's dignity was not maintained as personal information was discussed by staff in the presence of some people.

Observations and comments from people and relatives showed that staff were kind, caring and patient in their interactions with people.

Staff offered choice and explanations to people whilst providing support.

Requires improvement



Is the service responsive?

The service was responsive. People's care records were reviewed regularly. They contained information about people's personalised needs and preferences and how these were to be met.

We saw activities take place at the service and people were supported to access various activities in the community.

Good



Summary of findings

Feedback was sought by way of meetings for the people who used the service. Relatives said they were kept informed about their family members and had opportunities to give feedback. There was a complaints procedure in place. There were no complaints at the time of our inspection.

Is the service well-led?

Areas of the service were not well led. There was a lack of management oversight of staff training. The principles of the MCA 2005 and DoLS were not fully embedded within practices we observed at the service

Management and staff spoke positively about the team and enjoyed their roles. Team meetings took place regularly and good practice was shared and acknowledged.

Incidents were monitored and overseen by the management. Audits were undertaken in a number of areas to identify areas for improvement.

Requires improvement



Oak 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 4 March 2015 and was unannounced which meant no one at the service knew beforehand that we would be attending.

The inspection team consisted of an adult social care inspector and a specialist advisor who had experience of working with, and managing services for, people with learning disabilities.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to

make. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted commissioners of the service, the local authority safeguarding team, Healthwatch and other stakeholders for any relevant information they held about Oak House. We received feedback from one community professional.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included informal observations throughout our inspection. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with two people and via telephone with five relatives of people, who lived at the home. We spoke with the acting manager, the deputy manager, a senior support worker and two support workers. We reviewed the care records of three people and a range of other documents, including medication records, staff recruitment records and records relating to the management of the home.

Is the service safe?

Our findings

Observations showed people were comfortable in their interactions with staff. Relatives told us should they have any worries, they would inform staff or management. One relative told us, “My [family member] gets looked after there as well as anywhere. If we saw anything wrong we would say.”

We saw there was a sufficient amount of staff to support people and staff were present and visible throughout the day. The service was undergoing a restructure and four support worker vacancies were being advertised at the time of our inspection. The acting manager told us these vacancies were covered by way of extra shifts for current staff and with the use of bank and agency staff where needed. Consistency was maintained for people living at the service by using regular staff for busier periods. All of the staff we spoke with felt they worked well as a team to ensure people were supported. One support worker told us that the team “All pull together and support the home well.” Another said the home “never felt short staffed.”

Four relatives we spoke with told us there were sometimes different people working at the service when we asked about staffing. Comments included, “One or two new faces but that’s inevitable”, “There used to be a core group of staff but some have left. Always new faces when we go”, “Sometimes have temporary staff but in general [my family member] prefers people he knows.” In the main, relatives accepted that some staff changes were expected and said this had not had a major impact on their family member.

We looked at staff rotas for the week prior to, and the week following our inspection. These rotas confirmed the staffing numbers the acting manager told us were in place. The acting manager told us that staffing levels were flexible if required, for example if extra staff were needed to support people to any appointments, this would be accommodated. They also said that staffing levels were reviewed dependent on the amount of people living at the service and their needs.

Relatives told us that their family members received the required support with their medicines. We saw that each person had their own lockable medicine cabinet in their room. One person’s was located directly outside of their room due to the size and layout of the room. Keys were kept by senior staff. This separation of people’s medication

reduced the possibility of errors. We looked at the content and associated medication records for three people in Oak House. Each person had documentation in place which included their photo, any allergies, and information about how they chose to take their medicines and what level of support they required. There was clear information about what medicine each person took, what this was for, possible side effects and what action should be taken if the medicine was forgotten or missed.

