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Pollard House

Inspection Report

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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Summary of findings

Overall summary

Pollard House provides accommodation and personal care for up to 28 elderly people accommodated three floors. On the day of the inspection there were 23 people living at the home. The manager told us 11 people who lived at the home had a diagnosis of a dementia. The service had a registered manager in place. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.'

People told us they felt safe in the home and nobody raised any concerns with regards to their safety. We found procedures were in place to ensure people were protected from abuse and staff understood how to apply these procedures to keep people safe from abuse.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted. CQC monitored the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. We did not observe any restrictions of people's liberty. The manager had a good understanding of DoLS and was able to give us examples of where they had sought advice from the local authority DoLS team to ensure people's freedom was not restricted.

Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) and how to ensure the rights of people with limited mental capacity to make decisions were respected.

The medicine management system required improvement. Robust documentation was not in place which meant it could not be evidenced that people's medication had always been given. Some people had not received their medication on time which meant they may have experienced unnecessary pain. These problems we found breached Regulation 13 (Management of medicines); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two healthcare professionals who regularly visited the service told us they thought the service was effective in meeting people's needs. We found people's choices and preferences had been sought in the way they wanted their care to be delivered and staff were familiar with people's needs. Care plans contained information on people's assessed needs, preferences and choices; although some sections required more detail adding to ensure staff had the necessary information to ensure they delivered effective care.

People were given choices with regards to their daily lives, although the mealtime experience required improvement. People said there was not enough choice of foods and we observed one person's comments regarding the food were not listened to.

The service worked effectively with healthcare professionals and was pro-active in referring people for treatment and diagnosis. Staff were good at following advice given by health professionals to ensure effective care.

People and their relatives all remarked that the service and its staff were caring and said staff were kind and compassionate. This was confirmed by the caring interactions and positive relationships between staff and people who used the service which we observed on the day of the inspection.

People were able to express their views and opinions in regards to their care through various mechanisms including a confidential comments and suggestions box, regularly resident meetings and resident/relative care plan reviews. We saw evidence people's views had been recorded and action taken in response.

Regular reviews of people's care took place and changes were made when people's needs changed. Staff were aware of people's ongoing care needs to enable them to deliver responsive and appropriate care.

People who used the service and staff all praised the manager and said they would listen to their concerns. We found an open and honest culture within the organisation with the manager committed to further improvement of the service.

We found risks to people's health, safety and welfare were identified in three of the five people's care plans we

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looked at. However, two people's care plans were missing risk assessment documentation which meant the service had not assessed the measures needed to keep these people safe.

An incident management system was in place and there was analysis and clear lessons learnt in place for safeguarding incidents. However, accidents such as falls were not analysed for trends although this was something the manager showed us they were in the process of implementing. There was no documentation in place showing the learning from accidents to reduce the likelihood of future harm.

Improvements were required to the provider's audit systems as the problems we identified with medication were not identified through the medication audit system. Deficiencies in risk assessment documentation were also not identified by the providers internal audit systems.

The above problems we found breached Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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People told us they felt safe in the home and nobody raised any concerns with regards to their safety. We found procedures were in place to ensure people were protected from abuse and staff understood how to apply these procedures to keep people safe from abuse.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted. CQC monitored the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. We did not observe any restrictions of people's liberty. The manager had a good understanding of DoLS and was able to give us examples of where they had sought advice from the local authority DoLS team to ensure people's freedom was not restricted.

Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) and how to ensure the rights of people with limited mental capacity to make decisions were respected.

The medicine management system required improvement. Robust documentation was not in place which meant it could not be evidenced that people's medication had always been given. Some people had not received their medication on time which meant they may have experienced unnecessary pain. These problems we found breached Regulation 13 (Management of medicines); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two healthcare professionals who regularly visited the service told us they thought the service was effective in meeting people's needs. We found people's choices and preferences had been sought in the way they wanted their care to be delivered and staff were familiar

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with people's needs. Care plans contained information on people's assessed needs, preferences and choices; although some sections required more detail adding to ensure staff had the necessary information to ensure they delivered effective care.

