

Care Concern Yorkshire Ltd

Moorfield House Nursing Home

Inspection report

Fieldhouse Walk
Off Stonegate Road
Leeds
West Yorkshire
LS17 6HW

Tel: 01132669991

Date of inspection visit:
03 February 2016

Date of publication:
04 April 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Our inspection took place on 3 February 2016 and was unannounced. At our last inspection on 23 September 2014 we found the provider was meeting all the regulations we looked at.

Moorfield House is a Grade 2 listed building located in a residential area north of Leeds. There is also a purpose-built extension to the main house. Moorfield House provides accommodation for 50 people on three floors with a passenger lift. There are single bedrooms and some have en-suite facilities. There are communal lounges and an activities room. The home is located close to local amenities and public transport routes. There is parking to the front of the home.

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

We saw medicines were not always managed safely. We found records of applications of creams and ointments were not always complete, instructions for the management of covert medicines were incomplete and found loose medicines had been left in a person's room. The registered manager carried out an investigation into this after our inspection.

Medicines that required refrigeration were appropriately stored and controlled drugs records were in order. We observed good practice on the medication round including checking whether people needed pain relief.

We looked at staffing levels and noted staff did not always have time to sit and chat with people who used the service. We found the dependency levels were only assessed on an individual basis and were not reviewed to establish a level of dependency of the service overall. We made observations, spoke with staff, people who used the service and visitors, reviewed rotas and spoke with the registered manager. We concluded there were not enough staff to meet people's care and support needs safely, which was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service lived in a clean, well maintained home. The provider ensured that equipment and fittings were regularly checked and serviced.

Care plans contained mental capacity assessments; however we found that best interest's decisions were not always adequately documented in people's care plans. A range of consents had been documented and signed for in people's care plans. Staff could tell us about people's mental capacity and how the Mental Capacity Act impacted on their work.

People told us they enjoyed the food and we observed that people who needed assistance with their meals

received caring support, although on some occasions staff needed to break off from assisting one person to attend to the needs of another. We saw people had been provided with adapted cutlery and crockery to help maintain their independence in eating. Records relating to nutrition and hydration were not always correctly completed.

Staff told us they received regular training and we saw records that evidenced this was kept up to date. Staff were further supported with annual appraisals and regular supervisions, though some records of supervision were not up to date.

Formal handovers were undertaken before the start of each shift, and we found these were meaningful discussions where staff spoke respectfully about people.

People told us they found the staff to be caring, and we observed good practice throughout the inspection. People who used the service looked well cared for and staff told us a number of ways in which they were mindful of people's privacy and dignity when receiving care and support.

The care plans contained information as to each person's aims in respect to each care and support need, but we found the records to be generic and lacking in detail as to how the aim would be achieved.

On the day of inspection we found a lack of meaningful activity which people who used the service could join in with. People spent long periods in lounges with no staff member present. We saw there was a plan of activities for each day of the week, but people who used the service told us there was a lack of things to do.

The provider had systems in place to ensure complaints and concerns were logged and acted on appropriately. We saw evidence that complaints were discussed in staff meetings. People who used the service said they would feel able to speak to the registered manager if they had any concerns. We saw a range of compliments from relatives of people who had used or were using the service.

There was a rolling programme of audits in place, however it was not always clear how some areas had been checked and some action plans contained insufficient detail to show how improvements would be made, by whom or when.

Staff and people who used the service expressed a high level of confidence in the registered manager. People told us they found her approachable and staff said they felt they were well supported and received honest and constructive feedback. Staff had regular meetings which they told us they found useful and said they felt able to speak openly. In addition the staff had completed a survey and we saw the registered manager had responded to areas of concern with an action plan, though it was not always clear how effective action was going to be taken.

We found the provider was in breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Medicines management was not always safe. Instructions for covert medication were not clear and we found loose medication in one person's room.