Where people required PRN (as required) medicines there was information including what the medicines were for, when these should be administered and in what amount. Some of the people living at Oak House were not able to communicate verbally and would use other ways to convey how they felt. For example one staff member was able to describe the physical actions one person displayed when they were in pain, but this was not reflected in their medication documentation. Although long term staff had this knowledge about people, the lack of this information, especially for unfamiliar staff meant there was a risk that people may not receive PRN medicines appropriately. We fed this back to the acting and deputy manager who told us they would review this to ensure relevant information was captured.

We checked the medication administration record (MAR) charts for the three people and saw that these were fully completed with the exception of a gap in one chart where nothing was recorded. We saw this corresponded to a PRN medicine where the code to say the person had refused had not been documented. This had already been identified at a previous audit and an incident form had been complete to follow up on. This showed that the audits were effective in finding and acting upon issues. We checked each person’s stock of medicine and found that it matched what was recorded on their MAR chart.

We looked at three staff members records. These showed that staff were observed a set number of times administering medicines before they were assessed as being competent. Observations were then repeated on an annual basis. Medication was audited monthly and we looked at the audits for the previous month as well as external audits that were completed every several months by the supplying pharmacy. Where any actions had been identified, we saw these had been followed up.

We checked two staff personnel files and saw these included relevant recruitment documents including

Is the service safe?

application forms, job descriptions and employment references. We saw each staff member had a Disclosure and Barring Service (DBS) check in place. DBS checks help employers to make safer recruitment decisions. This showed processes were in place to ensure the staff were assessed as being suitable to work within the home.

Care records evidenced that people had individual risk assessments in place which covered a range of areas and were reviewed regularly. For example, assessments of risk into mobility, skin integrity and nutrition. They were person centred and contained information about how people were to be supported to manage risks whilst promoting independence.

There were no current safeguarding investigations ongoing in relation to the home. We saw that previous incidents had been referred to the local authority and investigated where required. Staff understood safeguarding and said they would report any concerns to a manager. The senior team was aware of the procedures to follow to report concerns to the local authority. There was also a safeguarding lead at the provider's head office who could be consulted for

advice and guidance as well as a safeguarding policy accessible to staff in the office. This meant there were systems and processes in place for staff to follow to help protect people from the risk of abuse.

The premises were clean and the staff team told us that all of the communal areas had been decorated in December 2014. There were policies and guidance in place for staff to follow in relation to effective infection control. Infection control audits were completed by the acting manager.

People had their own equipment such as wheel chairs, standing frames and hoists which were assessed for safety. We observed staff using the equipment well and also evidenced them being well maintained and checked regularly by staff alongside annual maintenance by outside contractors.

We saw that there was a major incident management plan in place which was currently undergoing review. This provided information about what action should be taken in the event of emergencies to prioritise the safety of the people living at the service.

Is the service effective?

Our findings

All of the staff members we spoke with told us they completed an induction when they commenced employment at the service. A new member of staff described their induction period as four days training at head office training before they moved onto the service. They told us this consisted of mandatory training such as health and safety, safeguarding and manual handling. The acting manager told us that new staff would then undertake a shadowing period alongside an experienced staff member. This meant that new staff were provided with support to gain an understanding of their role and what was required of them.

Staff we spoke with felt supported by the management team and one member of staff told us “I was very nervous at the start of my employment but everyone has been lovely and supportive, it’s a lovely environment and I just love it here” and “My line manager always has time to talk to you to support you, they focus more on people than paperwork which is nice.”

Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. The acting manager and staff members informed us that supervisions took place every six to eight weeks. The last supervisions on file for the staff we spoke with were dated November 2014 which did not correspond with the frequency we were told that these took place. We were told performance appraisals were undertaken as part of supervisions. There was no system in use to monitor when these were due. The acting manager told us that the next supervisions were due to take place in the near future and a restructure at the service had caused some delays.

When we asked about further training, staff informed us that they completed their mandatory training during induction and then every April they were sent a training schedule for the following 12 months. Each member of staff was then expected to keep a record of what training they required and book themselves onto courses accordingly. One member of staff stated that “During supervision we talk about what we have done and what we have been booked onto.”

