

SheffCare Limited

Housteads

Inspection report

1 Richmond Park Grove
Handsworth
Sheffield
South Yorkshire
S13 8HX

Tel: 01142692469
Website: www.sheffcare.co.uk

Date of inspection visit:
23 May 2017

Date of publication:
19 June 2017

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?	Requires Improvement ●

Summary of findings

Overall summary

Housteads is registered to provide accommodation and personal care for up to 40 older people, some of whom are living with dementia. The home is situated in the Richmond area of Sheffield, close to local amenities and transport links. Accommodation is based on the ground floor. All of the bedrooms are single and communal lounges and dining rooms are provided. The home has a secure enclosed garden and car park.

There was a manager at the service who had been in post since December 2016 as acting manager. The manager took up the permanent manager role on 1 April 2017. The manager had applied to register with 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 and associated Regulations about how the service is run.

Our last inspection at Housteads took place on 26 May 2015. We found a breach in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regard to regulation 18; Staffing. The registered provider sent an action plan detailing how they were going to make improvements. At this inspection we checked improvements the registered provider had made. We found sufficient improvements had been made to meet the requirements of Regulation 18: Staffing, as staff had been provided with supervisions and appraisals at the frequency set out in the registered provider's policy.

This inspection took place on 23 May 2017 and was unannounced. This meant the people who lived at Housteads and the staff who worked there did not know we were coming. On the day of our inspection there were 39 people living at Housteads.

People spoken with were very positive about their experience of living at Housteads. They told us they were happy, felt safe and were respected.

We found systems were in place to make sure people received their medicines safely so their health was looked after. PRN (as and when needed) medicine protocols were in place to ensure staff knew when PRN medicine was required. One person's PRN protocol could not be located and was forwarded to us during the evening of this inspection.

Staff recruitment procedures ensured people's safety was promoted.

Sufficient numbers of staff were provided to meet people's needs.

Staff were provided with relevant training so they had the skills they needed to undertake their role. Some staff had a basic understanding of the Mental Capacity Act and would benefit from further training to enhance their skills and knowledge in this area.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the registered provider's policies and systems supported this practice.

People had access to a range of health care professionals to help maintain their health. A varied diet was provided, which took into account dietary needs and preferences so people's health was promoted and choices could be respected.

Staff knew people well and positive, caring relationships had been developed. People were encouraged to express their views and they were involved in decisions about their care. People's privacy and dignity was respected and promoted. Staff understood how to support people in a sensitive way.

A programme of activities was in place so people were provided with a range of leisure opportunities.

People said they could speak with staff if they had any worries or concerns and they would be listened to.

There were systems in place to monitor and improve the quality of the service provided. Regular checks and audits were undertaken to make sure full and safe procedures were adhered to. The efficiency of the quality assurance monitoring systems would be further improved by including the fire risk assessment action plan so this can be closely monitored to make sure recommended actions are undertaken and recorded.

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 were aware of their responsibilities in keeping people safe. People told us they felt safe. People were content and happy to be with staff.

Medicines were stored securely. Appropriate arrangements were in place for the safe administration and disposal of medicines.

The staff recruitment procedures in operation promoted people's safety.

Staffing levels were adequate to meet the needs of people who used the service.

Is the service effective?

Good ●

The service was effective.

Staff had been provided with relevant training to make sure they had the right skills and knowledge for their role and supervision and appraisal for development and support.

People were provided with a balanced diet and had access to a range of healthcare professionals to maintain their health.

Staff understood the requirements of the Mental Capacity Act (MCA) and considered people's best interests. Some staff had a basic understanding and would benefit from refresher training.

A refurbishment plan was in place which had identified replacing the carpet in the entrance to improve the appearance of the home.

Is the service caring?

Good ●

The service was caring.

Staff respected people's privacy and dignity and knew people's preferences well.

People living at the home, and their relatives, said staff were very caring in their approach.

Is the service responsive?

Good ●

The service was responsive.