Staff received training in safeguarding of vulnerable people, The provider undertook background checks during recruitment to ensure prospective staff were not barred from working with vulnerable people.

Risks associated with people's care and support needs were assessed and documented, however not all guidance for staff contained sufficient information to ensure that risk was adequately minimised.

Risks associated with people's care and support needs were assessed and documented, however not all associated guidance for staff contained sufficient information to ensure that risk was adequately minimised.

Requires Improvement ●

Is the service effective?

The service was inconsistently effective.

People's care plans contained mental capacity assessments, although best interest's decisions were not always recorded. Care plans also contained a number of consents, but these were not always signed by the person or their chosen representative.

People told us they enjoyed the food, and we saw people who needed assistance to eat were either provided with adapted cutlery and crockery or assisted by a member of staff.

Staff were supported through annual appraisals and regular supervisions, although the records of these were not always complete.

Requires Improvement ●

Is the service caring?

Good ●

The service was inconsistently caring.

People told us the staff were respectful and friendly, and we observed this during the inspection.

Staff told us how they respected people's privacy and dignity. We saw people who used the service looked well cared for.

We observed people who used the service were relaxed when speaking with staff, however we saw staff did not often have time to stop and chat with people.

Is the service responsive?

The service was inconsistently responsive.

People told us there was a lack of activity they could join in with and we found little happened on the day of our inspection.

People spent long periods in lounges with televisions that were on, but we did not see people being asked what they might like to watch.

The provider had systems in place to manage and resolve complaints. People told us they would speak with the registered manager if they had any concerns.

People and their relatives had opportunities to attend regular meetings with the registered manager.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

We found a rolling programme of audits in place, however these were not always clear and action plans were not always robust.

We received positive feedback about the registered manager and the culture in the home. Staff said they were well supported and received honest and constructive feedback which they appreciated.

The registered manager involved staff in the running of the home. There was an annual staff survey and we saw some action had been taken as a result. We saw evidence in meeting minutes that discussions were meaningful and staff were able to make suggestions for improvements to service delivery.

Requires Improvement ●

Moorfield House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 3 February 2016 and was unannounced. Our inspection team consisted of two adult social care inspectors and a specialist nursing advisor.

Before our inspection we reviewed information we held about the service including past inspection reports and notifications from the provider. We sent the provider a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition we contacted the local authority and Healthwatch to ask if they had any information of concern. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We received responses to our enquiries which we used in the planning of the inspection.

At the time of our inspection 46 people were living at Moorfield House. We spoke with nine people who used the service, three visitors, six staff including the activity co-ordinator, the registered manager and deputy manager, and made observations as to the environment and daily lives of people who used the service. We looked at five care plans, medicines records of eight people, and other records relating to recruitment, care and the running of the home.

Is the service safe?

Our findings

We looked at the procedures the provider had in place to ensure the safe management of medicines. People we spoke with could not tell us in detail about their experience but they and relatives we spoke with expressed no concerns.

Medicines were stored securely and appropriately in a dedicated room which was kept at a controlled temperature. Medicines which required refrigeration were kept in a fridge which was checked daily for cleanliness and temperature. We saw disposable medication pots were in use, which is good infection control practice.

Some medicines require additional secure storage. These are known as controlled drugs. We looked at the provider's management of controlled drugs. We found appropriate storage arrangements had been made, there was clear and accurate recording of controlled drugs and stocks of these medicines were correct.

We observed a medication round and saw each person's medication care plan identified any known allergies and contained information to help staff support people appropriately with their medicines. There was a lack of personalisation in the guidance for staff, for example the instructions did not detail when and how the person preferred to take their medicines. One person asked the nurse administering medicines if they could have theirs with orange juice, which was then provided.