People were given choices with regards to their daily lives, although the mealtime experience required improvement. People said there was not enough choice of foods and we observed one person's comments regarding the food were not listened to.

The service worked effectively with healthcare professionals and was pro-active in referring people for treatment and diagnosis. Staff were good at following advice given by health professionals to ensure effective care.

People and their relatives all remarked that the service and its staff were caring and said staff were kind and compassionate. This was confirmed by the caring interactions and positive relationships between staff and people who used the service which we observed on the day of the inspection.

People were able to express their views and opinions in regards to their care through various mechanisms including a confidential comments and suggestions box, regularly resident meetings and resident/relative care plan reviews. We saw evidence people's views had been recorded and action taken in response.

Regular reviews of people's care took place and changes were made when people's needs changed. Staff were aware of people's ongoing care needs to enable them to deliver responsive and appropriate care.

People who used the service and staff all praised the manager and said they would listen to their concerns. We found an open and honest culture within the organisation with the manager committed to further improvement of the service.

We found risks to people's health, safety and welfare were identified in three of the five people's care plans we looked at. However, two people's care plans were missing risk assessment documentation which meant the service had not assessed the measures needed to keep these people safe.

An incident management system was in place and there was analysis and clear lessons learnt in place for safeguarding incidents. However, accidents such as falls were not analysed for trends although this was something the manager showed us they were in the process of implementing. There was no documentation in place showing the learning from accidents to reduce the likelihood of future harm.

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Improvements were required to the provider's audit systems as the problems we identified with medication were not identified through the medication audit system. Deficiencies in risk assessment documentation were also not identified by the providers internal audit systems.

The above problems we found breached Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Are services effective?

People and their relatives told us that their needs and preferences were discussed on admission which ensured effective care was delivered. People said there was not enough choice of foods. Two health professionals who regularly visited the home told us that the home delivered effective care with one of them describing it as "Brilliant."

Staff understood people's preferences and needs were able to confidently tell us about the people they cared for, and how they ensured they provided personalised and effective care.

People's needs were assessed in a number of areas on admission and then reviewed regularly to ensure staff were provided with up-to-date information. Some sections of people's care records required more details such as mobility care plans to ensure enough information was present to enable staff to deliver effective care. Staff had received training in a number of areas such as moving and handling and dementia in order to meet people's assessed needs.

People were referred appropriately to healthcare professionals when health problems were identified such as weight loss. Advice from health professionals was recorded to ensure staff could follow their advice and deliver effective care. A healthcare professional told us the service was pro-active in referring people and seeking their advice.

The building had appropriate facilities to ensure people could comfortably live in the home, for example extensive lounge areas and appropriately sized rooms. Improvements were required to the design of the building to assist people living with dementia.

Are services caring?

People and their relatives all told us that staff were very kind and caring and we saw examples of this in the interactions we observed. Staff were seen to interact positively with people, displaying compassion. For example, one member of staff comforted a person

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who became upset using verbal and nonverbal communication techniques effectively and another provided companionship to someone who became withdrawn. We saw staff respected people's privacy, for example we observed them knocking on bedroom doors before entering.

We found the overall care experience was positive and found staff had developed close relationships with people understanding their needs and preferences. We found one area where the care experience could be improved. We observed there was a queue for the downstairs toilet and some people waiting to use it were left facing the walls with little interaction.

Staff we spoke with had a good understanding of how to ensure people's dignity was respected and were able to give us examples of how they ensured people's dignity was maintained. Staff understood people's diverse needs and the adaptions that the service made to ensure people were not discriminated against for having differing needs such as vegetarian or diabetic diets.

The service had recently introduced end of life books to enable people to be involved in planning for their end of life. Two people told us that the service had been sensitive when discussing deaths that had occurred in the home.

Are services responsive to people's needs?

People and the relatives told us their needs were met and the service was responsive to their needs. Two men told us they would prefer more activities for men as activities were female orientated. A programme of activities was in place, and the activities co-ordinator was able to tell us about how they were improving the activities to ensure they met all people's needs. All people said that they would feel able to speak to a member of staff if they had any concerns.

