Hoyland Hall Limited

Hoyland Hall Residential Home

Inspection report

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Barnsley
South Yorkshire
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13 November 2017

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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

The inspection of Hoyland Hall took place on 6 and 13 November 2017 and was unannounced on both days. At the last inspection Hoyland Hall was rated as requires improvement and identified two breaches which related to premises and equipment and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the premises and governance to at least good. During this inspection we found improvements had been made to the premises but there were further breaches of the Health and Social Care Act 2008 associated regulations.

Hoyland Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hoyland Hall has two floors with living accommodation on both floors which is accessible by lift. The premises had undergone some refurbishment and included large accessible wet rooms on each floor. There were 28 people living in the home on the days we inspected.

There was a registered manager in post. 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.

People and their relatives told us they felt safe and happy in Hoyland Hall. Staff knew how to report safeguarding concerns and we saw appropriate follow up action was taken.

Risk assessments did not always reflect current need or provide staff with the necessary guidance to support people safely. Risks were not always mitigated based on individual need. Personal emergency evacuation plans had incorrect information and some staff were not aware of how to use fire safety equipment. Fire drills were not conducted regularly enough.

We observed poor moving and handling practice which did not mirror people's assessed need, and records did not show how people's needs had changed over time. We saw all equipment had been checked in line with Lifting Operations and Lifting Equipment Regulations 1998 and other premises safety checks had been completed as necessary. However, there was no other evidence of any equipment checks taking place on the hoist or slings.

There was a mixed view of staffing levels as some people felt their needs were met promptly but others did not. We observed staff were continuously busy with specific tasks and this meant peoples sometimes had to wait.

Medicines were administered, stored and recorded safely and infection control practices were robust. The home was clean and odour free.

All staff had received an induction, supervision and training although this needed further consideration due to staff's lack of dementia awareness.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The registered manager did not have current information about people's Deprivation of Liberty Safeguards or their relevant conditions.

We did not observe positive mealtime experiences for people as they were waiting too long for food to be served, were not offered a choice of meal or beverage, records did not always show people's current dietary requirements and people who needed support did not receive this effectively.

We found people accessed health and social care services as needed.

The lounges were not conducive to social interaction and the premises were very cold on the first day, which had been remedied by the second day of the inspection.

Staff were considerate and caring towards people and respected people's privacy and dignity.

Care records were person-centred in style but had not been updated since 2015 in many cases. Although they were reviewed on a monthly basis this evaluation did not incorporate people's changed needs.

There was limited social interaction, partly due to the layout and because staff did not have time to provide extra support. We saw the registered manager had tried different options but people were reluctant to engage.

People and staff told they enjoyed living and working at Hoyland Hall. However, we found there was not a clear vision for the home and there was a lack of quality assurance measures in place from which to assess the effectiveness of care delivery. The provider visited regularly but their visits did not evidence robust scrutiny of documentation but focused on people's experiences and the atmosphere in the home which was very welcoming.

We found breaches of regulations in regards to person-centred care, the need for consent, safe care and treatment and a further breach of good governance. We have made a recommendation about the review of staffing levels.

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?

Requires Improvement

The service was not always safe.

Risks were not always managed effectively and staff did not always follow safe practice. People sometimes had to wait for staff attention.

People told us they felt safe and staff knew how to report concerns.

Medication was managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People had poor mealtime experiences due to a lack of choice, interaction and time waiting for food. The home layout did not promote social interaction.

The registered manager could not evidence all Deprivation of Liberty Safeguards had been adhered to properly and not all people had the required capacity assessments in place.

Staff had received supervision and training to support them in their roles and people accessed external health services when needed.

Is the service caring?

Good

The service was caring.

Staff displayed consideration and kindness to all people living in the home and relatives and visitors spoke positively of the welcoming atmosphere.

Staff knew people well and were able to discuss relevant topics with them.

Privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records, although person-centred in style, did not always reflect current need.

There were minimal organised activities.

Complaints were considered and responded to promptly.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although people and staff spoke highly of the registered manager, there was little evidence to support effective governance. There were no systems in place to monitor or improve safe care delivery and the vision for the home was limited.

People and their relatives were involved in discussions in the home and there was evidence of positive partnership working.

Hoyland Hall Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 6 and 13 November 2017 and was unannounced on both days. The inspection team consisted of two adult social care inspectors on the first day and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the service was inspected by one adult social care inspector.

Before the inspection we requested a Provider Information Return (PIR) which was returned to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with seven people using the service and seven of their relatives. In addition, we spoke with nine staff including four care workers, two kitchen assistants, the cook, a member of the domestic team and the registered manager.