People's care plans contained a range of information and had been reviewed to keep them up to date.

Staff understood people's preferences and support needs.

People living at the home, and their relatives, were confident in reporting concerns to the manager and felt they would be listened to.

Is the service well-led?

Requires Improvement ●

The service required improvement to be well led.

There were quality assurance and audit processes in place to make sure the home was running safely. However, The efficiency of the quality assurance monitoring systems would be further improved by including the fire risk assessment action plan so this can be closely monitored to make sure recommended actions are undertaken and recorded.

The manager had applied to register with CQC.

Staff told us the manager was supportive and communication was good within the home. Staff meetings were held.

The service had a range of policies and procedures available for staff so they had access to important information.

Housteads

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 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 23 May 2017 and was unannounced. The inspection team consisted of three adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of older people and dementia care.

Before our inspection, we reviewed the information we held about the home. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned as requested.

We contacted Sheffield local authority, Sheffield Clinical Commissioning Group (CCG) and Healthwatch (Sheffield). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During our inspection we spoke with 11 people living at the home and five of their relatives or friends to obtain their views of the support provided. We spoke with ten members of staff, which included the quality manager, the manager, the deputy manager, a team leader, three care workers, the activity coordinator, the head cook, a cook and a housekeeper.

We spent time observing daily life in the home including the care and support being offered to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, which included four people's care records, eight staff records and other records relating to the management of the home, such as training records and quality assurance audits and reports.

Is the service safe?

Our findings

People told us they felt safe living at Housteads and commented, "I have never seen anything, no abuse like you hear about" and "I am very safe here." We observed people we were not able to fully communicate with were happy in the company of staff and freely approached them. This showed people were relaxed in the company of staff.

Relatives of people living at Housteads told us they felt their family member was safe and commented, "I am extremely happy. I am glad we got [name of relative] in here," "Yes, [my relative] feels safe, so I do too" and "[Name of relative] is safe. They definitely can't get out and get hurt."

Staff confirmed they had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm. Staff were clear of the actions they would take if they suspected abuse, or if an allegation was made so correct procedures were followed to uphold people's safety. Staff knew about whistle blowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice. Staff said they would always report any concerns to the manager and they felt confident they would listen to them, take them seriously and take appropriate action to help keep people safe.

All of the staff asked said they would be happy for a relative or friend to live at the home and felt they would be safe.

We saw a policy on safeguarding vulnerable adults was available so staff had access to important information to help keep people safe and take appropriate action if concerns about a person's safety had been identified. Staff knew these policies and procedures were available to them. The staff training records checked verified staff had been provided with relevant safeguarding training.

The service had a policy and procedure in relation to supporting people who used the service with their personal finances. The service managed money for some people. We saw the financial records were kept electronically. They showed all transactions and detailed any money paid into or out of their account. We checked the financial records against the receipts held for three people and found they were fully completed and corresponded to the electronic record. Staff spoken with could describe the actions to take when handling people's money so safe procedures were adhered to and to help protect people from financial abuse.

We asked people about the help they got with their medicines and they told us they were happy with the support they, or their relative, received. Comments included, "[Name of relative] gets the right pills at the right times," "They [staff] give me medicines as and when I need them," "Yes, I get the right ones at the correct times" and "I get the right ones but sometimes I get my pill at night ten minutes early."

We checked to see if medicines were being safely administered, stored and disposed of. We found there was

a medicine's policy in place for the safe storage, administration and disposal of medicines so staff had access to important information.

We saw regular audits of people's Medication administration records (MAR) were undertaken to look for gaps or errors and to make sure safe procedures had been followed. We saw records of monthly medicines audits which had been undertaken to make sure full and safe procedures had been adhered to. We found the pharmacist had audited the medicines systems on 16 February 2017. The report from this visit showed no urgent concerns had been identified.