On checking staff training records we saw that there were members of staff with little evidence of up to date training. Two staff members told us they had recently completed training in equality and diversity but this was not evidenced in their records.

We saw that one person’s risk assessment referred to behaviour that challenged others they sometimes displayed. The assessment said that staff trained in a specific named technique to manage such behaviour should intervene when required. However, the staff we spoke with were not up to date in this training. When we asked the acting manager and deputy manager they were unable to say or provide evidence of who was trained in this technique. One person did not communicate verbally and their care plan said they used Makaton as a form of communication. Makaton is a language programme using signs and symbols to help people to communicate. When we asked four staff members about this, none of them were trained in the use of Makaton.

We saw that there was no robust system in place for staff training to be monitored and there was insufficient oversight to ensure staff had the requisite training for their roles. We found that the registered person had not protected people against the risk of being supported by staff not suitably trained and equipped with appropriate skills to meet their needs. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people’s best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw evidence of decision specific capacity assessments and subsequent best interest meetings in some people’s care records. However, these were not always consistent as we saw two capacity assessments in place which did not relate to any particular decision. The acting manager told

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us that not all staff had completed specific training in this area whereas senior staff and management would be required to complete an in depth course. The acting manager confirmed that no DoLS authorisations were in place and no applications had been made. Discussion with the acting manager showed that they were not fully familiar with the latest criteria in the use of this legislation and how this applied to protect people from restrictive practices. They said that following a review meeting in relation to one person who lived at the home, they were shortly going to be applying for a DoLS authorisation for this person. However, this had not been completed at the time of our inspection and we advised that each person at the home should be considered as to whether they met the current criteria to determine whether a DoLS authorisation was required.

During our observations in a communal lounge we saw one person was at times restrained in their chair by a lap belt, despite being able to move around the home unaided. We saw occasions where two staff members assisted the person to sit in the chair and fastened the lap belt attached. This was also in place on the person whilst staff were out of the room for short periods and one time while the person was being supported to eat. On another occasion we saw the person was supported into the chair with the lap belt not fastened. There was no information recorded about the lap belt in the person's care records to explain why or when it should be used. We queried this with the acting manager and deputy manager and there was a lack of clarity about why this lap belt was being used. The deputy manager said they believed it was sometimes used if staff were busy elsewhere assisting other people with personal care. We saw that the person was not asked whether they agreed to the lap belt and the deputy manager said they thought the person would not have capacity to make this decision. There was no capacity assessment in place or evidence the use of this was within the person's best interests and no risk assessment for its use. We informed the acting manager that this use of restraint could be considered unlawful and they should ensure least restrictive practices were used to keep people safe. They advised they would assess this situation to

consider alternative practices and make sure relevant legislation and processes were followed where required. The registered person had not protected people against the risk of abuse or improper treatment. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked one person if they liked the food that was prepared at the service and they responded "Yes." Another person responded to the same question by displaying positive body language. The acting manager told us that regular 'take away' nights took place and there was a choice of options at breakfast which provided variety for people. However the menus for people within the home showed only one option was available at lunch and dinner time. The acting manager told us this menu had been pre-set which meant there was little input from people to influence this. Although when asked, we saw one staff member offer a person a choice of whether they wanted this specific meal, this was not done routinely. This meant there was a risk that some people's nutritional preferences may not be met by lack of suitable alternatives and encouragement to choose and eat meals they enjoyed.

People were supported with nutritional needs by way of involvement with dietitians, nutritionists and speech and language therapists we saw evidence of this in care plans. The acting manager said food and fluid charts were used where required and provided details of one person where it was agreed they would keep a food diary following a noticeable weight change. The person had been seen by their GP and their nutrition was being regularly monitored as evidenced in care records.

There was evidence in care records of involvement with health professionals and people had health action plans and hospital passports in place. These are documents that detail what support a person needs to maintain good health and what support they would require if they needed to go into hospital. Relatives told us they were kept updated about, and involved in, changes to their family member's health and well being.

