Molescroft Nursing Home (Holdings) Limited

Holy Name Care Home

Inspection report

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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

This inspection took place on 15 and 16 May 2017 and was unannounced. At the last inspection on 20 and 22 April 2015, the overall rating for the service was Good.

Holy Name Care Home is a purpose built home encompassing a church site and is situated in a residential area of North Hull; it is close to main bus routes into Hull city centre. The service is registered to provide personal and nursing care for a maximum of 64 people, some of whom may be living with dementia. The bedrooms are all for single occupancy and all have en suites which consist of a shower, sink and toilet. There is a large dining room, a number of open plan seating areas, two small conservatories, a hairdressing salon and courtyard gardens for people to use. The service has a separate area for people living with dementia called Penny Lane.

The service had a registered manager; they also managed the company's other service in Beverley. This was a temporary arrangement whilst recruitment was underway for a new manager. 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 found that people had not always received their medicines as prescribed. This was due to unclear guidance in one instance and in others, staff recorded people as asleep for specific medicines at night. Staff had not referred back to people's GPs for advice regarding adjusting the times.

We found some people at risk regarding their food and fluid intake, and fluctuations in their weight were not monitored effectively. This meant people could lose large amounts of weight before this was identified and a plan put in place to address the loss. Menus provided people with choices and alternatives and people told us they liked the meals.

We found people had assessments of need completed but staff had not always recorded important information in care plans about how these were to be met. This meant staff may not have had full guidance on how to care for people in an individual way.

You can see what action we have asked the registered provider to take regarding these concerns at the back of the full version of the report.

Staff had received training in how to protect people from the risk of harm and abuse. There were also policies and procedures for additional guidance. Staff knew what to do if they had concerns, who to raise these with and which agencies to notify. Staff produced risk assessments for people to help minimise risk, whilst still ensuring people could make their own choices and decisions.

People who used the service were supported to make their own decisions and staff knew they had to gain consent prior to carrying out care tasks. When people were assessed as lacking capacity, meetings were held to discuss what decisions were to be made in their best interest. Some adjustments were required to the paperwork to make sure it was clear who was consulted in the decision-making.

People had access to community health professionals for advice and treatment. Staff knew when to consult these professionals.

Staff were recruited safely which ensured employment checks were in place prior to new staff starting work. There were sufficient staff employed to meet people's needs but two people who used the service and some health professionals commented about the availability of staff. The registered manager told us they would speak with people who used the service about this and look at the deployment of staff at peak times to see if this could be addressed.

People told us staff had a kind and caring approach. We saw people's privacy and dignity was respected and observed many positive interactions between staff and the people they cared for. Staff knew how to promote people's independence and need to make their own decisions.

There was a selection of activities for people to participate in and people told us they enjoyed them. We have made a recommendation regarding sourcing additional activities to enhance those provided to people living with dementia.

Staff received training suitable for their role; a log was maintained of the training completed by staff so the registered manager could keep this under review and plan courses to meet shortfalls and updates when required. Staff told us they felt supported by the registered manager and deputy manager, and confirmed supervision meetings had re-started.

The environment was safe, clean and tidy and staff had access to protective equipment when required. They had completed training in infection prevention and control and knew the measures to take to manage any outbreaks of infection.

The environment had suitable equipment in place to meet people's needs. Equipment items such as the lifts, hoists, wheelchairs, bedrails, hot water outlets, and electrical and fire-fighting appliances were serviced at regular intervals and checked daily to ensure they were safe and in working order. There was signage around the service to help orientate people living with dementia.

People who used the service and their relatives told us they felt able to raise concerns and complaints. There was a policy and procedure to guide staff in how to manage complaints.

The registered provider had a quality assurance system which included audits, checks and seeking people's views. This had re-started following a gap during management changes. In the interim some audits had not been completed or had not been as thorough as they should have been. We have judged that this will be rectified now the full system is back in action. We will check this out at our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People had not always received their medicines as prescribed.