We checked a three people's MAR and found they had been fully completed. The medicines kept corresponded with the details on MAR charts. Medicines were stored securely. At the time of this inspection some people were prescribed Controlled Drugs (CD's) (medicines that require extra checks and special storage arrangements because of their potential for misuse). We found a CD register and appropriate storage was in place. CD administration had been signed for by two staff and the number of drugs held tallied with the record in the three CD records checked. This showed safe procedures had been adhered to.

Some people were prescribed medicine on a PRN (as and when required) basis. We checked the care plan of one person prescribed PRN medication. The plan contained a section on medication which held some detail of the PRN medicine and when this should be administered. In addition, the care record held a behavioural charts log which described any challenging behaviours displayed and the staff actions to reduce agitation and calm the person. On some occasions PRN medicine had been administered and this was also recorded. Two staff spoken with were clear the person had PRN medicine, and when this should be administered. We found PRN protocols were kept with MAR so staff had clear information about when PRN medicine should be administered. However, we found no protocol was in place for the person identified. The manager rectified this and sent us a copy on the evening of our inspection to evidence this had taken place. In addition, the manager sent us a copy of the persons care plan to show it had been updated to include information relating to PRN protocols.

Training records showed day staff that administered medicines had been provided with training to make sure they knew the safe procedures to follow. Staff could describe these procedures and told us they were observed administering medicines to check their competency.

All non PRN prescribed medicines were administered by day staff. We identified some night staff were not fully trained to administer medicines, but had undertaken Paracetamol administration training from Sheffield Clinical Commissioning Group (CCG). We discussed medicines administration training for night staff with the manager and quality manager. We found seven of the eight night staff were trained to administer Paracetamol for PRN pain relief. Two staff had completed the full medicines administration training and a further four staff were booked to attend the training. The registered provider had an on call system and staff could attend the home to administer pain relief if needed. No call outs had been needed since the manager had been in post. We checked the rota for the three weeks following this inspection and found trained staff were on duty. The manager gave assurances that Paracetamol trained staff would always be available at night so people would not have to wait for pain relief. The quality manager said they would discuss night staff contracts with the registered provider's human resources department to explore medicines training being included in night staff contracts. We acknowledge the registered provider had previously reviewed staff contracts to ensure Paracetamol training was a condition of employment for all new night staff.

People living at the home, or their relatives spoken with generally thought there was enough staff to meet their [or their relative's] needs. Comments included, "There are enough staff. They are very nice," "They

could do with more [staff]. They are always so busy," "The levels are manageable but they could do with more [staff]," "Maybe there are less at the weekends but it's not a problem," "There are enough staff to look after [name of relative]" and "There always seem to be enough." No one spoken with said they had been impacted by a shortage of staff.

We looked at staffing levels to check enough staff were provided to meet people's needs. We found one or two team leaders and four or five care staff were provided each day. One carer would be based on each corridor and the fourth carer would 'float' between the three corridors to assist where needed. Staff told us there were enough staff provided, but it was 'tight' and the floating staff was always needed. Three staff were provided overnight. Staff spoken with confirmed these numbers were maintained. We looked at the staffing rota for the two weeks prior to this inspection and found these identified staffing levels had been maintained. On the day of the inspection the 'float' care worker had phoned in sick so the team leaders were working between corridors. We observed staff were visible around the home and responded to people's needs as required.

We looked at the procedures for recruiting staff. Staff recruitment records were held electronically. We checked six staff records and all contained the documents required by regulation. Each contained an application form detailing employment history, references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. The staff spoken with confirmed they had provided references, attended an interview and had a DBS check completed prior to employment. This showed recruitment procedures in the home helped to keep people safe.

We looked at four people's care plans and saw each plan contained risk assessments which identified the risk and the actions required of staff to minimise and mitigate the risk. The risk assessments seen covered all aspects of a person's activity and were individual to reflect the person's needs. We found risk assessments had been regularly reviewed and updated as needed to make sure they were relevant to the individual and promoted their safety and independence.