Is the service caring?

Our findings

We spoke with two people who lived at Oak House and both expressed that they liked living there. One person told us, “The staff are nice.” We asked the other person if they liked the staff and whether staff were helpful and the person indicated yes by nodding their head. One person said that they “loved” the staff member working with them. Other people displayed positive body language when communicating with staff.

Comments from relatives we spoke with were primarily positive about the service. One relative described Oak House as, “A perfect set up. A home from home.” Another told us, “The place is great, staff are smashing. My [family member] gets looked after” Another relative said they were “generally happy” with the service. Relatives felt the majority of staff were caring and one said of a specific staff member, “I love [name], she’s great. She goes out of her way for people, just a very caring person and it comes through.” One relative said of the staff, “They’re very caring. [My family member] likes them.”

A community dentist who had involvement with one of the people who lived at Oak House told us they had never been to the home but the person had been accompanied several times by staff to their appointments. They said, “These carers all seemed pleasant and helpful and concerned for this patient’s welfare.”

Our observations on the day showed that staff were kind and caring in their interactions with the people they supported. Staff spoke with people and ensured that they were happy at all times during the inspection. Communication between staff and people living at the service was friendly and good natured and people were comfortable when approaching staff and receiving support.

Staff communicated with people in ways appropriate to their needs and offered choice to people so that their preferences could be accommodated. This included showing people visual choices and seeing how people responded to these to gauge their preferences and provide them with their requested option. We had identified that one person’s care plan stated they used a technique of communication that no staff we spoke with were trained in. Staff told us that the person often used “their own language and signs” to communicate and staff were familiar with these and able to identify and meet the

person’s wants via this way. Although we saw staff communicate effectively with this person on the day of our inspection, the lack of clear information could lead to a risk of ineffective communication, especially for new or unfamiliar staff.

We observed a situation where people’s privacy and dignity was not maintained. This took place during a staff handover period in the afternoon within the main lounge. Three people who lived at the home were also present during the handover process. A staff member began to pass on personal information about GP appointments, ailments and bathroom use for all of the people who lived at the service. This process demonstrated that staff did not have awareness of ensuring they maintained confidentiality and dignity for the people living at the service. We fed back our observations to the acting manager so they could review ways of passing on information in a way that did not compromise people’s dignity.

Staff we spoke with told us that support was provided in line with people’s choices. One staff member said, “It all comes down to the person’s choice, what they want.” Another gave us an example of how people had been involved in choosing their own decoration for their bedrooms and we saw this reflected in the different rooms we looked at.

We saw in care records that people’s diverse needs had been taken into account. For example if people had certain cultural or religious requirements, these were incorporated within their care plans. Staff demonstrated an understanding of these and were able to describe any such needs each person had. Care records also contained information about people outside of their care needs such as their backgrounds, favourite things and family histories. This helped staff to form positive relationships and engage with people.

Advocates support and speak up for people in order to express their views, preferences and decisions. The acting manager told us that no-one currently used an advocate but said they were aware of an advocacy service that could be accessed via the local authority should this be required. However, we did not see evidence to show that details and information about advocacy services was made readily available to people living at the service.

We observed a situation where people’s privacy and dignity was not maintained. This took place during a staff

Is the service caring?

handover period in the afternoon within the main lounge. Three people who lived at the home were also present during the handover process. The senior staff member began to pass on personal information about GP appointments, ailments and bathroom use for all of the people who lived at the service. This process demonstrated

that staff did not have awareness of ensuring they maintained confidentiality and dignity for the people living at the service. We fed back our observations to the acting manager so they could review ways of passing on information in a way that did not compromise people's dignity.

Is the service responsive?