We saw the nurse waited with the person until they had taken it, then recorded this in the person's Medicines Administration Record (MAR), in line with good practice. Some people's medication care plans stated that some monitoring needed to be done before medicines were given. For example people with diabetes needed glucose levels measuring. We saw that monitoring was being done as required. During our checks on medication we went into one person's room. The person was not present. We found two medicines had been left unattended. We checked with the nurse and once the medicines were identified they confirmed the person who lived in the room did not take those medicines. We brought this to the attention of the registered manager during the inspection and they told us they would investigate. After the inspection we received an update from the registered manager including action they planned to take to reduce the risk of the error occurring again.

We looked at five people's MARs and found these were completed correctly with no gaps. We looked at the records relating to the application of creams needed by three people who used the service. Creams and ointments are also known as topical medicines. The Topical Medicines Administration Records (TMAR) were not always being used effectively. For example one person's TMAR had four occasions in the previous three weeks where no application of the cream was recorded. Another person's TMAR showed their cream had been applied on only two occasions in the previous three months. We saw the TMARs did not always contain detail as to what the topical medication was, and when and how the cream was to be applied.

We saw in notes from a pharmacy review meeting in January 2016 that permission for administration of covert medication should be in written form, from both the person's GP and the dispensing pharmacist. At

the time of our inspection one person was being given their medication covertly. Their medication care plan contained only written permission from the GP. The instruction to staff was that the medicine should be 'put in food'. There was no detailed guidance as to which foods did not affect the stability of the medicine and the rate at which it is absorbed, meaning the person may not be adequately protected from side effects associated with their medicines. When asked, the nurse told us all food was suitable for covert administration of medicines.

We concluded that although overall management of medicines was safe, the above examples constituted a breach of Regulation 12 (2) (g) Safe Care and Treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked people who used the service and their relatives whether they felt there were enough staff on duty at all times. One person told us, "They could do with some more staff; they are rushed off their feet." Another said, "Staff are always rushing off to get to other people." One visitor told us, "There are not a lot of staff around, they all seem to be busy." Another said, "There always seem to be staff around, I feel there are enough."

Staff we spoke with gave variable feedback on whether they felt they worked in sufficient numbers to meet people's care and support needs. One member of staff said, "There are enough staff, we do quite well. There's a low staff turnover." Another told us, "Usually there are enough staff, but not all days are the same. Some days we need more time. Sometimes it's tough."

We asked the registered manager how they determined staffing levels.. They showed us each person's care plan contained an assessment of their dependency level, taking into account factors such as mobility and continence. A dependency rating was produced for each person, but this information was not collated to establish the dependency in the home as a whole. The registered manager showed us minutes of a recent meeting with their mentor where they had discussed looking for a 'dependency tool', which is a way of determining staffing levels based on such information. They told us they would ensure they started using a dependency tool as a matter of priority and use it to review the staffing levels and ensure they reflected the level of need in the home. We reviewed rotas, spoke with the registered manager, deputy manager, staff and people who used the service, and made observations during out inspection.

We concluded that there were insufficient staff on duty, which was a breach of Regulation 18 Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014.

In the PIR the provider told us, 'Policies and procedures are in place to protect service users and staff working at the home from harm. Staff are trained to identify the need to raise any concerns and complaints to the Manager. Risk assessments are completed in the residents' care plans to identify the risks of poor nutrition, skin integrity, falls, and continence. Service users risk assessments are updated monthly by their named nurse in their care plans and any concerns are escalated to the appropriate professional.'

People who used the service said they felt safe at Moorfield Nursing Home. One person told us, "I feel safe, yes. I have a mate or two to talk to." Another said, "I know I'm safe knowing I'm not going to fall."

We looked at the care plans of five people who used the service. We saw these contained a number of risk assessments linked to people's care and support needs. These included pressure area care, nutrition, moving and handling and falls. Risk assessments were regularly reviewed and we saw evidence of review linked to a change in the person's needs. Most risk assessments contained guidance to assist staff minimise risk, although there was some variation in the detail included. For example, one care plan had instructions

for staff to reposition the person to help minimise the risks associated with pressure ulcers. There was no guidance as to the frequency of repositioning. Although we saw records of when staff had helped the person to reposition there was no consistency to the amount of time between such actions being taken.

