HICA

Prospect House - Care Home

Inspection report

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Date of inspection visit:
31 March 2016

Date of publication:
16 May 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 31 March 2016 and was unannounced. We previously visited the service on 11 September 2014. We found that the registered provider did not meet all of the regulations we assessed. We carried out a follow up inspection on 21 December 2014 and found that the registered provider had met the regulations.

The home is registered to provide accommodation for up to 24 people who have a learning disability or autistic spectrum disorder. On the day of the inspection there were 19 people living at the home. The home is situated in Goole, in the East Riding of Yorkshire. There are four units within the home, each with a kitchen, dining room, lounge area, bathroom and bedrooms. In addition to this, there are two flats for people who are able to live more independently, although at the time of the inspection the flats were unoccupied. There is a passenger lift so people are able to access the first floor if they cannot manage the stairs. There is a large communal room on the ground floor that is used for group activities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at Prospect House.

People told us that they felt safe whilst they were living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. This included training on the administration of medication. We saw that medicines were administered safely.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff.

People's nutritional needs had been assessed and people told us they were very happy with the food provided. We observed that people's individual food and drink requirements were met.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and outcome. There were also systems in place to seek feedback from people who lived at the home, relatives and staff.

Staff, people who lived at the home and a health care professional told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote safety and optimum care to people who lived at the home. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

Staff had received training on safeguarding adults from abuse and this meant they were aware of how to refer any concerns to the safeguarding authority.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home. We saw that different meals were prepared to meet people's individual nutritional needs.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

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

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and staff told us they would support people to make a complaint if they had difficulty in doing so.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Prospect House - Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 31 March 2016 and was unannounced. One adult social care (ASC) inspector carried out the inspection.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities who commissioned a service from the registered provider. The registered provider was not asked to submit a provider information return (PIR) prior to this inspection. The PIR is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with one person who lived at the home in depth and chatted to others. We also spoke with two members of staff and the registered manager. Following the day of the inspection we spoke with a health care professional.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Prospect House. One person said, "Staff made me feel very welcome and I feel very safe here." We asked staff how they kept people safe and they told us that their training on topics such as safeguarding adults from abuse and medication helped them to provide safe care. They said that the premises were secure and they were aware of anyone entering or leaving the building. One member of staff told us, "We administer medication safely and we make sure people get enough to eat and get the right food, for example, we know about their allergies." Another member of staff said, "We observe all of the time and we check for hazards like water temperatures, wet floors, that the hoist is working properly and that wheelchairs are safe."

We reviewed the folder where safeguarding information and alerts were stored. This included a report from the local authority that highlighted some important issues that had been identified during safeguarding serious case reviews. The folder included blank alert forms, forms to be used to report any complaints regarding 'transfer of care' from hospital back to the care home, body maps and copies of the different types of notifications that might need to be submitted to CQC. There was also information to guide staff on the action to take should a medication error occur 'out of hours', HICA's 'standard operating procedure' in respect of safeguarding adults from abuse and CQC guidance on statutory notifications. The registered manager had attended the safeguarding 'threshold' training provided by the local authority. This provided a monitoring system for managers to help them identify which incidents required managing in-house, and which incidents needed to be reported to the safeguarding adult's team. This information was recorded in the safeguarding folder.

The 'alerter' folder was divided into months and notifications and alerts were stored accordingly. The registered manager produced a weekly safeguarding report that included details of any Deprivation of Liberty Safeguards (DoLS) applications that had been submitted to the local authority for consideration and any accidents or incidents that required a safeguarding alert to be submitted.

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. They were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or had any concerns. One member of staff told us that "Any abuse would be picked up by staff" and that the information would be passed to the registered manager, who would listen to their concerns.

Staff told us that people had lap belts to keep them safe in wheelchairs and bed rails to prevent them from falling out of bed and hurting themselves. They understood that this was a form of restraint and told us that these decisions had been made following best interest meetings. Some people had behaviour management plans in place that recorded the behaviours that they might display and how staff should approach the person to manage these situations. One person's care plan recorded, "When [the person] becomes emotionally upset they will become verbally abusive, throw items, lash out at other people and slam doors. Staff to speak calmly to [the person] and ask what the problem is. If they do not respond, give them space. Ensure that other service users are safe. Staff to ask other service users to vacate the area." Care plans also

recorded any known 'triggers' that might lead to behaviours. This meant that all staff were following the same guidance when situations arose.