Our findings

We observed that staff responded to people's needs and wants. One person at the service was going on a holiday later in the year. We spoke with staff who told us that they worked with the person to find out where they wanted to go and what staff the person wanted to support them on this holiday. We asked the person if they were looking forward to their holiday to which they replied "Yes." We then asked if they had helped pick the staff team that were going to support them on the holiday and the person responded "Yes." This showed that people were encouraged and given opportunity to influence their own support to suit their preferences.

Four of the five relatives we spoke with told us they felt staff knew their family members well and could therefore respond appropriately to their needs. Comments from a relative included, "I feel as though they've got [my family member's] best interests at heart", "They all have a good relationship with [my family member]. He likes a joke and they have a laugh with him" and "They know what he likes, got a good understanding of him. They know him inside out." One relative felt that sometimes their family member's needs were not always met. They said, "When new staff join they don't always know him that well" which had caused some inconsistencies within their care needs. They cited some examples of where their family member had not been supported in their preferred way but said there were no "major issues" and they had informed staff of the problems at the time.

In the main, observations and discussions with staff showed they knew people's needs and preferences well although we found some instances whereby staff were not fully aware. One staff member when asked about a person's morning and evening routine gave information which was contradictory to that detailed within the care plan. This meant there was a risk that people may not be fully supported in the correct way if staff were not familiar with people's preferences.

We looked at the care records of three people at the service. There was evidence that the care plans had been reviewed regularly and in response to changes in need. The service operated a keyworker system so that each person had a named staff member as a point of contact. Senior staff members were responsible for the reviewing and updating of care plans and risk assessments of the people

allocated to them. Changes were communicated in a log book for all staff to read and be aware of. Care plans were person centred and there was evidence of involvement of the person themselves, family and other professionals. Relatives we spoke with all said they were kept informed, involved and updated about their family member's care.

In the morning we saw that two people went out with staff to take part in activities and then for lunch. This corresponded with the planned activity time tables in their care plans. The time tables displayed many different activities in and out of the home. The acting manager told us about a staff member from head office who provided opportunities for people to participate in activities at the home. We saw this staff member present during our inspection helping two people to make decorations and masks for a forthcoming party which had been decided by the people living at the service. We saw the sensory room, which was a new addition since our last inspection of the service, and the deputy manager told us this was very popular with the people living at the home.

Relatives told us about activities in the community that their family members participated in. One said, "[My family member] does so many things there, even little things. They take [my family member] everywhere with them, shopping, there's a lot going on. They know them so well." Another told us of their family member, "[My family member] goes out, bowling and shopping. Went ice skating too." However, two relatives commented that although the service had their own vehicles, there was sometimes a lack of staff that could drive these which then limited opportunities for people to go out. Another relative felt their family member would benefit from more one to one support with a specific interest they enjoyed.

Meetings of people who lived at the home took place regularly. The acting manager told us these were generally at a frequency of six weeks. We saw the minutes from the meeting that took place in January 2015. As some people at the home were not able to communicate verbally, people's involvement was documented by descriptors of their response to certain questions which evidenced that people were able to influence and put forward their views about how the service ran and what they would like. The minutes we saw related to how people wanted to celebrate a specific occasion.

The acting manager told us that formal relatives' meetings had been trialled in the past but with little success. They

Is the service responsive?

said that this was in part due to the size of the service which meant that relatives were involved on a regular basis with the service in some format albeit at differing times and frequency. All relatives we spoke with felt they had sufficient opportunities to keep updated and be involved with the service. One relative said, "Communication is good." They said there used to be opportunities for formal meetings but didn't really see the requirement for these. They went on to tell us that one relative was a representative and spokesperson who could put forward the views of other relatives and people at provider level if they felt they had any issues to raise.

There was a complaints policy in place. The service had received no complaints within the last 12 months. Relatives we spoke with all said they knew how to complain should they have the need to. They told us, "I would tell them straightaway if there were any problems but I've no complaints", "I would raise anything, any problems if I had any and would feel comfortable in doing so" and "Any issues and we go to management or to Hollybank (the provider). Always been resolved."