We looked at the recruitment records of three staff. The provider had undertaken background checks including references and application to the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be barred from working with vulnerable people. The information they provide helps employers make safer recruitment decisions.

Training records we looked at showed staff had received safeguarding training. Staff we spoke with demonstrated a good understanding of the principles of safeguarding people who used the service from abuse. They understood their responsibility to report any concerns. Staff told us they would speak to either the registered manager or an external body such as the local authority or CQC. Staff said they were confident the registered manager would act on what they were told.

We saw the home was kept clean and well maintained. We looked at records which showed regular testing of gas, electrical, fire systems and other equipment in the home, and found them to be up to date.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the care plans of five people and found capacity assessments were in place but were not always easy to locate. One person's capacity assessment was not stored with their care plan. Assessments also included a variety of consents, including consent for administration of medication, information sharing and photography. We saw people's wishes were respected, for example one person had not given consent to be photographed and we saw their MAR sheet did not have their photograph on it. Another person had not given consent for the administration of medication and we saw a plan in place to ensure that staff supported them to take their own medication safely.

We saw some evidence of people or their families signing for consents, however there were some care plans where a person had been identified as not having capacity and no signatures had been obtained for consents. In addition we did not find evidence that best interest's decisions were being recorded. We discussed this with the registered manager during the inspection. They were able to talk in detail about how best interest decisions had been made, but told us these had not always been recorded. We discussed this with the registered manager during the inspection and they told us they would take immediate action to improve this.

We looked at the approach to food and nutrition in the service. In the PIR the provider told us, 'The chef discusses the menu with all new residents and also asks for feedback from existing residents regularly. Various diets are provided by the kitchen and all the kitchen staff have training around diets and textures. A picture book is available for residents who have dementia to help them to choose their foods.'

We asked people who used the service whether they enjoyed the meals at Moorfield Nursing Home. One person said, "The food is ok." Another said, "I really enjoyed my breakfast. I had a cooked breakfast, it was lovely." A visiting relative told us, "The food always looks and smells nice when I come." We saw people were regularly provided with drinks. One person said, "We have snacks and drinks throughout the day, we never go hungry." We saw notices displayed in the home encouraging people to ask staff for a snack or drink at any time. Suggestions included sandwiches, biscuits, hot drinks and juice.

We observed the lunchtime meal in both dining rooms. Picture menus were available in the dining room to help people make their choices, and the options for the meal were displayed on a chalkboard. The food served looked appetising and looked colourful on the plates and we observed most people finished their meals. Staff asked people if they required any assistance to cut or eat their meals and respected the person's choice. Some people ate their meals in their rooms and we saw they received assistance if they needed it. In the dining room, some people had been provided with adapted cutlery and crockery so they could retain their independence with eating. Some people had assistance to eat their meal. We observed staff were patient and focused on the person they were supporting and spoke to them, using encouraging phrases such as "Are you enjoying that?" and "Are you ready for some more?" On several occasions however, the staff member was seen to break off and assist another person without telling the person they were supporting why their meal had been interrupted.

We looked at records being kept about people's nutrition and hydration and found these were not always being used effectively. For example we saw although some intake of fluid was being recorded, a daily total was not being calculated and no output being measured. One person's recorded intake of fluid was less than 200ml per day. This meant monitoring was not effective and risks associated with dehydration were not being adequately minimised. We also saw some food and fluid charts were in place when there was no documented need for close monitoring. We brought this to the attention of the registered manager during the inspection and they told us they would take immediate action. We observed reminders were given during handover that food and fluid charts should be updated properly and the registered manager said they would speak with the community nursing team to identify people who no longer needed close monitoring.