Regular checks of the building were carried out to keep people safe and the home well maintained. We found a fire risk assessment, dated 8 September 2016, had been undertaken to identify and mitigate any risks in relation to fire. A fire risk assessment action plan had been undertaken but this had not been kept up to date to reflect work that had been undertaken or planned. This is fully reported on in the well led section of this report.

We found a policy and procedures were in place for infection control. Training records seen showed all staff were provided with training in infection control. We saw monthly infection control audits were undertaken which showed any issues were identified and acted upon. One domestic staff spoken with said they always had enough equipment to do their jobs and had clear schedules and routines to make sure all areas of the home were kept clean. This showed procedures were followed to control infection. We found the home was generally clean. However, the carpet in the entrance area was old and marked. This did not create a good first impression. The quality assurance reports checked showed this had been identified and was being replaced. One person told us, "It's great, they are always cleaning and sprucing. The bedroom is always spotless."

Is the service effective?

Our findings

We checked progress the registered provider had made following our inspection on 26 May 2015 when we found a breach in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regard to regulation 18; Staffing. The registered provider sent an action plan detailing how they were going to make improvements. At this inspection we found sufficient improvements had been made to meet the regulation.

At our last inspection we identified staff were not receiving regular supervision and appraisal for development and support and we issued a requirement notice in relation to this. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles.

We looked at the supervision matrix for all staff. This showed care staff had been provided with supervision at regular frequency and an annual appraisal. Staff spoken with confirmed they were provided with regular supervision meetings.

People we spoke with told us they thought the care staff were well trained and performed their jobs well. We checked the staff training matrix which showed staff were provided with relevant training so they had appropriate skills. Staff spoken with said they undertook induction and refresher training to maintain and update their skills and knowledge. Mandatory training such as moving and handling, first aid, medicines and safeguarding was provided. The matrix showed training in specific subjects to provide staff with further relevant skills were also undertaken, for example, training on dementia awareness. This meant all staff had appropriate skills and knowledge to support people. Some staff said they would prefer different learning opportunities as the majority of the training was undertaken electronically. This method of training does not suit all learning styles.

We found new staff were completing the Care Certificate as part of their learning and development. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. It is based on 15 standards, all of which individuals need to complete in full before they can be awarded their certificate.

We asked people living at the home and their relatives about support with healthcare. People living at the home said their health was looked after and they were provided with the support they needed. The relatives spoken with had no concerns regarding the health care support provided to their family member. Comments included, "They [staff] would sort it out [(Health Care)]," "The optician has just been in and they [staff] would get the doctor in," "The doctor is brilliant, attends straight away" and "They [staff] keep an eye on their weight."

The care records showed people were provided with support from a range of health professionals to maintain their health. These included district nurses, GPs, psychiatrists, and dentists. People's weights were regularly monitored so any weight and health issues were identified quickly.

We found a varied and nutritious diet was provided to support people's health and respect their preferences. Staff were aware of people's dietary needs and preferences so these could be respected. We saw people were regularly offered drinks and snacks. Staff told us and records seen verified food was always discussed at 'residents meetings' so people could share their opinion.

People told us the food was good and they enjoyed the meals. Comments on the food included, "I would prefer to be at home but I am comfortable and well fed," "There is good choice and plenty to eat," "I am quite happy, you are given a choice. The portions are good," "It's very good, so good I've put some weight on," "I have had a meal here and tasted a few puddings, quite nice, good portions. They generally have fruit, grapes and things" and "For me the snacks are adequate. I only have to ask."

People said they could always have an alternative to the menu if they preferred. We observed part of the mid-day meal on all three corridors. The dining tables were neatly set out and looked welcoming. Tables were laid with table cloths, cutlery, condiments and glasses. The care staff took time to support people and were patient when serving meals. The food was well presented and there was a wide range of choices for people.

We spoke with the cook who was knowledgeable about people's individual needs and likes and dislikes. They had copies of people's diet and nutrition assessments so individuals likes, dislikes and needs could be catered for.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with understood the principles of the MCA and DoLS. Staff also confirmed they had been provided with training in MCA and DoLS. This meant staff had relevant knowledge of procedures to follow in line with legislation. However, some staff spoken with only had a basic understanding would benefit from refresher training to underpin their knowledge.

