Care Quality Commission

Horizon Care Homes Limited

Wood Hill Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection on 23 and 24 March 2015 and it was unannounced.

Our last inspection of the service took place on 30 April 2013 and 01 May 2013 and we found the service was meeting the requirements of the regulations we inspected at the time.

Wood Hill Grange Care Home is located in north east Sheffield. The home has a secure landscaped garden and car park. Wood Hill Grange Care Home provides accommodation for up to 73 older people over four floors accessed by two lifts. The home has 19 rooms on the ground, first and second floor and 17 rooms on the third (top) floor. Each room has an en-suite shower room. There are two lounge /dining areas on each floor of the home. On the day of our inspection, there were 71 people living at the home.

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 and associated Regulations about how the service is run. The registered manager was present on both days of our inspection.

Summary of findings

The service ensured people were protected from abuse and followed adequate and effective safeguarding procedures. We found care records were personalised but could be improved with more information for staff to provide person-centred care and support.

We found good practice in relation to decision making processes at the home and in line with the Mental Capacity Act 2005 (MCA) Code of Practice, with the principles of the MCA and Deprivation of Liberty Safeguards being followed.

There were issues around medicines at the home, where some medicines being used were out of date or had been dispensed incorrectly by the pharmacist.

There were good quality-monitoring systems in place at the home that were carried out on a monthly basis. We saw that, where issues had been resolved, action plans needed updating to reflect this.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which is now replaced by 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?

Requires Improvement

The service was not always safe.

There were issues with the management of medicines at the home, where some medicines that were in use had passed their expiry date and were not stored correctly, or in line with guidance.

People were protected from bullying, harassment, avoidable harm and abuse that may have breached their human rights.

We saw risks to individuals were managed so that people were protected and their freedom was supported and respected. We also found staffing levels at the service were adequate to meet people's needs.

Is the service effective?

Good

The service was effective.

People received care, which was based on good practice, from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Consent to care and treatment was sought in line with legislation and guidance and people were asked for their input into care and support planning.

People were supported to have sufficient to eat, drink and maintain a balanced diet and other relevant professionals were involved with this in order to meet people's needs.

The home ensured people had access to healthcare services and received ongoing healthcare support to maintain good health.

Is the service caring?

The service was caring.

Positive, caring relationships were developed between staff members and people who used the service and people who lived at the home were able to express their views about their care, treatment and support.

We saw people had their privacy and dignity respected and promoted.

Is the service responsive?

The service was responsive.

People received care and support that was responsive to their needs. People were not always encouraged to take part in activities, but social isolation was avoided through conversations and interactions with others.

Summary of findings

The home encouraged, explored and responded to people's experiences, concerns and complaints in a timely manner.

Is the service well-led?
The service was well-led.

We found there was a positive culture at the home that was person-centred, open, inclusive and empowering with good management and leadership present throughout.

The service delivered a high quality of care and carried out regular audits. We found audits were not always signed when complete, but were assured this would be done in future.

Wood Hill Grange 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 checked whether the provider was 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 23 and 24 March 2015 and was unannounced. The inspection team was made up of two adult social care inspectors and a pharmacist specialist advisor. We had received a Provider Information Return (PIR) from this service prior to our inspection. 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.

Before our inspection, we spoke with stakeholders from the Local Authority and National Health Service (NHS). Stakeholders told us about any concerns they had previously had, which we checked during our inspection.

Before our inspection, we received some concerning information regarding the care and welfare of people at the home. We also received information about the management of medicines at the home. We checked this during our inspection and it transpired that concerns around medicines were due to a data transfer error.

During our inspection, we spoke with the managing director, registered manager, one clinical lead, three care staff, the administrator, six people who lived at the home and the relatives of three people.