The home had recently begun involving people and their relatives in care plan reviews and we saw that several recent reviews had taken place with people's views clearly recorded. The manager was able to give us examples of how the service had responded to these views and made changes to the care delivered. People were also invited to express their views through regular resident meetings and the weekly manager clinic where the manager sat down with people on an informal basis.

Care plans were regularly reviewed by staff and there was evidence that regular changes were made to their care plans to ensure the service was responsive to people's needs. We saw evidence that mental capacity was considered in the communication section of care plans. This ensured staff had information on the level of support people needed in making decisions in relation to their care.

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Staff were aware of the people's needs we asked them about such as who was diabetic and what to do if they became ill. Staff were able to tell us about strategies the service had put in place to prevent people from falling, for example installing pressure mats in people's rooms.

Are services well-led?

Staff and people who used the all praised the management at the home and said they were visible and dealt with any concerns or complaints they had. Mechanisms were in place to allow staff, people or their relatives to confidentially raise concerns through the comments/suggestions box and we saw examples of how raised concerns had been effectively managed. We saw the manager was involved in day to day care tasks and regularly engaged with people who used the service asking them about their day. This showed us that they sought people's experiences in order to understand how well the service was doing. We found staff and management to be motivated to deliver the best quality care and were able to openly tell us about the improvements they wanted to see in the home.

People and their relatives were involved in the running of the service with their views sought through regular meetings and regular quality questionnaires. We saw examples of changes that had been made to the building and the activities on offer as a result of people's views.

We found although there were enough staff to meet people's needs there was no formal mechanism in place to determine safe staffing levels which meant that should people's needs change, it risked that there would not be an appropriate mix of suitable staff.

The incident management system was inconsistent with some incidents such as safeguarding being fully investigated with clear lessons learnt, but others such as falls not being investigated, therefore risking that appropriate preventative action was not taken as a result of incidents.

Quality assurance and audit systems were in place for example around medication. However, these systems had not identified the problems we found with the way medicines were managed within the home. Systems had not identified the missing care plan documentation which we found.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke with 14 people who used the service and three relatives. People and their relatives said they felt safe in the home and had no concerns over their safety.

People said the home and its staff were nice. One person told us "I am here for respite and will be going home. I want to go home, but it has been fine here." Another person said "I was offered a bigger room upstairs when it was empty. It was nice of them but I wanted to stay in my room."

People said their freedom was not restricted and they were able to go outside if they wished. People said that their rooms were nicely decorated and they were encouraged to personalise them. People said they were consulted regarding changes at the home. For example one person said they had been informed about building work telling us, “They will move me to a different room whilst the work is done, and I will go back to my own room once the painting is finished.”

People and their relatives said needs were assessed on admission and had access to external healthcare professionals.

People said that the food could be better and that they didn’t get much choice at mealtimes. One person told us "The food is bland."

Two people said there could be more activities for males, for example one person said “There is nothing for blokes to do.”

People and their relatives said staff were caring and friendly. One person said “staff are lovely.” People said they felt able to complain and that the manager was “good”.

Two visiting health professionals told us the home delivered effective care. One of them told us that the home “Was brilliant”.

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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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited the service on 29 April 2014. We used a number of different methods to help us understand the experiences of people who used the service. These included talking with people, observing the care and support being delivered and looking at documents and records that related to peoples support and care and the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of a Lead Inspector, a Medicine Management Inspector who looked in detail at the processes and systems with regards to the management of medicines, and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the service, which included the provider information return, a document sent to us by the provider with information about the performance of the service. We contacted the local authority commissioning and safeguarding teams to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health professionals who regularly visit the service.

On the day of our inspection, we spoke with 14 people who used the service, three relatives, and four members of staff.

At the last inspection in November 2013 the service met all the national standards that we looked at.

Are services safe?

Our findings

People we spoke with told us they felt safe in the home. Nobody raised any concerns about their safety.