In the PIR the provider told us, 'Staff are given a two day induction training that covers all the mandatory training. They then shadow a senior staff member for two weeks or until they are deemed competent to work independently. Staff who do not have any qualifications in care complete the Care certificate. All staff are given a two day induction training yearly to up skill and refresh their induction training This is being provided by 'The Care School 'in Shipley. The induction covers all the mandatory training and C.P.R.A training matrix is in place to monitor staff training.'

We asked people who used the service whether the staff had the knowledge and skills to provide support and care. One person told us, "The care is absolutely brilliant." Another said, "The staff seem to be ok. If I need anything they come to me." Another told us, "They move me very carefully." A visiting relative said, "It all comes down to the care that [name of relative] receives. I think that's they are still with us." Another told us, "I come regularly and see what goes on. I am happy with the care."

Staff told us they received regular training to support them in their roles. One member of staff said, "There is a lot of training. All the mandatory courses are done at the care school. It's very good training." Another told us, "We get plenty of training, and you can ask for extra training if you want it." Staff told us they had received recent training in moving and handling, safeguarding, oral care and pressure sore prevention.

Staff were further supported through a regular programme of supervision and an annual appraisal, although we saw there had been a period when supervisions had not been taking place as planned. For example, three staff records we looked at had no supervisions recorded after August 2015. Staff we spoke with told us; that supervision happened regularly and said the latest one had been recent. One member of staff told us, "I had my last supervision less than a month ago. We talk about how I am faring, any issues I am facing and how the manager can help me to cope with any challenges. You can talk about training as well."

We looked in detail at the supervision records of three staff. We saw a standard agenda was used which

included any issues the staff member had faced, areas of concern about their ability to be effective and an action plan for improvement.

Staff we spoke with told us they had received training in the MCA and could tell us about ways in which they supported people appropriately to make decisions. One member of staff said, "It's not for us to make decisions for people. We are told about people's capacity to make decisions, and it's all there in the care plan." Another said, "When I am assisting someone to get dressed the person chooses what to wear whenever they have capacity to decide. If someone can't decide then I will offer different clothes and support them to make a choice."

At the time of our inspection three people were subject to a DoLS and we saw documentation was appropriately completed. The provider had made information about DoLS available on noticeboards in communal areas of the home.

In the PIR the provider told us, 'The care home involves specialist practitioners when seeking advice on various issues regarding the residents care: Dietitian, General practitioner, Speech and language, Continence adviser, Care Homes Team, Chiropodist, Joint Care Managers, Safe Guarding, Deprivation of Liberty and Best interest assessors.'

People who used the service told us about how well the provider helped them access healthcare professionals. One person said, "An optician comes to the home and I go out to see a dentist." Another told us, "I see a specialist regularly. They arrange transport but I can go on my own." A visiting relative told us, "There was brilliant care when [name of person] went into hospital. There was a carer at the hospital with them."

A staff member told us they got to know about changes in people's care and support needs during a handover at the beginning of their shift. They said, "We discuss residents' health and any additional care needed."

Staff told us there was a formal handover at the start of each shift. We observed one handover during the inspection. There was a detailed discussion about each person using the service, including any changes in care and support needs, and additional monitoring needed and any specific requests from people such as to have a bath. We saw an additional member of staff had been called in to provide one to one support for someone whose health had changed that day.

A staff member told us they got to know about changes in people's care and support needs during a handover at the beginning of their shift. They said, "We discuss residents' health and any additional care needed."

Staff told us there was a formal handover at the start of each shift. We observed one handover during the inspection. There was a detailed discussion about each person using the service, including any changes in care and support needs, and additional monitoring needed and any specific requests from people such as to have a bath. We saw an additional member of staff had been called in to provide one to one support for someone whose health had changed that day.

Is the service caring?

Our findings

In the PIR the provider told us, 'Residents at Moorfield House are supported by staff in a person-centred way. They are treated as individuals and all their likes, needs, and preferences are documented in their care plans for staff to work from. The home has a dignity champion who monitors practice and will challenge any bad practice. Staff are compassionate and caring and put the residents at the heart of everything they do.'