We looked at documents kept by the home including the care records of six people who used the service and the staff personnel records of eight staff members. We also looked at the quality monitoring systems at the home and documents kept for these.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which have now been replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at the home if they knew what keeping safe meant and if they knew how to report any concerns. Everyone we spoke with told us they understood what keeping safe meant and what they would do if they had any concerns. One person told us; "I'd just talk to [the clinical lead] and tell them what the problem is." Another person told us; "I do feel safe here, and I'm kept safe by the staff. I know they make sure that anything I do is safe." One relative we spoke with told us; "I do feel like [relative] is safe. There's never been any issues. In fact, I've never even had to speak to any staff about concerns because there aren't any."

We asked two people who lived at the home and one relative if they felt there were enough staff at the home. One person told us; "Well I get everything I need. More staff would be good, but we always want more. It's not like there aren't enough staff to see to us or anything." The relative told us; "There's always someone about. If [relative] needs anything, they just ask and it's done. Don't get me wrong, more staff would be great but there are definitely enough staff for the people that live here."

We looked at the homes staffing rota's to see if they were flexible and sufficient to meet people's individual needs. We found staffing levels were adequate, with each person who lived at the home having their care and support needs met. Rota's demonstrated that management at the home took into account the layout of the building and ensured staff were deployed to different areas and floors of the home to ensure consistent and adequate staffing levels.

We spoke with the managing director and the registered manager about staff deployment and how they ensured staffing levels had the right mix of skills, competencies, experience and knowledge. The registered manager told us there was a senior member of staff on each level of the home to ensure leadership was visible throughout the building. They also told us all staff undertook an induction programme at the home to carry out training in line with relevant legislation. On the day of our inspection, we found there were 14 care assistants and three nurses on duty throughout the home. This demonstrated the home ensured there were enough staff on duty to meet people's needs.

We looked at medicines at the home and found that a liquid medicine for one person had been recorded in the controlled drug register but was not stored in the controlled drug cupboard. Although it is not a legal requirement, it is good practice to record this particular medicine in the controlled drug register and keep it stored in the controlled drug cupboard. We spoke with the registered manager and managing director about this, who told us they would ensure good practice was followed in future.

We found eye drops for a person who was at the home were not stored in the fridge and had exceeded their expiry date due to them having been opened on 31 January 2015. Eye drops should be disposed of four weeks after opening. We also found these eye drops had continued to be used for the person and the bottle was empty. We also found different eye drops that were being used for the person which was also out of date. When we spoke with the nurse about this, they were not aware that the eye drops had expired. The nurse told us there were no more eye drops left and a repeat prescription would be requested to obtain these. This meant that this medicine was incorrectly and unsafely stored. In addition, the medicine was no longer available for the person to use due to the bottles being empty.

We found one person had not received a medicine that they had been prescribed to be administered once per week in the morning. We also found the reasons why the drug had not been administered were not recorded on the person's medication administration record (MAR) chart. We asked the staff nurse why this had not been administered. They told us this was due to the person being asleep during their medicines round, although we saw the person had received their other morning medicines. The nurse told us that the person would receive this medicine the following day. The nurse told us they had not contacted the pharmacist or GP for guidance on this missed dose. The Care Quality Commission pharmacist specialist advisor advised the nurse that this particular medicine could be given at any time in the day, as long as this was recorded on the MAR chart and that, leaving the dose until the next day would have an effect on the medicine administration day in the future. This meant that, although the person was not administered medicines unsafely, staff members did not record actions and reasons on relevant documents, or seek professional guidance from their own pharmacist.

Requires Improvement

Is the service safe?

We found a bag on a shelf in the clinical room with medicines in for one person and a label on the bag with a different person's name on. We asked the nurse about this, who told us this had been used as there were no other bags available when the person had been transferred to the home. We found medicines in this bag, dispensed by the pharmacist were still sealed but were not the correct medicines that the person required, as per their MAR chart and this had not been identified by staff. This meant resources were not always available to store medicines safely and processes for checking medicines were not always effective.