Staff were able to confidently describe to us of how they would act and protect people from abuse. Staff told us they would raise any concerns with the manager and in their absence would contact the local authority safeguarding team to ensure issues were escalated and action taken. Staff told us they had been on safeguarding training. Safeguarding training aims to give staff the skills and knowledge to quickly act on allegations of abuse and keep people safe. We looked at the training matrix, which confirmed that staff had received this training.

Prior to the inspection, we spoke with the local authority safeguarding team who had not received any recent safeguarding concerns regarding the home. The most recent safeguarding referral took place in September 2013 and the manager was able to tell us of clear action they took following this incident to keep people safe. The manager told us they had recently been on a managers safeguarding course run by the local authority which had given them a greater understanding of the subject and helped them better judge the thresholds for reporting incidents to the local authority. This showed us the manager had a clear understanding of safeguarding issues in order to keep people safe.

The manager told us that there were no Deprivation of Liberty Safeguards (DoLS) orders in place. We did not observe any restrictions of people's liberty during the inspection. The manager was able to give us several examples of when they had contacted the local authority DoLS team to discuss whether scenarios classified as a deprivation of liberty. This showed us the manager regularly sought advice to ensure people's freedom was not overly restricted.

People told us their freedom was not overly restricted. There were key codes on external doors to protect people; however, these did not restrict their freedom. For example, we saw one resident had chosen to go out into the garden and several other residents told us they were able to go outside if they wished. The manager told us some residents were able to independently manage the door codes so they could enter and leave the building themselves.

We found staff had a good understanding of how to ensure decisions made for people were in their best interest. This included involving relatives, health professionals and independent advocates. Most staff had received training on the Mental Capacity Act (MCA) and DoLS, which meant they had learnt about how to ensure the rights of people without capacity were protected.

We found staff had a good understanding of how to deal with behaviour that challenges in order to ensure the safety of people who used the service. For example, one member of staff discussed with us a former resident who exhibited challenging behaviour and was able to talk knowledgeably about how they managed and resolved the situation in a manner which protected themselves and others and did not distress the resident.

In three of the five care plans we looked at, we found risks to people's health, safety and welfare had been identified and assessed. Each of these three files contained a dedicated risk assessment document with several key risks identified and their severity assessed. These included the risk of falls and wandering about the home, and contained detailed control measures to assist staff in managing these risks. In all five care plans, the pen picture at the front of the care plan also provided an overview of the key risks to each individual to ensure staff were aware of the risks people presented.

In two of the care files we looked in we found there were no risk assessment documents. These people both had health conditions which required managing in order to keep people safe, for example diabetes. However there was no risk assessment in place to ensure these risks were assessed and appropriately managed. We raised these issues with the manager who could not explain why risk assessment documentation was missing in these two people's files. Following the inspection, we received confirmation that the manager had put risk assessment documentation in place for these two people.

Medicines were not always handled safely. Most medicines were supplied in a monitored dosage system. This was used correctly to support the safe administration of medicines in the home. However, we found that the medicines administration records were not always completed to support and evidence the correct administration of medication. We saw gaps in the record keeping for three people that meant we could not tell

Are services safe?

whether their medicines including tablets, inhalers and eye drops had been given correctly. Additionally, we could not evidence that the correct dose of Warfarin was administered to a fourth person.

Controlled drugs were not safety handled. We saw that the medicines administration records were not always completed when controlled drugs were administered. We saw that there had been delays in administering controlled drugs to two people, increasing the risk of breakthrough pain.

Care plans did not clearly record assessments of people's individual medicines needs. One person had chosen to self-administer one of their medicines. However, a self-administration risk assessment and care plan had not been completed to identify any support needed with this. Similarly, where the covert (hidden) administration of medication was used, appropriate arrangements were not in place to ensure this was assessed and monitored in order that this person's best interests were protected. Where people regularly refused medication records of GP advice was not consistently sought.

Medicines were safely locked away but where oxygen was stored, warning signs were not displayed and cylinders were not anchored to prevent them from falling over.

The problems we found breached Regulation 13 (management of medicines); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because there were not appropriate arrangements in place to record and safely administer medicines. You can see what action we told the provider to take at the back of the full version of the report.

Are services effective?