We saw that, when a person had been involved in an accident or incident, a copy of the accident or incident form was stored in their care plan. We noted that a '72 hour' monitoring form was also used when people had been involved in an accident, as staff were required to observe the person for signs of ill health for three days after the accident or incident had occurred. The registered manager told us that she checked accident records to monitor whether there were any areas for improvement or to identify whether any patterns were emerging. We saw the monthly analysis form; this recorded a summary of the accidents that had occurred each month, including full details of the accident, any medical treatment the person had required and any action taken.

We saw that one person was having regular falls (seven in March 2016) and these were recorded in their falls diary and their health monitoring form. The person had not suffered any injuries as a result of these falls. However, medical attention had been sought and the person was being closely monitored. Their care plan had been updated to record that the person must be reminded to use their walking aid.

Risk assessments had been completed for any areas that were considered to be of concern. These recorded the identified risk, the action needed, and the statement 'Will the above actions maintain the resident's independence?' People had risk assessments that identified any areas of risk in their bedroom, and other topics covered by risk assessments included falls, access to the community, bathing / showering, medication, nutrition, moving and handling and mobility. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date.

Some people were not able to verbally communicate that they were in pain or explain to staff when they were distressed. There was a pain assessment tool and a Disability Distress Assessment tool that recorded 'cues to distress' such as vocal signs when consenting / when distressed and appearance when consenting / distressed. This helped staff to monitor a person's physical and emotional well-being when they were not verbally able to express these feelings. This also helped staff to make a decision about administering 'as and when required' (PRN) medication, and we noted there were protocols in place for the administration of this type of medication.

The medication folder included the home's protocol for obtaining medication 'out of hours', the use of codes to indicate why people had not taken their medication, sample signatures for staff (so that records could be checked if needed), the organisation's protocol for ordering medication and a pharmacy 'tip' for PRN medication.

Only senior staff assisted people to take their medication and training records evidenced these people had undertaken appropriate training. We spoke with a senior member of staff who explained the home's medication procedures to us. We saw that people had a lockable cupboard in their bedroom where their own medication was stored, although medication administration record (MAR) chart were stored in the medication room. We saw that temperatures were checked in each person's cupboard and in the medication room to ensure medication was stored at the correct temperature; we noted that temperatures were recorded consistently and that they were within recommended parameters. We checked the medication for three people who lived at the home and found that it was stored securely.

We checked the MAR chart folder. Each person had a 'front' sheet that recorded their name, date of birth, date of admission to the home, the name of their GP, their preferred name and any known allergies, as well as a photograph. The MAR folder also included each person's support plan in respect of the administration

of medication, including their individual PRN protocol. We reviewed people's MAR charts. We saw that codes to indicate why some medications had not been administered were used appropriately and that there were no gaps in recording. Any new instructions, such as medication being discontinued by the person's GP, were clearly recorded on the person's MAR chart. Creams were recorded on a separate 'Topical MAR' chart. Most handwritten entries, but not all, had been signed by two people. This is recommended to reduce the risks of errors occurring when information is transcribed from labels on to the MAR chart.

The medication room contained a cabinet to store homely remedies and the controlled drugs (CD) cabinet; these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We checked that the amount of stock held in the CD cabinet matched the records in the CD book and we found that these balanced. We noted that one medicine was stored in the CD cabinet but not recorded in the CD book. We took advice on this following the inspection and found that there was no legal requirement to store this medicine as a CD; staff had chosen to do so as they wanted to ensure it was stored securely. There was also no requirement for the medicine to be recorded in the CD book although this was considered to be good practice. We shared this information with the registered manager following the inspection.

We saw one person was given their tablet but they were not given a drink of water to help them swallow it. It may be that this person did not wish to have a drink, but it is recommended that people have a drink of water after taking their medication to make it easier to swallow.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy, apart from when people went to see the GP themselves and collected their own prescription. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Prospect House.