Is the service well-led?

Our findings

The registered manager was absent at the time of our inspection due to a planned period of leave which she had notified CQC of beforehand. The substantive deputy manager was managing the service in her absence. From discussions with the acting manager, it was evident she had a good understanding and knowledge of the people who lived there. She informed us that she received support from head office whilst she was managing the service.

We had identified that improvements were required as to how staff training was monitored and managed to ensure staff were skilled to meet the needs of the people they supported. The lack of oversight and a robust system had led to inconsistencies which we identified during our inspection. We also identified that the principles of the MCA and DoLS were not fully embedded within practices we observed at the service. This meant that there was a risk of people not being fully supported in ways that were within their best interests.

The acting manager said the registered manager was supportive and “wants what’s best for people” and said the current workforce was “one of the best teams we’ve had.” The staff we spoke with were positive about how the service was managed and the staff team said they ‘all pulled together.’ They also felt that there was a lot of support from head office. A senior staff member told us they felt the staff team was “The strongest and most supportive since the home opened.” One member of staff said, “I love this place, it’s the best job I have had.”

Relatives we spoke with were generally pleased with how the service was run. One relative told us, “If we weren’t happy we wouldn’t have let [our family member] stop there. The place is great except for a few niggles that you’re going to get anywhere.” Other comments were, “No concerns or issues at all”, “Management’s ok, approachable” and “The staff seem to enjoy working there. I know some of them really well.”

Staff we spoke with had a good understanding of the whistle blowing policy. Whistleblowing is when a worker reports suspected wrongdoing at work. One staff member stated that “I did raise a concern and it was handled

quickly.” They then went on to identify the chain of people who they would report any concerns to in certain circumstances. This demonstrated that there were structures in place to identify and report any concerns.

The acting manager and support staff we spoke with told us that team meetings occurred every month and that the last one was February 2015. We looked at the minutes of team meetings that had taken place in January and February 2015. These included discussions of updates about the people who lived there, staffing updates and other relevant information such as changes in policies, procedures and working practices. We saw in meeting minutes that staff were recognised and thanked for good practice. One member of staff told us “In the last staff meeting, three members of staff were praised for excellent recording”. They also stated that “Praise for good work takes place in supervisions.”

There were also separate team meetings for senior staff and we saw the minutes of the latest one in February 2015. This covered training, staff responsibilities amongst other pertinent information. We saw that a new staff member had suggested a way of improving handover procedures to make this more robust for staff returning from days off. We later saw the handover sheet that had been designed and was to be implemented as a result of this suggestion. This showed that team meetings were used as an effective way to share and implement best practice and look at ways of improving the service.

There were a number of detailed policies and procedures in place at the service, some of which were under review by head office. The acting manager told us that she had recently implemented a ‘policy of the month’ system whereby staff had to read and familiarise themselves with a different policy each month. They would be asked about their understanding of the policy in supervisions to ensure staff were familiar with what was required of them.

There was a process in place for recording incidents. These were recorded electronically on the service’s computer system. Each staff member had access to the system to document incidents and each one was assigned to the manager or senior staff member to oversee so they would be aware of any trends or themes arising. These were then reviewed and monitored by head office as an extra level of analysis and to look at ways of minimising and preventing recurrences.

Is the service well-led?

We saw evidence of audits undertaken at the service, for example in infection control, finances and medicines with areas for improvements identified. The service was currently undergoing a restructure and a quality assurance officer had recently been recruited. The head of residential services informed us that this person would be responsible for undertaking monitoring of the service, a role that they

had previously undertaken. We asked for the latest monitoring reports which were stored at the provider's head office. We were informed these were unavailable due to a system problem causing a number of computer files at head office being erased which included these reports; as such these were not seen by us.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

Care or treatment was provided in a way that included acts intended to control or restrain that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to the person or another individual if the person was not subject to control or restraint.

It was not established that people were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Staff did not receive such appropriate training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

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