(for example, treatment is effective)

Our findings

People and relatives told us that their needs and preferences were discussed on admission to the home. They told us they thought this process was thorough in assessing their needs. People told us they had choices with regards to their daily lives but thought the choice and quality of food was poor, with one person describing it as "bland."

We saw detailed information on people's needs, likes, dislikes and daily routines was recorded within the pen picture section of people's care plans which provided clear and summarised information to staff on how to meet people's individual needs. These were personalised and it was clear they had been written in conjunction with the person or their relative. For example, in one person's file, information was present on their breakfast preferences, the level of support they required and how quickly they usually ate their meal. During the inspection, we saw this person was provided with their preferred breakfast showing staff were delivering effective care in line with their preferences and needs. Another person's file contained detailed information on the items of clothing they could put on themselves and where they needed assistance to ensure staff provided the correct balance of assistance and independence.

Two visiting health professionals told us the home delivered effective care. One of them told us that the home "Was brilliant". They told us that their team had told staff some people required their legs elevating to reduce the risk of swelling and that when they visited staff had always been seen to follow that advice. They told us they would be happy for their relative to stay at the home.

We found people were given some choices, for example in what they wanted to do and where they wanted to sit. However, there was a lack of choice and respect of people's preferences during the lunchtime meal. For example, one person said to a member of staff who served lunch, "I don't like dumplings" but there was no verbal response or action taken. People were not enthusiastic about the food and all responded that there was a lack of choice and they did not feel that they were consulted about what kinds of things could be on the menu.

We found people had their needs assessed on entry to the home in a number of areas which included mobility, nutrition and continence. More detailed plans of care were then put in place, in the form of daily plans of care which provided more detailed information for staff in order to provide effective care. We found useful and personalised information was recorded which matched with what staff told us were people's care needs. However, in the "is this service safe" section of the report we identified two people where key risks to their health, safety and welfare were not identified and managed. In these areas more detailed information was needed to ensure staff delivered effective care.

We found some areas of care plans required more detail in order for staff to deliver effective care. For example one person's care plan mentioned they had pressure reliving equipment but did not provide any further detail as to the type of equipment. Another person's mobility care plan did not clearly detail the method used to support them in a variety of tasks. This person's relative told us they thought staff may not have used the most effective handling techniques when assisting them to the toilet. In this instance, the lack of clear information may have prevented staff from delivering effective care.

Staff we spoke with had knowledge about people's assessed needs that we asked them about. Staff had received training in a number of areas which including first aid, moving and handling, fire safety, dementia, and infection control to enable them to meet people's needs. We found that completion of training could be improved in a number of areas to ensure all staff were up-to-date in all the mandatory topics available. Information sent to us prior to the inspection and comments from the manager on the day of the inspection confirmed to us this was a key priority for the service.

We asked the manager if they were working to any best practice guidance or national standards with regards to the provision of dementia care. They told us that they were not working towards any standards or using any guidance at presence. This meant that the care in this areas may not have been as effective as it could be had the relevant guidance and research been consulted. There were no design features in place to assist those living with dementia for example, the use of pictures so people could identify their rooms or easy read signage to effectively direct people around the home.

Are services effective?

(for example, treatment is effective)

The manager told us they were awaiting new end of life care guidance. Following the inspection, they confirmed to us this had been put in place and staff were receiving the training. This would ensure a consistant approach to end of life care in the future.

We spoke with people and no concerns were reported about access to external healthcare professionals. We saw evidence people had been referred appropriately for example following weight loss. We saw the service supported people to access health appointments such as diabetic clinics and hospital appointments. Details of contact with health professionals such as district nurses was recorded in the daily notes and then summarised within monthly care plan reviews providing concise and summarised information of any advice given from health professionals so staff could deliver appropriate care. We spoke with a visiting health professional who told us staff were pro-active in seeking their advice and that referrals were made appropriately when people's needs changed.

All people who used the service responded positively to questions about their rooms, and one relative confirmed that they had been encouraged to re-arrange furniture and personalise the room to the resident's taste. The manager was able to give us examples of where people had been involved in the decoration of rooms though the people we spoke with said that they had not been involved in any decisions with regards to decoration.