On the day of the inspection there was the registered manager, three care workers, a domestic assistant and a cook on duty, plus the home's administrator. The registered manager told us that the staffing levels they aimed to achieve were one support worker on each of the four units plus one senior care worker, and the minimum number of care workers on duty would be three. We checked the staff rotas and saw that there were always three or four care workers on duty, plus a senior care worker. There were two 'waking' night staff on duty each night. In addition to care staff, there was an activities coordinator, domestic assistants, a chef and an administrator on duty; this meant that care staff were able to concentrate on supporting people who lived at the home.

The staff rotas evidenced that staffing levels were flexible so the needs of people who lived at the home could be met. On the day of the inspection one person was receiving one to one support and other staff had accompanied people on a day out to the seaside, and there were still enough staff on the premises to support the people who had remained at home. Staff told us that there were sufficient numbers of staff employed to ensure people received the support they required.

The registered manager carried out a review each week; this included a record of staff absences and who had covered their shift.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. We noted that the MOT certificate for the home's mini bus and the certificate to evidence that hoists and slings had been serviced were out of date; the manager assured us that there were an up to date certificates in place and she forwarded copies to us after the inspection.

The handy person carried out in-house checks on water temperatures, window opening restrictors, wheelchairs, door closures, hoists and slings, bed safety rails and the emergency call system.

There was a fire risk assessment in place and we saw that fire drills had taken place in December 2015 and March 2016. This helped to make sure that people who lived and worked at the home understood what action to take in the event of a fire. The home's handy person carried out a weekly fire test including checks on the fire alarm system, emergency lights, fire doors and portable fire-fighting equipment. This showed that the fire safety arrangements in place at the home were robust.

There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations. This included information about evacuating the premises, alternative accommodation and important telephone numbers, plus a list of each person's prescribed medication. There was also a personal emergency evacuation plan (PEEP) in place that recorded the support each person would need to evacuate the premises in an emergency.

We walked around the building and saw that communal areas of the home, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw evidence that best interest meetings had been held to help people who lacked capacity to make decisions about their care and welfare. We saw the records for best interest meetings that had been arranged to discuss a person's dental treatment, a person going out on their own and for flu vaccinations.

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 authorisations to deprive a person of their liberty were in good order. We found that the registered manager and staff displayed a good understanding of their roles and responsibilities regarding MCA and DoLS and promoting people's human rights, and had received appropriate training. Any authorisations in place were being appropriately managed.

People's care plans recorded information about the tasks they could do without help in a decision making tool. The care plan then recorded whether capacity assessments, best interest meetings, referral to an Independent Mental Capacity Advocate (IMCA) or support plans were needed for this area of care.

Staff described to us how they helped people to make day to day decisions, such as holding clothes up to help people decide what to wear, and showing people different meals so they could decide which meal they would prefer. Staff said, "We get to know what they like and dislike" and "We ask people – we interact."

We observed that staff had the skills they needed to carry out their roles. Records evidenced that new staff carried out induction training over a five day period and also shadowed experienced staff as part of their induction training. This was confirmed by the staff who we spoke with. One member of staff described how they had attended for five days training at the organisations head office, followed by one day's training at Prospect House and then two weeks shadowing experienced staff. They said that they made them feel more confident when they became part of the staff rota.

The training record evidenced which training was considered to be essential by the organisation and how often refresher training was required. Essential training included safeguarding adults from abuse, back care, fire safety, first aid, infection control, food hygiene, health and safety, respect, MCA and pressure area care. We saw that staff had completed essential training although some refresher training was overdue. This was identified as requiring action in the monthly review undertaken by the manager on 29 February 2016 and as a result refresher training on moving and handling had been arranged for April 2016. Staff told us they had attended a variety of training courses in the last year; these included first aid, safeguarding adults from abuse and fire safety. They said, "All staff have enough training."

A health care professional told us that they provided training on Buccal Midazolam (a medication prescribed for people with epilepsy) and that the organisation provided in-house training on Epilepsy. This meant that staff received training that helped them to manage the health needs of people who lived at the home.

There was a supervision policy and guidance notes in place. The registered manager told us that they aimed to have supervision meetings with people every three months and the records we saw showed that this was being achieved. Staff told us they were well supported, both by their colleagues when they were new in post and by the registered manager. One member of staff said, "This was the best move I ever made" and another told us, "I can talk to the seniors and to [Name of manager]."