There were clear records kept of DoLS authorisations and the care plans seen showed evidence of capacity assessments and decisions being made in the person's best interests. For example, one person's plan held evidence of a best interest meeting to agree the decision to provide 24 hour care.

We looked at four people's care plans and found care was provided to people with their consent. The care plans seen held people's signatures, where people had been able to sign, to evidence they had been consulted and had agreed to their plan. Where people had been unable to sign, the plans had been signed

by the person's representative. Consent to care and treatment, medicines and photography were included in the files seen. This showed important information had been shared with people and their advocates and they had been involved in making choices and decisions about their care. One person told us, "They [staff] explain and ask for consent."

We found the home was designed and adapted to meet the needs of people using the service. Accommodation was provided over the ground floor, separated into three 'corridors'. One corridor accommodated people who were living with dementia. People were free to wander freely in this area and clear signage and pictures helped to identify the different areas. The home had an enclosed garden provided with a variety of seating that people could enjoy. We found a refurbishment plan was in place which had identified replacing the marked entrance carpet to improve the appearance of the home.

Is the service caring?

Our findings

People living at Housteads and their relatives all made positive comments about the home. People told us they were happy and well cared for by staff that knew them well. They said staff, including the manager, were good at listening to them and meeting their needs. Relatives said they were always welcomed in a caring and friendly manner. Their comments included, "The staff are lovely, kind, caring and compassionate," "All of them [staff] have been very nice and patient," "Girls [staff] who come to me have a chat, they are all very good," "They [staff] treat me with respect look after my dignity," "They [staff] respect my privacy," "Very good, friendly, amenable, kind and courteous," "The staff know [name of relative] well," "They [staff] support [family member] to be independent. They are doing more here than they were before" and "They [staff] know us as people."

People told us they were involved and consulted about their [or their relative's] care. Comments included, "I am involved in my care plan" and "I am involved in [name of relative's] care."

Staff told us they enjoyed working at the home and said the staff worked well together as a team.

During our inspection we spent time observing interactions between staff and people living at the home. Staff had built positive relationships with people and they demonstrated care in the way they communicated with and supported people. We saw in all cases people were cared for by staff that were kind, patient and respectful. We saw staff acknowledge people when they entered a communal room. Staff shared conversation with people and were attentive and mindful of people's well-being. People were always addressed by their names and care staff knew them well. People were relaxed in the company of staff. This showed people were treated respectfully.

We saw staff discussed people's choices with them and obtained people's consent so they agreed to what was being asked. For example, staff asked people's permission to enter their rooms. We saw people were able to choose where they spent their time, for example, in their bedroom or the communal areas. People were able to bring personal items with them and we saw people had personalised their bedrooms according to their individual choice. People were invited to attend 'residents' meetings', where any concerns could be raised, and suggestions were welcomed about how to improve the service. This also showed people were treated respectfully.

We did not see or hear staff discussing any personal information openly or compromising privacy. Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information needed to be passed on about people was passed on discreetly, at staff handovers or put in each individual's care notes. This helped to ensure only people who had a need to know were aware of people's personal information.

Staff told us the topics of privacy and dignity were discussed at training events and they were able to describe how they promoted people's dignity. Staff told us they treated people how they would want to be treated. We saw staff interacting respectfully with people and all support with personal care took place in private. This showed people's privacy and dignity was promoted and respected.

The care plans seen contained information about the person's preferred name and how people would like their care and support to be delivered. This showed important information was available so staff could act on this and provide support in the way people wished. The staff asked said they would be happy for a relative or friend to live at the home and felt they would be safe.

Staff spoken with said they had been provided with training on end of life care so they had the skills and knowledge to care for people when this support was needed. One relative told us, "We discussed end of life, it was very hard." Another person confirmed, "End of life has been discussed."

Is the service responsive?