We found space was available to enable people to comfortably sit, relax and engage in activities in any of the three communal lounges. Appropriate dining facilities were in place and people had access to privacy in their rooms. There were adequate toilet and bathroom facilities.

Are services caring?

Our findings

All people and their relatives responded very positively when asked if staff were caring and friendly. For example one person said, "Staff are lovely." This was supported by observing interactions during the visit. For example, one person responded to being brought tea and biscuits to their room by smiling broadly and saying, "You are my best friend." It was clear that the staff knew people well and enjoyed interacting with them. Patience and non-verbal communication such as smiles and appropriate touch were observed in interactions with those residents who were less able to communicate directly.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During the SOFI observation, we found staff regularly checked up on people asking them if they were okay and if they needed anything. We saw people were provided with regular interaction in order to keep them occupied, for example we saw a staff member engage with someone in conversation who had become withdrawn. We saw one person became upset, staff quickly identified this and comforted them, using verbal and non-verbal communication techniques, calming them down. Most of the interactions we saw between staff and people that used the service were positive and we saw a high level of dignity and respect given to people.

We found the overall care experience was positive and found staff had developed close relationships with people understanding their needs and preferences. We found one area where people's care experience could have been improved. There was a regular queue to use the downstairs toilets. One person was observed in the corridor with a member of staff. The resident was in a wheelchair facing a wall, with the staff member behind her, there was no communication between the two of them. A person was observed in the same location later in the day and said, "This feels like the naughty seat." Whilst the geography of the area explained the positioning of the wheelchairs, it would be possible to wait without the person left facing the wall.

The staff we spoke with had a good understanding of how to ensure people's dignity was maintained for example in offering them privacy when discussing confidential matters or covering them when hoisting.

We saw staff respected people's privacy, for example we observed them knocking on bedroom doors before entering.

We saw evidence people's diverse needs were understood by staff and provided with individualised care. For example, in the provision of diabetic desserts for those with diabetes. The manager was able to give us examples of how they had catered for people's individual and diverse needs in the past. This included providing Polish food for a resident and vegetarian options. Staff and management told us that religious clergy visited the home regularly to meet people's spiritual needs and there was evidence of this within care plan documentation.

The manager told us that nobody currently required end of life care in the home. We saw they had implemented an end of life book which provided information on people's end life preferences and choices. However, completion of these books was mixed with two out of five people we looked at not having them in place. The manager recognised that ensuring completion of these was a key priority for the service in documentation sent to us prior to the inspection. Two residents we spoke with told us about recent deaths in the home and said that they were told about these in an appropriate and compassionate way showing that staff had talked about death in a sensitive manner.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People and their relatives told us that the home met their care needs and spoke positively about the standard of care they received. One person said "I am here for respite and will be going home. I want to go home, but it has been fine here." Two men who used the service told us they wished there were more activities available for males to do.

Care plans showed people's views had been recorded in regards to decisions about their care, for example how they liked personal care to be delivered and what time they like to get up in the morning. On looking through care plans, we saw evidence in three out of five records that recent care plan reviews had been undertaken involving the person or their relatives. The manager confirmed to us that this was a new addition to the care package and that they were in the process of ensuring the remaining people or their relatives were involved in a review of care. In the reviews which had been undertaken we saw evidence views had been recorded. People recorded views were generally positive and we saw evidence that minor concerns had also been reported. The manager was able to tell us about clear action they had taken to address these minor concerns.

We saw posters advertising a weekly manager clinic. We asked the manager and staff about these and they told us that the manager sat in the lounge and discussed people's views, comments and concerns. This provided opportunity for people to express their views on an informal basis.

We saw evidence that mental capacity was considered in the communication section of care plans. This provided information to staff on whether people were able to make decisions for themselves and the level of support or assistance they required in communicating these decisions.

Staff we spoke with were able to confidently describe how they supported the people we asked them about to make decisions about their care and support.