We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked medicines to ensure current and relevant professional guidance was being followed. We spoke to the clinical lead nurse, who told us that each floor of the home had their own controlled drugs cupboard and designated area where medicines were stored, both of which complied with the law. Controlled drugs are prescribed medicines that are controlled under the Misuse of Drugs legislation to prevent them from being misused, obtained illegally and causing harm. All medication was administered by a trained nurse or trained healthcare assistant.

We carried out a stock check of medicines on two floors at the home, including controlled drugs and found they were correct, as per the service's Medication Administration Records (MAR) and controlled drugs register. We saw medicines that were stored in fridges were secure, with fridges being locked when not in use. We also found that temperature checks were carried out daily to ensure medicines were stored correctly and safely.

We found staff used MAR charts to confirm they had administered medicines as prescribed. MAR charts contained details of medicines, side effects and allergies that the person had. There was also information present about PRN (as required) medicines. We saw people's medication records contained their preferences on how to take their medicines.

We saw staff respected people's choice. One person was offered a medicine that is used as a laxative. This person told the staff member they did not require this medicine and had their views listened to. The staff member documented this on the persons MAR chart.

We looked at guidance provided for one person regarding the use of covert medicine administration. Covert medicine administration means administering medicines to people that are disguised in food and drink. This decision had been made in the best interest of the person and with the involvement of the persons GP, pharmacist and relatives of the person.

During our inspection, we spoke with two staff members about safeguarding at the home. Both members of staff were able to explain to us about the different types of abuse, the signs to look for and what they would do if they had any safeguarding concerns. This demonstrated staff were knowledgeable about safeguarding and knew how to protect people from abuse and avoidable harm.

We looked at the care records of six people who lived at the home. We found these care records contained risk assessments in all relevant areas to protect people from discrimination, including discrimination on the grounds of age, disability, race and gender.

We saw risk assessments were in place in care records to ensure that risks to people were managed appropriately. We saw people who lived at the home and their relatives were involved in discussions and decisions made about any risks they may take. For example, we saw evidence in one care record of a risk assessment being carried out for the use of bedrails due to the person previously having fallen out of bed. We saw this assessment had been agreed by the person's relative and had been reviewed on a regular basis to ensure it was still appropriate.

We found a number of methods were used to share information on risks to people's care. In all care records looked at, we found daily notes and additional supplementary information, such as weight charts were maintained and up to date. We also spoke with staff members about how they ensured information was passed on to the relevant people. Staff told us they conduct a handover, to inform staff members of the next shift of any relevant information.

We checked care records to see if there were plans in place for responding to emergencies. We found care records

Requires Improvement

Is the service safe?

contained information for staff on what to do in emergency situations. For example, in one care record we looked at, we found a 'hospital passport' that contained information about the person, should they need to be admitted to hospital. This included details of the person's medical history and conditions, allergies and other relevant information. This meant the home had documents and procedures in place for dealing with an emergency.

We found an accident and incident log at the home that was well maintained. We saw accident forms had been completed following an accident or incident. We also saw evidence that accidents and incidents underwent monthly monitoring, where information was inputted into a grid detailing all accidents and incidents throughout the month, where they had taken place, the time of the incident, if it was witnessed or unwitnessed, the type of accident (i.e. fall) and the action taken. This demonstrated the home maintained an accident and incident log that contained all relevant details.

We walked around the home and found the premises were well maintained. We found the home was nicely decorated, with no unpleasant odours present. We saw equipment was well maintained, with all hoists in a good condition and any electrical equipment having undergone Portable Appliance Testing (PAT). This meant the home managed the premises and equipment to ensure people were kept safe.

We looked in eight staff files to ensure safe and effective recruitment practices were followed at the home. We found all staff files contained relevant pre-employment checks, including Disclosure and Barring Service (DBS) checks, reference checks from previous employers, proof of address and photographic identification. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This meant the service followed safe recruitment practices.

Good

Is the service effective?