We saw the 'handover' meeting that was held at the beginning of the afternoon shift. These meetings ensured that staff were made aware of any changes to a person's care needs, and that they had up to date information about each person who lived at the home.

We observed the lunchtime experience; tables were set with tablemats and napkins and people were offered clothes protectors. Individual meals were prepared for people who had specific dietary requirements and people were offered a variety of choices, especially people who were reluctant to eat. Everyone was offered a choice of dessert. When people required assistance to eat their meal, this was provided on a one to one basis by staff, and we saw that people were allowed to eat at their own pace. People told us they liked the meals at the home and one person said, "I am on a healthy eating programme but I still get nice meals. Staff know what I like and don't like." Staff chatted to people and this made the mealtime a social experience.

Care plans recorded the equipment people required to enable them to eat independently, such as adapted crockery and cutlery. Nutritional assessments and risk assessments had been carried out and we saw that advice had been sought from dieticians and speech and language therapists (SALT) when there were concerns in respect of eating and drinking. Some people had a food diary in place; these recorded the meals the person had eaten at breakfast, lunch, during the afternoon, tea time, supper. People were also being weighed on a regular basis as part of nutritional screening. These arrangements enabled staff to monitor people's nutritional well-being.

Staff told us they would recognise if someone was unwell, even if they could not verbally express this, as they knew them very well. They told us that the senior member of staff on duty would call the GP surgery to request a visit, although some people preferred to visit the surgery and they would be accompanied by staff.

Health monitoring forms recorded any concerns about a person's health, such as the need to contact a health care professional and any accidents or incidents that had occurred. We saw that any contact with health care professionals was recorded, including the reason for the contact. An additional form was then used to record information about the contact in more detail. People's records evidenced that advice had been sought from health care professionals, such as dentists, district nurses, the community learning disability team, chiropodists, and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. A health care professional told us that staff asked for advice appropriately and then followed that advice. They said, "Staff get in touch if they have any concerns."

People had health passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that health passports included some details in colour and symbols to help the person concerned to identify the information in the passport.

We saw that those people who could move around the home unaided were able to find their way around the

home and that there was a lift to enable people to access the first floor. One person told us they had purchased a new wheelchair and they were able to mobilise around the home easily, including using the passenger lift.

Good

Is the service caring?

Our findings

One person had recently moved to live at the home and told us it was a "Positive move." They told us that they felt staff cared about them. This was confirmed by the staff who we spoke with. One member of staff said, "We work as a team. Some staff go out of their way. For example, this week I'm working late to decorate my resident's room" and another told us, "Yes, you have got to care to do this job." We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient in the way the interacted with people.

A health care professional told us that, when care staff accompanied people to appointments, they had "Good factual information" about the person concerned. They said that staff could respond to questions from health care professionals as they knew each person well, and "Were genuinely interested in people's care."

Staff explained to us how they respected people's privacy and dignity. Their comments included, "We make sure doors are closed and that everything is at hand so we don't have to leave people", "When helping to bathe people, we ask them if they want us to stay or not" and "We knock on doors. We talk to them and tell them what we are doing."

We saw that people's bedrooms had enough space to enable them to see visitors and health care professionals in private, and that there were other areas of the home where people could have private meetings.

People's care plans recorded information about the tasks they could do without help. One person's care plan recorded, 'I can …. pick my own clothes, undress and dress myself. I need support to …. I need help with my bra'. Another person's care plan recorded, 'I can …. eat most foods, choose what I would like for my meals. I need support to …. to tell me what my choices are'. Staff told us they promoted independence. One staff member told us about a person who lived at the home who liked staff to 'give them' a drink. They said they could actually do this for themselves and staff encouraged them to do so.

The registered manager told us that they had been working with people's relatives to explain the implication of DoLS applications and authorisations. As part of this process relatives were sent information about advocacy services such as the Alzheimer's society and Independent Mental Capacity Advocates (IMCAs), and told about the role of CQC and Skills for Care. This meant that people had been made aware of advice and advocacy services that were available to them. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that

anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered manager told us that people who lived at the home were asked for their views about new members of staff. They were asked to complete a form that was in symbol format and included questions about staff listening to them and respecting their choices. This showed that people were involved in some of the decisions about the service that was provided for them.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. An initial assessment had been completed; this covered areas such as relationships, emotional / psychological care, personal care, leisure, communication, night care, mobility, eating and drinking, medical / physical health and finances. The assessment also included the reason for the initial referral, the person's life history so far and the names of health care professionals involved in the person's care. Any risks that were identified during the assessment process were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk. We noted that assessment and risk assessment information had been incorporated into an individual plan of care.