There was sufficient staff on duty but occasionally, a shortage was perceived on the residential unit by people who used the service and health professionals on. The registered manager told us they would seek the views of people who used the service and look at staff deployment at peak times on the residential unit.

Staff had received safeguarding training and knew how to protect people from the risk of harm and abuse.

The service was clean and tidy and systems were in place to prevent and control the spread of infection.

Is the service effective?

Requires Improvement

Some people at risk of poor nutritional intake had not always had close monitoring of their food and fluid intake and fluctuations in their weight. People we spoke with liked the meals provided to them and menus provided choices.

People received care and treatment from a range of community health care professionals.

The registered provider worked within mental capacity legislation and deprivation of liberty safeguards when people were assessed as lacking capacity to make their own decisions.

Staff had access to training, supervision and support. This helped them to feel confident when supporting people who used the service. Shortfalls in training had been identified and planned.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Requires Improvement

People had assessments of their needs completed and care plans were formulated from these. Some people's care plans lacked important information about how staff were to support

them in an individual way. This could lead to people not receiving the right support.

There were activities for people to participate in. Those people spoken with told us they enjoyed these. We have made a recommendation about sourcing additional activities for people living with dementia.

There was a system in place for managing complaints. People who used the service and their relatives told us they felt able to raise issues with staff and these would be addressed.

Is the service well-led?

Requires Improvement

Staff told us the registered manager and deputy manager were approachable and would listen to any concerns they had.

There was a quality monitoring system in place which had stalled during the recent management changes. However, this was back on track and audits and checks had been completed for a range of areas. We have made a recommendation about developing a system to oversee daily monitoring charts for those people at risk.

Holy Name Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 May 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience on the first day and one adult social care inspector on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding and contracts and commissioning teams about their views of the service. We also received information from five health care professionals who visited the service.

During the inspection, we observed how staff interacted with people who used the service when supporting them and particularly at mealtimes. We used the Short Observational Framework for Inspection (SOFI) in the dementia care unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who used the service and two people who were visiting their relatives. Two other relatives completed a short questionnaire during the inspection. During the inspection, we spoke with the registered provider and the HR manager. We also spoke with the registered manager and the deputy manager who are qualified nurses, another nurse, five care workers (two of whom were seniors), the cook, the apprentice activity co-ordinator and a domestic worker.

We looked at seven care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 37 people and monitoring charts for food and fluid intake, weights, behaviour and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included recruitment files for four new staff, training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

We found medicines were not always managed appropriately. This had led to some people not receiving their medicines as prescribed, some recording shortfalls and a poor system of disposing of unused medicines.

For example, one person was prescribed a medicine to calm their anxieties but we could see from their medication administration record (MAR) that there were several weeks when this had not been given in accordance with the instructions from a consultant psychiatrist. The GP was contacted during the inspection and verified the person was to receive this 'when required'. One person was prescribed a pain relief patch to be administered every 72 hours but on two occasions there were gaps of 76 hours and on one occasion a gap of 68 hours. One person was prescribed a food supplement four times a day but the MAR showed they were offered this three times a day.

Some people were recorded as asleep at the time of the evening dose of medicines; this was especially noticeable for a person prescribed eye drops every 12 hours. Staff had not consulted with the person's GP to check if the timing could be altered to ensure they received two doses each day. When we arrived at the service, we saw a medicine pot (with tablets inside) had been left by a person's bed. Staff confirmed the person had been assessed as unable to self-medicate and they should be observed when taking their medicines.

Eight people's MARs had gaps in administration for some medicines so it was difficult to audit if they had been omitted intentionally or if this was a recording oversight. There were some protocols in place for when people received their medicines 'when required' or when there was a variable dose such as one or two to be taken. However, the protocols were not consistent and these did not always provide staff with sufficient guidance. This meant there was a risk of people not receiving an appropriate dose of medicine suitable for their need.

There were several large, full containers of unused medicines and nine full sharps containers in the treatment room on the ground floor. These containers were overfull and one of them had loose tablets spilling onto the floor of a cupboard. These were addressed with the registered manager and collected by the contracted waste disposal service on the second day of the inspection.