Our findings

We spoke with people at the home about their involvement in care and support planning. Each person we spoke with told us they, and their relatives, had been involved in the planning of their care and support and that they received this in line with their wishes. One relative we spoke with told us; "I've been asked for my opinions about [relative's] care and whatever I have said, they've made sure it's ok with [relative] and done it that way." We saw one person was sat in their room watching television, wearing a shirt and tie. We commented on this and this person told us; "I like it that way. I like to wear a tie so [care staff] make sure I have one on. It's nice."

We asked people about the food available at the service. One person we spoke with told us; "The food is alright." Another person we spoke with told us; "I told [care staff] I wanted more choice on the menu at tea times. They've sorted that out now and there is more choice than before."

One person we spoke with commented on their room. They said; "I like to spend a lot of time in my room. It's kept clean and tidy and [care staff] help if I need anything doing." Another person spoke with us about their room and any problems or improvements. They told us; "I reported a broken light fitting and they sorted it out straight away."

We found people were supported to have their care needs, preferences and choices assessed by staff with the necessary skills and knowledge, who had completed an induction on beginning their employment at the home. We looked at records of staff supervisions and found that in five of the eight records seen there had been a period of four months or more where staff had not received formal, written supervision. Supervisions are a meeting between a staff member and their manager to discuss any concerns, development or training areas. At the time of our inspection, we found all staff had received supervision within the last month and annual appraisal within the last year. The registered manager told us supervisions would be undertaken on a monthly basis.

In all eight staff files we looked at, we saw staff were up to date with all required training, including mental capacity and mandatory training areas.

We looked in care records and saw that people had completed mental capacity assessments in place, which were reviewed on a monthly basis. We also saw detailed information about decisions that each person had capacity to make, including consent to care and treatment, photographs and involving people in their care planning.

The Care Quality Commission (CQC) 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 found that, where people lacked capacity to make complex decisions, relevant others had been involved to make a 'best interest' decision, including other healthcare professionals and relatives of the person. For example, we found in one care record details of a person lacking capacity to make decisions and being at risk of falling out of bed. A 'best interest' decision was made to fit bed rails to the person's bed to maintain their safety during the night in the least restrictive way possible. This demonstrated the home involved relevant others when assessing and monitoring people's capacity to ensure restraint was not used inappropriately.

We checked how people were supported to have sufficient to eat, drink and maintain a balanced diet. We saw food available at the home contained good nutritional value, with vegetables available at each meal. We also saw there was a choice available for everyone at the home. People we spoke with told us that, if there was nothing on the menu that they wished to eat, they were able to request something else and this would be provided.

We looked in care records to see if people were supported to maintain a well-balanced diet, particularly for people who had complex needs. We found care records contained details of people's food and fluid intake and information was available for staff to read, should the person have any special dietary needs. For example, in one care record we looked at, we saw the person had diabetes. Information was provided in this care record stating that this person was a 'diet controlled diabetic' and a Malnutrition Universal Screening Tool (MUST) was completed on a monthly basis to continually assess the person's risk of becoming malnourished and/or dehydrated.

We also saw another care record that contained details about the person having difficulties swallowing and were at risk of choking, with information for staff on how to ensure

Good

Is the service effective?

this person was supported safely and adequately. This file also contained details regarding the involvement of the Speech and Language Therapy (SALT) team and Multi-Disciplinary Team (MDT) to assist with this persons eating and drinking needs.

In all care records looked at, we found a record was kept and reviewed on a monthly basis of people's weight and Body Mass Index (BMI). This demonstrated the home ensured information was available so people received a suitable diet and had the risks of becoming nutritionally compromised reduced.

During our inspection, we tried a sample of the food available at the home and found it to be served at an adequate temperature. People were not rushed and appeared to enjoy mealtimes.

Care records we looked at contained details regarding the involvement of other healthcare professionals to assist in meeting people's needs. We found in all care records a document with information about GP visits made to the person and another with information about visits to people from the Multi-Disciplinary Team (MDT). This demonstrated the service referred people to relevant health services to ensure their care and support needs were met when their needs changed.

Good

Is the service caring?