Care plans included a one page profile that recorded information under the headings, 'What is great about [the person], 'What is important to [the person]' and their support needs. This provided a quick summary for staff without them having to read the full care plan. The areas covered in care plans were communication, medical / physical health, eating and drinking, night care, mobility / equipment and emotional / psychological care. We saw that each area covered in care plans recorded 'What's important? How will this happen? Who will help? and How often?'

Care plans included specific instructions about people's preferences, such as '[The person] likes to sit in the same place at mealtimes' and '[The person] prefers their bath straight after tea'. Care plans also included an 'Intensive interaction' form that recorded any one to one time key workers or other staff spent with people. We saw that these recorded activities such as manicures, shopping and hairdressing appointments.

We saw evidence that care plans were reviewed and updated each month to ensure they were up to date, and more formal reviews had been organised by care managers to review the person's care package. We noted that health care professionals who were involved in the person's care were invited to these reviews. This meant that the appropriate people were involved in reviewing a person's care package to ensure it continued to meet their needs.

People received person-centred care. We observed a senior staff member helping someone to take their medication via Percutaneous endoscopic gastrostomy (PEG) feeding. We saw that this staff member had eye contact with the person, used simple language and some basic sign language. The person concerned responded appropriately and this led to good interactions and successful administration of medication.

Staff told us they thought there was enough for people to do to keep them occupied. We saw that a weekly activity planner was displayed on the notice board and that it included activities for mornings, afternoons and evenings over a seven day period. Activities included the gardening club, sing-a-long exercises, swimming, computer time, men's club board games and a ladies pamper morning. One to one time was also included on the planner. One person told us they particularly enjoyed the 'Oomph' exercise parties and that these were helping to improve their mobility. They also enjoyed watching films and they told us there was a large screen in the communal room where they could watch them.

Some people attended day centres, some people attended a local drama group called 'Castaways' and other people enjoyed going out to the shops with staff. We saw that activities were recorded on individual activity checklists in people's care plans. The local authority currently provided transport to take people to and from day centres, but this was due to cease. The home had a mini-bus and they were advertising for a driver so that people who had chosen to attend a day centre could continue to do so.

People were supported to keep in touch with family and friends, and any contact with relatives or friends was recorded on a contact sheet. One person told us about visits from family and friends and how they had brought items into the home so they could personalise their bedroom.

We saw that the organisation's complaints procedure was displayed in the home and that the complaints log included a copy of the organisation's fact sheet and a complaints form ready for completion. The registered manager completed a monthly complaints analysis; there had been one complaint received in July 2015 and the records evidenced the complaint had been resolved. Complaints had also been received in December 2015 and January 2016. Following receipt of the January 2016 complaint, a meeting had been arranged with the relative concerned followed by a letter of explanation being sent to the family. We saw that both complaints had been dealt with in a satisfactory manner.

One person who lived at the home told us that they could talk to their key worker or other staff if they were worried about anything. They said that this made them feel they would also be able to raise any concerns or complaints and they would be listened to. Staff told us that, if someone raised a concern with them, they would record the details and pass them to the registered manager. Another member of staff said that they would inform the senior person on duty or the registered manager. Staff added, "The manager would listen" and "The issue would be dealt with." The registered manager told us that all relatives had been sent a complaints leaflet, and that any complaints received from relatives would be discussed at relative meetings (unless they were confidential).

We saw a notice displayed in the entrance hall that recorded the dates of the meetings for people who lived at the home; these were held every month. The minutes of the most recent meeting showed that new menus and 'HICA in Bloom' had been discussed. People at the home had suggested that a music night be held to remember their friend who had sadly passed away and this had been arranged.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) for a number of years; this meant the registered provider was meeting the conditions of their registration and that there was a level of consistency for people who lived and worked at the home.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew about the specific needs of people living at Prospect House. One member of staff said, "The manager has an open door policy and she listens. She knows the service users really well" and another told us, "Everyone respects the manager. She checks that staff are OK and she appreciates us." A health care professional told us that management had improved at the home since the current registered manager had been in post. They said, "There is better leadership and organisation."