The shortfalls in medicines management meant there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of the report.

Medicines were held securely and were stored at the correct temperature. We observed staff administer medicines to people in a patient and professional way. People spoken with told us they received medicines on time. Comments included, "Always exactly right" and "They are usually on time and yes, the right tablets. I have no issues; pain relief is always available." A relative said, "Yes, they get their medications every morning and is never in pain."

Staff confirmed they had received safeguarding training. They knew what constituted abuse and the signs and symptoms that may alert them to concerns. They were also able to accurately describe the actions to take to safeguard people and to which agencies they would pass on important information. Staff said, "We are here to protect people; I would not tolerate any abuse in this home." We saw there were systems in place to safeguard people's finances when they asked for monies to be held in safekeeping for them. People who used the service told us they felt safe and protected and that staff answered call bells promptly. Comments included, "I feel safe. There's staff around and I feel safe in my own room", "Yes, absolutely I feel safe", "Yes, at night I have a call button and they come within five minutes" and "The whole thing is safe; night staff come on and they come around and check I am alright." A relative said, "They are settled; I visit twice a day and the staff are good. The equipment around them keeps them safe."

Staff had completed individual risk assessments for people to help minimise risk with the least restrictions possible. These included moving and handling, falls, nutrition, skin integrity and the use of specific equipment such as bed rails. Staff were able to describe how they coped when people were anxious or distressed and their behaviour put themselves and other at risk of harm. They told us the care plans gave them directions and guidance on how to manage these situations.

We found staff were recruited safely with full employment checks in place prior to them starting work at the service. These included an application form so gaps could be explored, references, an interview and a disclosure and barring service (DBS) check. This included a police check and assurance that the potential candidate had not been excluded from working with adults at risk. Qualified nurses had an additional check to ensure they were registered and there were no conditions on their registration to practice. These measures helped the registered provider make safer employment decisions. New staff confirmed they were going through a period of induction and they were working through a booklet which was signed off by their mentor when they were competent. They said, "I haven't been here long but the support has been really good; the managers are really helpful" and "I did some shadowing shifts when I first started and have just started to be part of the rota."

There were mixed comments about staffing numbers especially in the residential unit on the ground floor. The building was spread out over a large area which may account for the perception in shortfalls in staffing numbers in this area. Comments about staff response times from people who used the service were, "No, sometimes there's a 25 minute wait, mostly in a morning when I need assistance to get out of bed", "I used the buzzer at 8.30pm last night to go to bed; staff were annoyed as they were busy with handover", "The call button is answered pretty quick; within 5 minutes. It is just that they are so busy", "The girls who look after me are brilliant. There are no waits and they come within five minutes if I press my buzzer", "Usually there are enough staff unless there is a sudden emergency. Staff are always there if I have an off day" and "My buzzer is answered quickly but I know when to press and when not to."

Two relatives said, "Yes, on this floor there are only seven people and if she needs the toilet they take her straightaway" and "Yes, there is enough staff." Health professionals commented on the size of the building and said there did not always appear to be many staff around when they needed to speak to them. We observed staffing levels were sufficient on Penny Lane. Staff had time to sit and talk with people and there was a calm and relaxed atmosphere. Staff said, "The dementia unit is always well staffed; we get time to talk to people and do things with them."

The staffing rotas showed there were between eight and ten carers and a nurse during the day and six carers and a nurse at night for a total of 52 people. The registered provider told us this increased when more people were admitted. Staff told us that usually shifts were covered for short notice absences but sometimes staff were taken from the residential unit to cover for the nursing unit. They said this sometimes

left them short staffed. Staff said, "Sometimes it gets a bit short on the residential unit when staff are taken away to cover on the nursing unit", "The managers are really good they will come in and cover if they have to" and "I make sure all shifts are covered and try to bring staff in to cover where I can." There were additional administration, catering, domestic, laundry and maintenance staff, which meant that care staff could concentrate on supporting people.