Care plan documentation showed people had their individual needs assessed so staff could deliver responsive care. Care plans were reviewed monthly and there was evidence that additional information was added which showed the service was responsive to people's needs. For example information about changes in medication, mobility and any risks that had emerged. Clear information was present on how to ensure people's care needs were met in a number of areas which included diet and nutrition, continence, mobility and personal care. Specific care plans and information were in place where required such as information on ensuring effective catheter care was provided and how staff should respond should there be any problems. We saw evidence in daily records that people's care was recorded and any concerns highlighted and acted on. The manager told us that as part of monthly care reviews, they reviewed all daily records to ensure any changes in people's needs or habits were identified.

We saw evidence people's weights were recorded monthly or more often if required. Weights were analysed each month and were saw evidence that referrals were undertaken where weight loss was identified.

Staff were aware of the people's needs. We asked them about such as who was diabetic and what special precautions they required should the need intervention. Staff were able to tell us about strategies they had put in place to prevent people from falling such as installing pressure mats in bedrooms.

We observed care delivered in line with people's needs as identified in their care plans. For example, we saw appropriate pressure relieving equipment used as specified in people's care plans. People who required a special diet such as diabetics all responded that this was adhered to well.

Two visiting health professionals told us they thought the service was responsive to people's needs and that they pro-actively sought advice if people's conditions changed. They told us the service was good at altering care and support depending on people's needs.

Food and fluid charts were in place for residents who were identified as of risk of malnutrition or dehydration so the service could ensure they were having an appropriate level of food and fluids.

We saw evidence regular staff meetings were an opportunity to review and evaluate the care given to residents. Each person who used the service was talked about individually and if their needs were changed. There was clear advice given to staff to ensure responsive care was provided and such as reminding staff to ensure people's feet were kept elevate or changes in care that were required following medical advice.

Are services responsive to people's needs?

(for example, to feedback?)

Care plans considered people's social life and the activities which were important to them to prevent them becoming socially isolated. There was a programme of activities for the month posted in the entrance hall which showed activities were available most days. Two males told us the types of activities were skewed to the females, one saying, "There's nothing for blokes to do." The activities co-ordinator spoke enthusiastically about the programme and how they had developed the range of activities by consulting all people. They worked both in communal areas and one to one with residents in their room, citing playing games and simply spending time talking. They said that the men did engage with some of the activities that may be perceived as having a female bias and that they were working on finding ways to engage with and include everyone. We observed during the inspection staff asking people what future activities they wanted to be involved in.

We saw information on how to complain was clearly displayed in the home as well as in the service user guide. All residents said that they would feel able to speak to a member of staff if they had any concerns regarding their care or general experience at Pollard House. We saw evidence people's concerns and complaints were recorded through the comment and suggestion boxes, care plan review and resident meetings. The majority of people said the manager was effective in dealing with their complaints, however, one person said that although requests were acknowledged they were not always actioned. They told us, "I asked for something to cool my room two weeks ago and was promised a fan. It has still not appeared."

Are services well-led?

Our findings

The home had a registered manager in place. Feedback regarding the manager was overwhelmingly positive. People were aware of who the manager was with many able to cite recent conversations with them.

During the SOFI observation we saw the manager regularly providing care and engaging in conversation with people who used the service, for example asking them about their day. This showed us the manager maintained a strong presence in day to day life at the home and in understanding the outcomes for people who used the service.

Staff praised the manager and said they were always visible around the home and actively involved in people's care. Staff said they were approachable and that they did their best to resolve issues and problems which occurred.

We saw evidence people who used the service were involved in the running of the service through regular resident meetings. We looked at documentation from these meetings which showed that all residents were included and those that did not attend were asked for their views on a one to one basis. We saw evidence people's views had been recorded in a number of areas such as activities and food. The manager was able to give us examples of action they had taken following these meetings to improve the service for example in the provision of new activities.

People and their relatives were also asked to complete regular quality questionnaires. We looked at the most recent resident questionnaire from 2014. Results were overwhelmingly positive. 12 people responded with four stating the care was good, and eight excellent. We saw evidence action had been taken following people's comments, which showed that people's views were used to make changes to the service. For example, one relative was impressed that door handles had been replaced following their previous request.