People we spoke with told us a number of ways in which the service was caring. One person said, "I have a nice room, I have all my own things in there." Another told us, "The staff are very respectful when helping me with my personal care." A visitor said, "The staff are respectful, always friendly. They stop and talk to [name of person]." People told us staff were mindful of their privacy and dignity at all times. One person said, "They don't rush me." Several people told us the staff always knocked on their door before coming into their room, and we observed this was the case throughout the inspection.

A visitor told us, "Staff know what [name of person] likes and doesn't. The staff know them well."

We asked staff for examples of how they ensured they showed respect for people's privacy and dignity. One member of staff said, "You always knock before you go in someone's room, and then say who it is." Another told us, "I make sure the door is closed, and use towels to protect people's modesty when helping them dress or undress."

We saw people who used the service looked well cared for. People had clean; well-presented clothing and personal grooming had been attended to. A visitor told us, "[Name of person] is always clean and tidy when I come." We observed people were relaxed when speaking with staff, although most communication was task based, for example when responding to requests for assistance.

Is the service responsive?

Our findings

In the PIR the provider told us, 'Residents are encouraged to take part in the ongoing activities within the care home. Links with the local library helps resident to maintain some independence. Families and friends are welcomed into the care home and are encouraged to eat and drink with the residents. The local Access bus visits the care home to take some residents out or shopping regularly.'

We spoke with the activity co-ordinator who told us, "I try to start activities about 10.30, people like to read the papers and do colouring." Another member of staff told us, "I think there is enough for people to do, but I'm not sure if there was an activity yesterday."

There was a board in the entrance hall which listed a planned activity for morning and afternoon, seven days a week. These included a service of faith twice weekly, high tea, talking about the news, one to one time, entertainment, film shows and baking and cooking. We saw some displays of photographs in the home showing people enjoying entertainment, celebrations, reminiscence days and singing. People who used the service did not always feel there were enough activities. One person told us, "I get bored, there's nothing to do really." Another said, "I can't really think of any activities, we don't really do any."

On the morning of the inspection there was no advertised activity, and we saw people spent time either in their rooms or in one of two lounges. Televisions were on in both, however no one appeared to be watching them and we did not see staff offer any choice of programme. There was very little interaction between people who used the service and on some occasions people were vocalising for assistance because there were no call bells within reach and no staff present in the room. Although staff responded in a timely fashion they were focused on the assistance required and did not have time to spend chatting with people. On one occasion a person was moving across the room when a member of staff came in and asked him what he wanted. He indicated he had been looking at something but the member of staff did not talk to him about this. They encouraged him to return to his chair and left the room. The advertised activities for the afternoon were 'one to one time' and 'film show'. We saw a member of staff playing cards and chatting to a group in one lounge, however people seated in the front lounge did not appear to be engaged in any activity.

The provider told us about ways they involved people in the service. They said, 'Residents and families are invited to meetings regularly to express their views suggestions and opinions. The home has two suggestion boxes at both entrances. Residents and stakeholder surveys are sent to people yearly, collated and action planned. Staff also have a sheet for any verbally communicated issues that do not want to be logged as complaints these are addressed with the manager and action taken to deal the issue.'

People we spoke with told us about their involvement with review of their care plans. One person said, "I feel involved, I asked for only female carers and that's what I get." One person's relative said, "I have always been involved in the care plan." We saw some evidence of people's involvement with their care plans in a section called, 'Ask the resident their aim.' We found the information was generic and did not fully evidence how the provider planned to support people to achieve their aims. For example the aim stated in one person's

continence care plan their stated aim was 'to remain dry.' In another person's nutrition care plan the aim was 'to maintain a healthy diet.' We discussed this with the registered manager during the inspection and they told us they would review this area of the care plans.