We have asked the registered manager to check out the negative comments made by two people about staff response to call bells to see if better deployment of staff could address the issue.

We observed the service was a safe environment. It was very clean and tidy and staff had access to personal and protective equipment such as gloves, aprons and hand gel. Some minor issues with the environment were addressed during the inspection. Equipment used in the service was maintained and regularly checked by specialist assessors. Maintenance personnel completed checks on equipment such as call bells, hot and cold water outlets and fire-fighting equipment. There was also a business continuity plan in place to manage incidents which may disrupt the running of the service such as utility failures or floods.

Requires Improvement

Is the service effective?

Our findings

We had concerns regarding some people's nutrition and hydration needs. This was especially in relation to ensuring people ate and drank sufficient amounts, adherence to dietetic advice and monitoring people's weight when they were at risk. For example, one person was admitted to hospital from home; they were weighed during their hospital stay and referred to a dietician but not weighed on discharge or admission to the service ten days prior to the inspection. Their relative told us they were concerned about the person's food intake and that they may have lost additional weight. We asked staff to weigh the person and found they had lost a significant amount of weight since the first record was made in hospital. It is unclear when the majority of the weight loss had occurred as the person was not weighed on admission to the service. The staff team had re-referred the person to the dietician when they were admitted to Holy Name and contacted the dietician again during the inspection to follow up the referral.

We found staff had not discussed with the relative, the person's likes and dislikes and the texture of food they preferred to eat. This had led to the person declining meals and staff not having a full understanding of their needs. We saw the dietetic service had responded to the re-referral a few days prior to the inspection and requested specific information. We found this information had not been supplied to them yet. The person's food and fluid intake was recorded but there were lots of times when they declined parts of their meal and only a few entries when the 'Nutrition Mission' record was completed. Nutrition Mission was a system of delivering additionally fortified meals and fluids for those people at risk. Staff used a universal nutritional screening tool to assess risk but did not always adhere to the flow chart of responses, for example the initiation of Nutrition Mission.

There were several other people who had lost some weight; these had been recorded but it was unclear what action the staff had taken and whether or not the people received a fortified diet. Again food and fluid intake charts did not reflect this in a consistent way. One person had records in the daily notes that they persistently had a limited diet and fluid intake but there was no monitoring chart to review this properly and to ensure an optimum level of fluid was achieved. Staff routinely recorded in care plans that people were to have one and a half to two litres of fluid a day. However, staff did not 'total' the fluid balance charts and did not have a system of checking amounts throughout the day to see if people at risk were on track to meet these targets. Health professionals said they had to remind staff to accurately complete food and fluid intake monitoring charts.

Not ensuring people had adequate food and hydration was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of the report.

We recommend the registered manager refers to National Institute for Health and Care and Excellence guidance on how to calculate the optimum levels of hydration for people.

People told us they enjoyed the meals provided to them although one person said they would prefer the food to be hotter. This was mentioned to the registered manager to address with staff. Comments included,

I don't bother with breakfast. I go to the dining room for lunch; it was roast pork yesterday and it was nice", "There is normally a choice of two meals and lots of drinks; it's enough for me" and "In general, the food is very good. I ask for small portions and get that; there is always a choice and I choose where I eat." One person told us they didn't always like the tea time meals; this was mentioned to the registered manager to address. A relative said, "[Name] eats everything which they weren't doing at home. They are well fed and have put on a stone since they have been here."

The cook told us they received information about people's dietary needs and we saw these were on display in the kitchen to remind catering staff. The menus provided people with choices and alternatives were available if needed. The dining experience was calm and sociable for people; they were asked where they wanted to sit and clothes protectors were offered and put on people if they accepted them. Staff asked people which choice of meal they wanted in the morning and food was handed to people already plated up. People were asked if they had finished their meal before plates were removed. The registered provider told us they made a note of food wastage so they could check if people liked what was on offer and adjust the menus.