Our findings

People living at Housteads, and their relatives said staff responded to their [relative's] needs and knew them well. They told us they, or their relative, chose where and how to spend their time and how they wanted their care and support to be provided. People also told us they could talk to staff if they had any concerns or complaints. Their comments included, "They [staff] know us as people," "They [staff] know if you prefer to have your door open," "They [staff] know what you like and chat to see if things are alright," "I can choose what I want to do," "I have no complaints but if I did I would just say it," "I haven't wanted to complain" and "We only grumble to each other, I have never made a real complaint."

All of the people spoken with, or their relatives, said they were happy with the activities provided and they [or their relative] were free to choose to join in or not, depending on their preference. Comments included, "I can do different things to other people if I want," "The activities are good," "There is enough going on for me" and "Good activities, there is something going on every day."

We found an activity worker was employed for 24 hours each week to ensure there was a range of meaningful activities on offer. The manager told us a further 11 hour activity worker post was being advertised so more leisure opportunities could be provided to people. We spoke with the activities worker. They showed they were highly committed to the activities being enjoyable and beneficial. People told us and records showed a range of activities were provided. Records showed recent activities included visiting entertainers, singing, reminiscence and exercise classes. On the day of our inspection we saw people enjoyed participating in a game of bowls in the morning and 'chairobics' in the afternoon. Both activities were well attended. The manager told us the home was involved with a falls project with Sheffield International Venues (SIV) and Sheffield University. Research had shown the eight week exercise to music project had reduced falls. In addition, the home had participated in Sheffield University 'In Life' dementia studies project which used technology to support reminiscence. The manager told us these events had been very successful. The manager also said they had worked with SIV so activity workers within the organisation were accredited to run exercise to music activities.

We were not able to fully communicate with some people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent 30 minutes observing care and interactions on the corridor which accommodated people living with dementia. People appeared content and staff interacted and spoke with them in a patient and caring manner.

Throughout our inspection we saw staff support people's choices. We heard staff asking people their choices and preferences, for example, asking people what they would like to drink, where they wanted to spend time and what they wanted to do.

Before accepting a placement for someone an assessment of the person's needs was carried out so the manager could be sure they could provide appropriate support. This assessment formed the basis of the initial care plan. The four records seen all contained an initial assessment that had been carried out prior to

admission. The assessments and care plans contained evidence people living at the home and their relatives had been asked for their opinions and had been involved in the assessment process to make sure people could share what was important to them.

People's care records included an individual care plan. The care plans seen contained details of people's identified needs and the actions required of staff to meet these needs. The plans contained some information on people's life history, preferences and interests so these could be supported. Health care contacts had been recorded in the plans and showed people had regular contact with relevant health care professionals. This showed people's support needs had been identified, along with the actions required of staff to meet identified needs.

The care plans seen had been signed by the person supported and/or their relative to evidence their involvement. Relatives told us they had been involved in their family member's care planning so their views could be taken into account.

Staff spoken with said people's care plans contained enough information for them to support people in the way they needed. Staff spoken with had a good knowledge of people's individual health and personal care needs and could clearly describe the history and preferences of the people they supported. This meant people were supported by staff that knew them.

The care plans checked identified any specific support that was needed to maintain health. The care plans contained details of the intervention from other healthcare professionals so the person was fully supported to maintain their health.

One person's file held information in one section which was limited and would benefit from further detail so staff were fully informed. We discussed this with the manager who updated the care plan during the evening on the day of our inspection. This showed a responsive approach.

There was a clear complaints procedure in place. The complaints procedure gave details of who people could speak with if they had any concerns and what to do if they were unhappy with the response. We saw people were provided with information on how to complain in the service user guide provided to them when they moved into Housteads. This showed people were provided with important information to promote their rights and choices. We saw a system was in place to respond to complaints. A complaints record was available to record action taken in response to a complaint and the outcome of the complaint.

All of the people living at the home and their relatives spoken with all said they could speak to staff if they had any worries.

Is the service well-led?