Our findings

We spoke with people about the staff members who worked at the home. Everyone we spoke with told us staff treated them with kindness and compassion. One person told us; "The [care staff] are great. They're marvellous." Another person told us; "[Care staff] definitely look after you. They do a great job." One relative we spoke with told us; "Care at this home is very caring. It's about the person and not just the job." Another relative told us; "The staff are great. Sometimes they are really busy so I help out but they are really very nice."

We asked people if they felt they were listened to by staff and if they knew how to complain. Everyone we spoke with told us they were respected and anything they had to say was listened to and acted upon. One person told us; "I know how to complain but have never had any real need. If there's something I want, [care staff] sort it before I have to complain." Another person told us; "I've never complained but I do attend the monthly residents meeting. If I had a complaint, I'd raise it there."

People said they were able to go out and were not restricted to staying in the home all time. One relative told us; "There's one team leader in particular who sets a very high standard and they make sure all the residents are treated with dignity and care." This relative also told us; "I had to go into hospital after I broke my hip and a care assistant brought [relative] to the hospital to visit me. It made me feel better and definitely made [relative] feel better and reassured."

During our inspection, we carried out observations of interactions between staff and people who used the service. We saw people were treated with dignity, respect, kindness and compassion by staff who clearly knew them well. We saw people's needs were met in a caring way, which respected their views and preferences. For example, we saw one person required assistance to use the toilet. We read this persons care record and found that they preferred to have a female care assistant support them. When the person asked for assistance with the toilet, a female care assistant made herself available to assist with this. This meant the service ensured people's needs were understood and respected and that people felt they mattered and were listened to.

We spoke with staff at the home about the people they cared for and supported. Staff members were able to tell us information about people who lived at the home, including their likes and dislikes. We saw information in care records that detailed people's life histories, preferences, likes and dislikes. However, we found this information to be lacking in detail. We spoke with the managing director and registered manager about this, who told us they would seek to include more information in care records as part of care record reviews.

We looked in care records to see if people were involved in making decisions and planning their own care. We saw people and their relatives had been involved in care planning, which included their preferences regarding how they would like to receive their care. For example, one care record we looked in contained a preference sheet for medicines. This document stated; "[Person] prefers that a nurse gives tablets with a spoon and takes her medication slowly." We observed the nurse administering medicines to this person and saw that this preference was respected. This demonstrated people were listened to and had their choices and preferences respected.

In all care records we looked at, we saw care plans were signed by the person who lived at the home and/or their relatives to demonstrate their involvement and agreement.

We asked the registered manager about advocacy services that were available at the home, and if any information was given to people who lived at the home. An advocate is a person that speaks on behalf of someone, when they don't have the ability or capacity to do so for themselves. The registered manager told us no information was given to individuals at the home as a matter of routine but that posters and leaflets were available and present on notice boards. We looked at notice boards throughout the home and saw information on advocacy services was present.

We carried out observations to see if people were given privacy and respect when receiving care and support. We saw care staff knocked on people's bedroom doors before entering and closed bedroom doors when providing personal care.

We also looked in care records to see how privacy and dignity was promoted and maintained through care planning. We saw information relating to the maintenance of privacy and dignity. For example, in one care record we looked at, we read; "Staff to give [person] choices and

Good

Is the service caring?

respect her decisions. Knock on the door and ensure the curtains and door is closed." We also saw another document in this care record that asked if the person had a preference of the gender of care staff that provided them with personal care. We saw this record stated the person preferred a female care assistant and found that daily notes demonstrated that only a female care assistant had carried out these tasks. This demonstrated the service respected, promoted and maintained people's privacy, dignity and choices.

We spoke with relatives and asked them if they were able to visit the home at a time that was convenient for themselves. All relatives we spoke with confirmed they were able to visit the home and their relatives at any time, with no restrictions.

Care records detailed information about how the body of a person who had passed away was to be cared for in a culturally sensitive and dignified manner, and in line with the persons own choices. For example, in one care record we looked at, we found details that the person had expressed wishes to be cremated when they had died. This demonstrated the home sought information about people's wishes after they had died, as well as whilst receiving care and support at the home.