We found people had access to a range of health care professionals for advice and treatment which included GPs, district nurses, dieticians, speech and language therapists, opticians and chiropodists. Health professionals told us there had been times when they had to remind staff to ensure people, who required them, had compression stockings applied which could result in a breakdown of previously healed leg ulcers. However, the registered manager told us applying the compression stockings was difficult as the person often declined to wear them. We found one person had developed a sore area two days before the inspection but this had not been passed onto a senior care worker to contact the district nurse for advice and treatment. This was completed on the day of inspection and was assessed by a nurse as a small superficial sore.

There were monitoring charts in place for pressure relief and generally these were recorded appropriately. Health professionals said they had to remind staff to accurately complete pressure relief monitoring charts in order for them to assess treatment needs. They did state that staff communicated well with them when there were concerns about pressure area and wound care needs. These issues above were discussed with the registered manager, deputy manager and registered provider so they could take appropriate action.

In discussions, staff could accurately describe the symptoms of a chest infection or urinary tract infection and the actions they should take if there were any concerns. People who used the service told us their health needs were met. Comments included, "They call a doctor when needed and sometimes I see a district nurse", "I have had new teeth since I've been here", "I have my toe nails done every six weeks, see an optician yearly and saw a dentist a few weeks ago" and "I had an emergency GP out a few weeks ago for my feet and they gave me antibiotics; the district nurse comes to check on my feet and my nails are also done."

Relatives said, "They would call a doctor if required. I take [Name] to the Parkinson's clinic every six months and they have their feet done every eight weeks" and "They are looked after very well. We are impressed with both the nursing and care staff and the treatment they give. Although they have been bed-bound for three years, they do not have any bed sores."

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. Also 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 saw the registered provider was working within the principles of the MCA for the people who used the service; applications for DoLS had been submitted to the local authority and some had been authorised and others were awaiting assessment and authorisation. All staff had received training in MCA and DoLS and understood the principles. They knew some service users had a DoLS in place and how this should be managed. One member of staff said, "I know one person has a DoLS and that they are to protect them so we can keep them safe."

We found there was some inconsistency regarding documentation for best interest decisions. For example, one person had a completed capacity assessment for a specific decision but the best interest document did not state who was consulted and was not dated and signed. This meant it was difficult to evidence who had made the decision and when. This was mentioned to the registered manager to check all best interest documents to ensure they were completed fully.

Records showed that staff had access to training, supervision, support and appraisal. Staff confirmed they received the training required to develop their skills. They told us they had just begun to receive supervisions again as this had lapsed over the last 12 months due to management changes. Not all staff had completed dementia care training but there was a plan in place for this to be carried out in 2017. People spoken with told us staff knew how to care for them. Comments included, "Yes, staff use the hoist and there is always two of them."

The environment was suitable for people's needs. Corridors were decorated with pictures, were wide which made them suitable for people in wheelchairs, and had coloured hand rails which made them more visible. Toilets had grab handles to assist people when getting on and off and bathrooms had either specialist sit in baths or equipment to help people access the baths. There were two lifts, one of which was for people admitted on a stretcher.

There were pictorial signs throughout the service to orientate people and fire extinguishers were held in tamper-proof containers. Several people had memory boxes outside their bedroom door; these were filled with memorabilia to help orientate people to their own room. The manager of the dementia unit told us they had plans to make the area more dementia-friendly by decorating the corridor with shop fronts and trying to make it look more a like street to assist with reminiscence and stimulate conversations; there were pictures on the walls of people undertaking activities. The lounge/dining area did not enhance the opportunity to socialise or engage in conversation as easy chairs were set out in rows all facing the television. This was mentioned to the unit manager to address.

Good

Is the service caring?

Our findings

People who used the service told us staff were kind and caring, and respected their choices, privacy and dignity. Comments included, "Staff do their best; they work hard and are all very nice", "I find them very pleasant but they haven't got time to sit and talk", "The staff are very, very caring" and "If I wake up at 4am, I put on my TV and if I want anything, they will fetch it." Other people said, "I more or less choose [what to do during the day]; nobody tells me", "I love my room and so do my visitors. It is exactly what I need. Wonderful, caring and friendly staff, and activities; I love it", "The carers are brilliant and the place is comfortable", "Very good. They are very friendly and respectful" and "The staff have hearts of gold and are all the better for knowing." One person made a negative comment; we told the registered manager and they informed us this would be addressed with the specific staff in question.