Our findings

The manager had worked for the registered provider for many years at other homes within the registered provider group. The manager had worked at Housteads as acting manager since December 2016, and permanent manager since 1 April 2017. The manager had applied to register with CQC.

The manager was visible and fully accessible on the day of our inspection. Throughout our inspection we saw the manager greet people by name and they obviously knew them well. We saw people living at the home; their relatives and staff freely approached the manager to speak with them. We found the atmosphere in the home was friendly and we saw positive interactions between people using the service, their family and staff.

People living at Housteads, their relatives and staff at the home spoke positively about the manager and deputy manager. People told us they knew the manager and deputy manager and found them approachable. People said they had confidence in the manager and deputy manager and they were encouraged to voice their opinion. People commented, "As far as I am concerned it is pretty good. The manager is doing a good job," "They would listen and change things, they are considerate" and "The manager is easy to talk to and will listen and act on your concerns. It is a friendly place. The atmosphere is generally happy. I would recommend it." One relative said, "We are not kept updated. We come in and find things have changed like new furniture."

We saw an inclusive culture in the home. All staff said they were part of a good team and could contribute and felt listened to. They told us they enjoyed their jobs. All of the staff asked said they would be happy for a friend or family member to live at the home.

We found a quality assurance policy was in place and saw audits were undertaken as part of the quality assurance process. We saw copies of a monthly report the manager completed, which in turn informed the monthly quality report that the quality officer undertook. We found both of these reports had been fully completed each month and identified areas for action. For example, the quality assurance report had identified and planned for the carpet in the entrance hall to be replaced as it was showing signs of age.

We saw monthly checks and audits had been undertaken by the manager and senior staff at the home. Those seen included care plan, medication, health and safety and infection control audits. A 'daily walk around' was undertaken by the manager or senior staff each day to check systems were in place and the home was safe.

During our inspection we identified the fire risk assessment action plan had not been updated to accurately reflect some recommendations had been acted upon or were planned to take place. For example, it was recommended intumescent strips were replaced on bathroom doors and some storage doors. The fire action plan did not state work had commenced on this within the registered provider group and would be undertaken at Housteads by 1 June 2017. Following this inspection the manager contacted us to confirm work had commenced on 26 May 2017. It was recommended magnetic doors were reviewed. The risk

assessment did not state these had been checked and were in working order. In addition, the manager sent us a copy of a risk assessment completed to evidence specific blinds identified within the fire risk assessment action plan were in place for security. Also, the manager sent us photographs of the fire assembly point notice and a self closing device fitted to the managers office door during the week of this inspection to show these had been provided as identified on the fire risk assessment action plan. The quality assurance systems would be more efficient and thorough if monthly visits could include the fire risk assessment action plan to make sure it remained up to date.

We saw records of accidents and incidents were maintained and these were analysed to identify any ongoing risks or patterns. Where an increase or pattern in falls had been identified, we saw records to show relevant consultations and referrals had taken place with health care professionals to support and improve the person's well-being.

People who used the service, relatives and healthcare professionals were asked for their views about their care and support and these were acted on. We saw surveys had been sent to people living at the home during August to October 2016. The returned surveys had been audited and a report and action plan dated April 2017 had been written so people had access to important information. We found surveys had been sent to relevant professionals in June 2016 and the responses were all positive. We found staff surveys had been sent to staff and the report of the results from the survey was dated January 2017.

Staff spoken with said some staff meetings and daily handovers took place so important information could be shared. Records showed corridor meetings had taken place but the corridor accommodating people living with dementia held fewer meetings than other corridors. Staff told us the management had an 'open door' policy and were very approachable.

The manager told us 'residents meetings' were held and planned so people had further opportunities to share their views.

The home had policies and procedures in place which covered all aspects of the service. The policies and procedures seen had been updated and reviewed as necessary, for example, when legislation changed. This meant changes in current practices were reflected in the home's policies. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme. This meant staff could be kept fully up to date with current legislation and guidance.

The manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. The manager confirmed any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed this.