Good

Is the service responsive?

Our findings

We asked people if they were aware of the complaints procedure and how to complain, if they felt the need to do so. Everyone we spoke with told us they knew how to complain and who to complain to. One person told us; "I know how to complain, I'm good at complaining! I'd just tell [care staff] if I had a problem. We can get in touch with the [managing director] too if we want to." We saw information on a notice board at the home, which had information on how to contact the managing director, should they wish to speak to them.

We looked in care records to see how people or, where appropriate, those acting on their behalf contributed to the assessment and planning of their care as much as they were able to. We found people and their relatives had contributed to care planning, and had signed to say they agreed with care plans. We looked on the notice board at the home and saw a leaflet titled "Care reviews". This document detailed the importance of relative's involvement in care and support planning and contained information under the sub-headings; "Benefits for you", "Benefits for our service and staff" and "Benefits for the individual". Information was also present on how to get more involved. This demonstrated the home encouraged people to be involved in the care and support planning of their loved ones.

We saw in care records people had been asked for their input regarding their levels of independence and what they felt comfortable in doing for themselves. We also found personalised information had been added into care records. For example, one care record we looked in contained information about the persons communication needs and stated that the person wore glasses, could hear well and could understand spoken word. This demonstrated the home took into account people's independence levels and what they were able, and unable, to do for themselves.

We looked in care records to see how people were involved in social activities to improve social interaction and avoid isolation. We found an activity record in each file contained details of what the person had done throughout the day. However, we found information on these documents demonstrated that people did not often take part in activities at the home. For example, on one record, we saw that, over a three month period, the person had "spent the day in the lounge" in excess of 50 days. We found this was consistent in all care records looked at. This meant people who lived at the home were not always encouraged to take part in social activities.

We spoke with people about activities at the home. People told us they did not take part in many activities but that there was always someone to talk to. One person told us; "I don't do many activities, as such, but I have a lot of people here who I am friends with and we always chat." Another person told us; "I have made an Easter bonnet and there are things like bingo and concerts for us." Other people we spoke with also told us they had formed good relationships with others who lived at the home. This demonstrated that, although people were not encouraged to take part in many activities, people did avoid social isolation through conversations and interactions with other people who lived at the home.

We looked at the activities board at the home and found there were details of activities that were available, as well as leaflets and posters about services in the wider community. We also visited the 'sister home', which was adjacent to Wood Hill Grange, where a range of facilities were available, including a coffee shop and a hydro-pool. We spoke with the registered manager and managing director about activities at the home, who both told us people visited the 'sister home' to partake in activities, although information in care records did not reflect this.

We looked in care records to see how people had their individual needs assessed, recorded and reviewed. We saw details of people's needs and wants were included in care records, which were all reviewed on a monthly basis, with the involvement of people and/or their relatives. We also saw this included reviews of people's preferences regarding their care and support and who provided this.

We looked at the way the service encouraged feedback at the home. We saw that monthly 'managers surgeries' were held at the home, where people and their relatives were able to book a meeting with the manager to discuss anything they wished to. We also saw that a monthly 'engagement and involvement' meeting was held at the home for anyone to attend. We spoke with people who lived at the home about these meetings, some of whom attended them. One person told us; "I attend the monthly residents meetings. It's a good place to say what you want and if there's anything you want changing like menu's or something." We also spoke with the registered manager

Good

Is the service responsive?

about how they encouraged complaints, compliments and feedback at the home. The registered manager told us they maintained an 'open door' policy, where people were able to speak with them when they wished. The registered manager also told us they ensured management was visible throughout the home via the clinical lead and other senior members of care staff.

We looked at the complaints file to see how complaints were addressed, explored and resolved. We found there were two complaints in the complaints log – one pertaining to menus and one regarding care at the home. We saw that the registered manager had conducted investigations and fed back to the complainant within 28 days of first receiving the complaint. This demonstrated complaints were explored and responded to in good time.