Relatives said, "Staff are very kind and considerate despite [Name's] dementia making them uncooperative at times" and "They are all very pleasant and helpful in every way." We saw the staff had received numerous thank you cards for the care they had delivered to people.

Health professionals stated, "Staff observe privacy and dignity always. I have always seen positive approaches and residents give positive feedback." One comment from a health professional referred to the care staff knowing a person's needs really well, having documentation ready for a review and contributing well to it. Other comments referred to health professionals receiving positive feedback about the staff team, witnessing instances when staff promoted privacy and dignity, and providing choices to people.

We observed staff were attentive to people throughout the day; the care workers all knew people's names and were very friendly, smiling and helpful. When the drinks trolley was taken round the service and when lunch was given out, we saw the care workers took the opportunity to chat to people. We saw a carer pass a person in the corridor; they stopped and chatted, took their arm and walked with them to the lounge. We observed some very good interactions on the dementia care unit. Staff were speaking softly and responding appropriately to requests. They sat next to people while they spoke with them and held hands to give reassurance. One person became very agitated if staff didn't respond quickly to them. We saw staff were patient and explained what they were doing and why they had not come straight away; this reassured the person and led to them being calm.

We saw people were treated with respect. People who used the service were smartly dressed, with shoes or slippers on. Staff were able to describe how they would promote dignity which included closing doors when undertaking personal care tasks, calling people by their preferred name and not referring to everyone as 'love' or 'darling' unless people were happy with that. They said they made sure people who used the service had choices in their daily lives, for example meals and clothing.

Staff were able to describe to us how they would maintain people's independence, for example ensuring existing skills such as being able to wash their hands and face and put on clothing were promoted and only offering assistance when required. Staff also described to us how they supported people to remain mobile and we observed staff promoting this on the dementia care unit by walking with people, gently assisting

them. Staff said, "It's good to keep some independence even if it just washing their hands and face" and "It keeps people active [walking in the unit]. Sometimes they don't want to do it, but we try to persuade them; sometimes it works and other times it doesn't."

All the bedrooms were for single occupancy and had full en suites which consisted of a shower, a sink and a toilet; this afforded people privacy. The bedrooms were nicely personalised with photographs, pictures, ornaments and small items of furniture, and all had call bells in reach.

People were able to remain at Holy Name and be cared for until the end of their life. Ten staff had completed end of life training. There were clear records of when people had a 'do not attempt cardiopulmonary resuscitation' order in place. People had care plans which stated where they preferred to be cared for at the end of their life.

We saw people were provided with information about the service. There were notice boards with a range of activities, a selection of leaflets in reception and menus were on display. People were provided with a 'service user guide' which described what was included in the service and what were additional extras such as hairdressing and chiropody.

We saw staff respected confidentiality. People's care files were held in lockable cupboards and filing cabinets and medication administration records were held in the treatment rooms. Staff personnel records were held securely. The registered manager confirmed that computers were password protected and the service was registered with the Information Commissioners Office. This was a requirement when confidential records were held on computers.

Requires Improvement

Is the service responsive?

Our findings

People had assessments of their needs completed, including risk assessments, prior to admission and staff used these to write care plans of how best to support people. Although some people had informative care plans, we found some of them lacked guidance for staff on how to support people in an individual way.