There was a relative survey in June 2015. One relative had mentioned that they were not sure who staff were, and as a result, staff photographs were sent to relatives. The registered manager told us that all surveys returned include an action slip so that there was a record of any improvements needed and the action that had been taken. A health care professional survey had also been carried out in October 2015 and a staff survey in January 2015, although we did not review the feedback from those surveys.

There was a notice in the entrance hall advertising 'Family and Carers' meetings. One had been arranged for 26 February 2016, although it did not go ahead. The registered manager told us that she had spoken with families and they told her they would prefer to have regular newsletters and just one meeting in the period leading up to Christmas. A meeting had been arranged for 21 October 2016.

Staff told us they attended staff meetings and that they could raise concerns and issues. They told us that every member of staff was required to sign the minutes of the meeting so that everyone knew what had been discussed and agreed. We saw that support staff meetings had been held in January and February 2016. The minutes of the support staff meeting in February 2016 showed that staff had been reminded that they had to be careful about what they discussed on social media sites, and that wheelchairs, food choices, accident / incident forms and mental capacity was also discussed. Senior staff meetings were also held in January and February 2016. The minutes of the senior meeting in February 2016 recorded, 'Seniors need to

be more proactive in respect of weights'. Discussion also included the nutrition / hydration week (the registered manager told us they held a 'healthy' tea party), completion of the MUST tool and the current key worker list. The registered manager told us that a full staff meeting was planned for May 2016. In addition to this, staff received a copy of the home's newsletter along with their pay slips. This was another method of communication that was used to keep staff up to date with important information.

At one time meetings were held for heads of department, i.e. the handyman, chef, housekeeper and manager. The registered manager said these had not been successful so a decision had been made to hold separate meetings. 'Kitchen' meetings, chef meetings and meetings for domestic staff had been held in March 2016. The minutes of the meeting for domestic staff recorded, 'Staff shouldn't bring their problems into work'. There was also a Health and Safety Forum; this was attended by the handy person, the registered manager and two people who lived at the home. This showed that people who lived at the home were involved in discussions about some aspects of the service that affected them.

We saw a variety of audits were being carried out to monitor the safety of the service and whether the service was meeting people's assessed needs. This included a training audit, an infection control audit, medication audits and care plan audits. We noted that the care plan audit included a check on people's weight records; any concerns identified were recorded in an action plan and the information was shared with catering staff so that adjustments could be made to the person's diet. The registered manager also carried out a quality audit each day. This included a twice daily 'walk around' the home to check on cleanliness and maintenance.

The registered manager told us that they had plans in place to improve the mealtime experience and people's nutritional intake. They referred to this as 'down tools' lunchtime. The chef would be observing mealtimes and checking people were happy with the menu. Domestic staff would be ceasing their duties at 12:00 and concentrating on encouraging people to eat their meal. A snack trolley was being introduced from 4 April 2016. This showed that the registered manager and staff were continually looking at ways to improve the service provided.

We asked staff to describe the culture of the service. One member of staff told us the home had a "Homely feel. This is more than a job. I think of the service users as my family" and another said, "[The home] is calm, friendly with a family atmosphere. We know the service users well." Staff told us that they would discuss any incidents that had occurred; they said issues would be discussed openly to try to find solutions and to prevent incidents reoccurring.

Staff told us they would use the home's whistle blowing policy if needed, and that they were confident the registered manager would respect their confidentiality. One staff member said, "We are here to support the service users – they come first" and another said, "It's important that we keep service users safe."

We saw that the home's notice board included information about staff incentives, such as 'Employee of the month'. Families and friends of people who lived at the home were invited to nominate an employee each month who they felt had gone 'over and above' their duties. This was appreciated by staff. One member of staff told us, "[The manager] has put things in place, like 'employee of the month'." The notice board also included information about other HICA incentives, such as HICA in Bloom (to encourage people to look after the garden at the home) and 'Oomph' exercise parties.