Some people who used the service told us they were aware of meetings they could attend to discuss the service. One person told us they were aware they took place, but chose not to attend. The most recent meeting had been held the day before the inspection and minutes were not yet available.

People who used the service told us how they would raise a concern or complaint about the service. One person said, "If I wasn't happy about something I would let staff know. I would tell someone." Another person told us, "I would know who to complain to. I would go straight to the manager." A visiting relative said, "I would speak to the manager [if they had a complaint]. I can also email as I have the address." People told us that had not felt the need to make any complaints.

We looked at compliments received by the service, displayed in the entrance hall. Comments included, 'Words cannot express our thanks to you all,' 'thank you for making [name of person]'s stay a happy and comfortable one,' and 'Thank you for looking after [name of person]. You helped to make the most of the time she had left.'

Is the service well-led?

Our findings

In the PIR the provider told us, 'Audits for accidents, infection, wounds are completed monthly by the Manager and issues and trends identified and action taken. Procedures are in place to check Fire Regulations, Food Hygiene, C.O.S.S.H, Moving and Handling, Medication and Infection Control. Environmental Health is audited annually in house and three yearly externally. The findings are action planned and implemented according to the audit findings.'

We looked at the programme of audits in place and saw the registered manager undertook a rolling programme of checks and review of information, but we found some audits lacked guidance to show how they were conducted and followed up. For example we saw there was a medication audit in place, but it was not clear from the records what had been checked and whether the required actions identified had been followed up. Although the registered manager was undertaking robust investigations into accidents and incidents and drawing together monthly statistics we found the objective in the action plan, 'reduce falls', did not show how this would be achieved or progress monitored. We discussed this with the registered manager during the inspection. They were able to tell us how, why and when audits were conducted and what actions they had identified as a result, but said they had not always recorded this in sufficient detail. They told us this was an area they had discussed in their supervision, and would take immediate action to ensure consistency of approach in their audit programme. We saw that issues raised during the inspection were put in an email to the registered manager's mentor for discussion in their next supervision.

There was a registered manager in post at the time of our inspection. One person who used the service told us, "The management is brilliant." A visiting relative said, "The manager is approachable, I don't have any concerns." Staff were equally positive about the leadership in the service. One staff member told us, "The manager is a good leader. It means she is supportive but not afraid to challenge me when something is not right. I like that, that's the only way to learn." Another said, "She gives you a sense of belonging. She is a good leader and works with us. We respect her." A further member of staff said, "I am very proud of what we do."

Staff we spoke with told us there was a supportive and positive culture in the home, and felt they were comfortable speaking to the registered manager who encouraged open and honest communication at all times.

We found the registered manager viewed the inspection process as an opportunity to drive improvement in the quality of service delivery. For example they encouraged open discussion of our findings throughout the inspection and were able to tell us about a number of improvements they planned to make immediately after the inspection.

The registered manager held regular staff meetings, records of which evidenced meaningful discussions about the service. In the minutes of the most recent meetings we saw discussions about staff training, issues identified with care delivery and equipment and staff satisfaction. We saw evidence that complaints were discussed to enable lessons learnt to be shared and staff suggestions were documented and followed up on.

The minutes also showed the registered manager regularly asked for staff suggestions to help form policy. For example in the minutes of one meeting the registered manager had asked for opinions on how to improve performance management.

We looked at the 2015 staff survey and found the results of this had been analysed and an action plan written to address areas of concern, however these were vague and did not show how the outcome would be achieved or measured. For example, staff had expressed concern about how well valued they were by the provider. The action plan stated, 'improve staff morale,' but did not identify how this would be achieved, by when or who would be involved. We discussed this with the registered manager during the inspection and they said they would speak to the provider about making improvements to this. We saw evidence that a new hoist had been purchased in response to staff feedback under 'tools to do the job.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not adequately protected from the risks associated with covert medication and topical medicines.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We concluded through observation and speaking with people and their relatives there were insufficient staff to meet people's care and support needs effectively.