For example, two people did not have sufficient information about their nutritional needs and risks which had led to staff not responded to their needs in a timely way. There was also evidence that staff had not responded by checking weighing scales when there were anomalies in people's weights. Two people had anxious and distressed behaviours which could be challenging for staff and others. Although the types of behaviours were recorded in daily notes, there were no care plans to guide staff in how to support both people in a consistent and person-centred way to help alleviate their distress. One of these two people had documentation to suggest they were given their medicines covertly. However, there was no plan to guide staff in how this was to be carried out and whether the pharmacist had provided information about the types of food or fluid the medicines could be hidden in. One person had a catheter in situ and both their assessment and care plan lacked information about the size of the catheter and when it was next due to be changed. Not having full information in care plans posed a risk of people receiving inappropriate or unsafe care.

Not ensuring people had full assessments and care plans to guide staff was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of the report.

People who used the service confirmed they had seen their care plan and told us staff were responsive to their needs. Comments included, "I have a care plan and as far as I know it is updated", "Yes, I was quite poorly when I came in and I am a lot better now", "I came here so poorly; they have done their job as I am ready to go home" and "Yes, there's plenty of choices and my family visit when they can." A relative said, "Yes, they [staff] went through the care plan initially; they tell me what is happening all the time."

People who used the service also said they had a range of activities to participate in. Comments included, "I think so [meaning sufficient activities]; I go out regularly to the town", "I play bingo once a week; they have singers in and I attend Mass", "It's good, we made Easter bonnets and creative cards. There are singers who we usually dance with", "I don't do activities by choice; I like my own space" and "I have joined in music sessions, bingo and exercise classes. I have done quite a lot; the social side is excellent." A relative told us, "[Name] likes to watch the artists and they do bingo; we are on a bus trip to St.Stephens (shopping centre) next week."

The main activity co-ordinator was not on duty but we spoke with an apprentice who assisted them about how they supported people to participate in meaningful activities. They described one to one sessions for those people who remained in bed, weekly bingo, arts and crafts, bowling, nail care, reminiscence, exercise classes, visiting entertainers and walks to local shops. There were several members of clergy who lived in the service and daily Mass in the Church provided spiritual comfort for them. The activity co-ordinator told us

they completed an 'All about me' document, which detailed people's past interests, what they would like to do and what they are able to do. They maintained a log of which person participated in activities and who declined. We saw a 'Memories Folder' which detailed activities in the past months such as an Indian food taster day, a visit from an Elvis impersonator, a fund raising day in March 2017, a Mexican Day, 'Dancing Dogs' and seasonal events at Christmas, Halloween, St. Patricks Day and Comic Relief. We saw the service had developed links with local schools. Pupils visited to chat to, and do arts and crafts with, the people who used the service, and they in turn attended concerts at the schools. The apprentice activity co-ordinator was enthusiastic and told us they really enjoyed their role. The notice boards advertised monthly 'residents meetings' and a wipe board detailed activities on offer. We saw a leaflet in several bedrooms which advertised the week's activities.

Observations on the dementia care unit showed there were some activities but these were not structured or specifically aimed at people living with dementia. For example, one member of staff had obtained some posters of newspapers published at the start of the Second World War. One person who used the service found this interesting but the staff missed an opportunity to engage with them to ask about their experiences or share these with others. The majority of people on the dementia unit spent periods of time in their bed rooms.

We recommend the registered manager obtain information from a reputable source regarding the provision of activities for people living with dementia.

The registered provider had a policy and procedure for managing complaints. The complaints procedure detailed timescales for investigation and responses to people who had raised them. Complaints were recorded and showed evidence of face to face conversations, telephone calls and formal meetings with people who had raised concerns. Staff told us they would resolve any low level complaint but more complex issues would be referred to the registered manager or deputy manager.