Good

Is the service well-led?

Our findings

We spoke with people who lived at the home and asked if they were able to speak with the manager. Everyone we spoke with told us they knew who the manager was and that, if they had an issue, they would feel able to speak to them. Most people also told us they would speak to the clinical lead or a senior member of the care staff team before speaking with the manager.

People we spoke with told us they felt they were involved in their care and treated equally, compared to other people who lived at the home. People told us they felt the home was a good place to live, with kind and compassionate care. One person told us; "I love it here." Another person told us; "They look after you really well here." One relative we spoke with told us; "Since my [relative] has lived here, she's been very well looked after. She is much better in herself."

It is a condition of registration with the Care Quality Commission (CQC) that the service have a registered manager in place at the home. The person who managed the day to day running of the service was registered with Care Quality Commission (CQC) as the registered manager and was present on both days of our inspection.

We looked at the minutes of monthly staff meetings that had taken place at the home to see how staff were actively involved in developing the service. We saw items on the agenda included; rota management, service objectives, conduct, accountability and responsibilities. Discussions held during these meetings included how the service could be improved, what worked well and what needed to be changed. We saw any actions from these meetings were recorded, target dates were set and the person/people responsible for meeting the action were identified.

We asked the registered manager how they ensured there was an emphasis on support, fairness, transparency and an open culture at the home. The registered manager told us they ensured there was a clear structure of management, with keyworkers in place for each person using the service. They told us staff were encouraged to make decisions to improve their confidence and ensured that no staff member was managing more than eight people at one time. We asked how they ensured communication was accessible. The registered manager told us there was an open email account available on each floor of the home for staff to use, should they wish to do so.

We asked to look at the statement of purpose for the service. We found the statement of purpose contained details of a clear vision for the home, including compassion, dignity, involvement, independence, respect, equality and safety. When we spoke with staff, it was clear they were aware of the vision of the home and how they contributed to ensuring this was met.

We spoke with the registered manager about the day-to-day culture of the service and asked how they kept this under review. The registered manager told us they conducted informal daily walk arounds of the service, where staff and people using the service were able to speak with them. The registered manager also told us they ensured this was monitored through the staffing/ management structure at the home, where any issues or concerns were reported up so they could be addressed. This meant the day-to-day culture of the service was monitored by senior and management staff, who were visible at all levels throughout the home.

We looked at staff supervision records to see if feedback was given from managers in a constructive and motivating way. We found that, during supervisions, feedback was provided, explaining to staff members any action they needed to take. We spoke with staff about supervisions at the home and the management support they received. All staff we spoke with told us they felt supported by management.

We looked at audits carried out at the home. We saw audits included; annual fire extinguisher audits, annual catering audits and annual emergency lighting tests/audits. We also saw evidence that all kitchen equipment had been checked for safety when it had been installed. This meant health and safety audits at the home were completed on an annual basis to ensure the safety of people who lived at the home.

We saw a monthly audit was completed by a member of the senior management team within the organisation that included; standard checks; safety, availability and suitability of equipment; service user comments; staff comments; premises; and any other comments. Action that had been identified through these audits were recorded.

Good

Is the service well-led?

We saw audits that had been carried out by the registered manager. We found pressure ulcer evaluations were carried out (at least) monthly, which identified the number of people with pressure areas, treatments, actions, other involvement, equipment and the condition of the pressure area. Other audits completed by the registered manager included; monthly infection control audits and monthly weight loss monitoring audits.

An unannounced service inspection was conducted at the home by a member of the management team four times per year. During this inspection carried out by the provider, observations were carried out of staff interactions with people and checks were made of documentation held in people's care records. We saw any actions identified had been recorded on an action plan.

A recurring theme we found with action plans that had been developed by the service was that, when actions had been completed, they had not been signed off to state this. We spoke with the registered manager and managing director about this, who told us they would ensure all action plans were signed off in future, when actions had been completed.

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	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— Where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; The proper and safe management of medicines.