During the inspection we saw evidence that a member of staff was conducting one to one surveys with people regarding the quality of the food. This was an opportunity to improve the quality of the food particularly given some of the comments given to us by some people regarding the quality of food. Staff told us these views would be given to the chef and manager to ensure improvements were made.

Safeguarding and whistleblowing policies were in place guiding staff on how to raise concerns and we saw they had been signed by all staff to demonstrate understanding of them. Staff said they felt able to raise concerns with the manager. We saw a confidential comments/suggestions box was in place and the manager showed us examples of how staff had used this to voice concerns or suggest improvements and there was evidence that actions had been taken.

The comments/suggestions box was also used for people or their relatives to voice their concerns or complaints. We looked at a number of recent concerns that had been raised and saw evidence that the manager had responded to them with clear actions recorded and evidence that the manager had spoken to the relatives and people concerned. Complaints were analysed on a monthly basis to look for any trends or general areas for improvements.

We found staff and management to be motivated to deliver the best quality care and were able to openly tell us about the improvements they wanted to see in the home. The manager was able to clearly describe to us the key priorities and improvements that the service was working towards. It was evident they were committed and determined to ensure these improvements were made. The planned improvements were consistent with what staff told us were the key areas for development such as evaluating the quality of the food, training and involving people more in care plan reviews. This showed us both staff and management were consistent about the challenges and priorities for the service.

Although the manager had a "to do list", there was no formal service improvement plan in place which detailed how the service would continue to improve, priorities and timescales for this action. The manager told us they would put a service improvement plan in place to ensure a structured plan was in place for the service to work towards.

Emergency plans were in place which included personal evacuation plans for residents to ensure that they were evacuated safely in the event of a fire. These considered people's mobility and their cognitive ability. The staff we spoke with had a good understanding of how to ensure people were evacuated in the event of a fire.

Although we found there were enough staff in the home to meet people's needs, there was no formal tool used to

Are services well-led?

determine safe staffing levels. The dependency of residents was assessed regularly however, this information was not centrally collated and analysed to be used in determining whether there were enough suitable staff to meet people's needs. This meant that should people's needs change, or if resident numbers increased, the lack of formal tool for determining staffing levels could result in insufficient staffing levels

The provider had an incident management system in place but the way incidents were managed was inconsistent and depended on the type of incident. Safeguarding incidents were recorded on a dedicated incident form, and we saw evidence that clear investigations were undertaken with recommendations that had been actioned to prevent a re-occurrence. Accidents that we found in people's care records had been correctly recorded in the accident book. However, within the accident book there was no space to detail any investigations. The manager showed us how they planned to ensure all accidents were transferred from the book onto incident forms so that they could be properly investigated and analysed for trends, however, this had not been done for any incidents in 2014. This meant that there was a risk that appropriate preventative action was not taken following incidents to reduce the likelihood of a re-occurrence. One relative of a person raised concerns about the current incident system telling us that they could not clearly see the number of falls and preventative action taken as a result of falls.

Audit and quality assurance systems were in place, we found these had not picked up on some of the risks which we identified during the inspection. For example, regular medication audits were undertaken but they had not identified the gaps in completion of medicine records and the lack of robust systems in place for the management of controlled drugs. Quality assurance and audit systems had not identified that some people's files were missing care plan documentation such as risk assessments.

The problems we found breached Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because appropriate arrangements were not in place to monitor and assess the quality of service provision, identify risks to people's health, safety and welfare, and analyse incidents which resulted in or had the potential to result in harm. You can see what action we told the provider to take at the back of the full version of the report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with unsafe management of medicines as appropriate arrangements were not in place for the recording and safe administration of medicines.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 10 (1)(a),(1)(b), (2)(c)(i) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the quality of service provision (1)(a)The service was not regularly assessing and monitoring the quality of the service provided (1)(b)The service was not identifying, assessing and managing risks to the health, safety and welfare of people (2)(c)(i) Analysis of incidents that resulted in or had the potential to result in harm did not take place