People who used the service told us they felt able to raise concerns and they indicated who they would speak to. Comments included, "I would see [Name], the unit manager, but I can't think of anything", "I'd try to get hold of the manager, but I don't know who it is. I think there is a lady called [Name] too", "I would go down to the reception desk and ask to speak to the manager. I have never had anything to complain about" and "I would tell the senior and ask for the owner; I tell them issues." Relatives said, "I would see [Name] she is the unit manager but I've never had any problems" and "Yes, management react very positively [when concerns are raised]." Another relative told us they had an issue with the family member's food but this was addressed.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had a quality assurance system that consisted of audits, meetings and questionnaires to ensure people were able to express their views. The registered manager told us some audits had slipped over the previous few months due to a change in management but we saw these had restarted. The audits we saw included the environment, health and safety issues, housekeeping, infection prevention and control, medicines management, activities and care plans. There were also clinical audits such as the number of people with pressure damage. We found the quality assurance programme lacked structure and had been completed in a reactive way rather than planned way when the registered provider became aware of shortfalls. Some of the audits had missed important issues such as a build-up of medicines waste, inconsistent monitoring people's nutritional and weight concerns and some shortfalls in care planning. We looked at complaints, accidents and incidents and found that while these were recorded, there was no analysis undertaken to identify trends or learning. There were no audits of how many people developed chest, urinary tract and wound infections, which would enhance the clinical audits and focus attention on prevention rather than just treatment. The registered manager told us they would address this and add to the audit programme.

There was no system for overseeing the recording of food and fluid intake at regular intervals throughout the day is implemented to ensure those people at risk are on track to reach their optimum nutritional and hydration levels. This would ensure these records are completed in an effective, consistent and accurate way and that health professionals have access to important information when required.

Not having an effective quality monitoring system meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of the report.

Due to recent management changes, the registered manager was temporarily managing Holy Name Care Home as well as another service in the company. They worked two and a half to three days at the service each week. Recruitment was underway for a new manager who would have sole responsibility for Holy Name Care Home. There was a deputy manager, a human resources manager and the registered provider who were available to support the staff team in the interim. The registered manager was aware of their registration responsibilities and we received notifications of incidents which affected people's health and welfare in a timely way.

One health professional told us the recent management changes had led to a shortfall in communication with them and felt care staff sometimes lacked clarity about their responsibilities in managing information between residential and nursing care. For example, they asked the community nurse to speak with the nurse on duty when it was the senior care worker who would be responsible for the discussing and handing over of information. One health professional felt communication was improving and others said, "Well-led management; they do their upmost to resolve issues that may arise" and "A new manager has recently started; senior carers communicate effectively and staff appear to be starting to work together as a team."

We found some people did not know who the registered manager's was due to the recent change. This was mentioned to the registered manager so they could ensure people were aware of the change and who to speak with if they wanted to raise any issues. Some people commented that they felt the service was well-managed. Comments included, "Yes, the place is well looked after" and "As far as I can tell, yes." Relatives said, "Yes, no complaints; I am happy with everything they do here."

We spoke with the registered manager, deputy manager and the human resources manager about the culture and philosophy of the service. They told us they felt able to raise concerns and could make suggestions about how the service was managed. The registered provider's statement of purpose and the service user guide highlighted the aim of the service was to provide 'the best possible service for all our residents'. It focussed on key values such as respecting and listening to people and offering choice and flexibility. We found these values were followed through into practice.

Staff told us the management style was open and inclusive. They found the management team approachable and could go to them for advice and guidance. They told us they had attended staff meetings and had been asked for opinions about the running of the service. We saw minutes of these meetings which reflected the discussions held with staff. Staff stated, "[Registered provider's name] is very approachable", "I don't feel intimidated by the management team; they are all really nice" and "I haven't been here long but I can ask anything and they will take the time to answer; it makes you feel valued."

We saw people who used the service and their relatives were asked to complete surveys and could attend meetings to express their views. Some people felt the meetings were constructive but others were not so sure and wondered if changes were ever made after voicing their views. The registered provider showed us an 'actions log' that detailed what they had done as a result of issues raised at 'resident and relatives' meetings. They will ensure these are displayed in a more 'user friendly' format such as a 'You said, we did' notice.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people's care plans included full information about how their needs were to be met in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured there were appropriate systems in place for the safe management of medicines and to ensure people received them as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider's strategy for meeting the hydration and nutritional needs, and monitoring weight, for those people at risk was not sufficiently effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured adequate systems were in place to monitor and improve the quality of the service delivered to people.