We looked at eight care records including risk assessments, four staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with at Hoyland Hall told us that they felt safe. One person told us, "If I didn't feel safe I'd tell [name]. They're a good carer." They also said, "I have a latch on my door and I can use it if I have to." One relative said, "You could have knocked us over with a feather when they told us they'd rather stay here. They used to say they'd come into one of these places over their dead body, so they must feel safe to have chosen to stay here." Another relative told us, "They are safe here. They press the buzzer and staff come and see to them."

Staff demonstrated a good understanding of what constituted abuse and how they would report this. One care worker told us, "It could be physical or verbal. If I had any concerns regarding a member of staff I would tell the manager; if it was the manager I would tell the Care Quality Commission." Another staff member told us they had never seen anything of concern regarding the conduct of other staff members but would happily report it if they did. We looked at safeguarding records and saw there was one safeguarding issue in 2017, which had been investigated and completed. However, we did not always see the outcomes were then implemented as learning points.

We observed some poor moving and handling practice. One person who was unable to safely weight bear was transferred from a comfortable chair into a wheelchair using a handling belt and turntable. However, as this person was not able to support themselves this placed considerable strain on both care staff and had the potential to harm the person as their weight was being completely taken by the care staff.

Another person was also moved using the same equipment but was unable to follow directions from the staff, and one care worker commented, "They always step off it" referring to the turntable. Once they were in the dining room chair, the chair was then pulled by two staff up to the table, again placing care staff at risk of injury. This should have highlighted this method of transfer was no longer safe for this person and yet it continued to be used until we spoke with the registered manager. A further person whose record said they were to be hoisted was transferred from a wheelchair into a comfortable chair in the lounge with two staff using a handling belt and turntable. This meant staff were not adhering to the moving and handling plan.

Staff told us five people needed a hoist to transfer safely and one care worker said, "It can take up to twenty minutes to hoist one person. If we had one more person (care worker) it would help a lot." We observed transfers using the hoist were safely managed although noted the same sling was used for two different people which posed an infection control risk. One care worker told us there was only one hoist in the home and staff were unclear what they would do if it broke down.
People were not always spoken with during the transfers as staff concentrated on the procedure which meant those who had memory problems were unaware what was happening to them. We also saw brakes were not always applied to wheelchairs when people were being transferred into them, meaning there was a risk the wheelchair could move.

Moving and handling risk assessments were contradictory for some people as in one record we saw "assisted to complete a stand transfer or to be hoisted." There was no methodology for staff to follow or

details of the specific equipment people used. Some risk assessments had been completed initially in 2015 and not updated to reflect current need. The monthly evaluations did not consider this either.

We asked the registered manager who assessed people's moving and handling needs and they advised us it was them. When we questioned why the person who should have been hoisted was not, they advised us this was because they had recently seen the physiotherapist who said using a handling belt was acceptable if they were taking their weight. We observed this person was unable to take their weight and could not find any notes in the person's care record to confirm this approach. Although the registered manager was able to describe safe moving and handling techniques, we did not always observe this in practice. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as people were being placed at risk of harm by unsafe methods of transfer and inconsistent practice.

Accidents and incidents were logged with details of what happened and whether any injury was incurred. Different prevention measures were considered such as bed rails and comments were noted where these would not be appropriate. Other risk assessments included skin integrity, specialist equipment, mobility and nutrition. As with the moving and handling records, although these were reviewed on a monthly basis, they were not always updated to reflect change in need. Risk reduction measures were generic rather than person-specific such as checking for hazards and fit of footwear.

The emergency evacuation list was not up to date as some people had moved rooms. We spoke with the registered manager on the first day of the inspection and they agreed to update it. However, on the second day the same list was still on display in the medication room. Some of the details on the list were also incorrect as one person was listed as needing two staff to help them stand and assist into a wheelchair and yet this person was hoisted. People's personal emergency evacuation plans were not dated which made it difficult to assess the validity of the information. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as records were insufficient to mitigate the risks to people in the event of a serious incident.

There was mixed feedback about the response times of staff. One person said, "It's champion here, you press that buzzer, it lights up, and they're here in about two minutes, none of this waiting about lark" and another told us, "I press my buzzer and they come. I don't have to wait a long time and that's at weekends and in the evening too." A further person spoke very positively of the staff, saying how prompt they were answering the buzzer. One relative told us, "There's always staff around. They always make time to discuss any issues."

On the first day we inspected one senior care worker and three care workers were on duty in the morning but this reduced to one senior and two care workers in the afternoon. This was confirmed as a usual staffing ratio by care workers. One care worker told us, "It would help if we had more staff as we would get a proper break." We looked at staffing rotas and found all shifts were covered as required. The registered manager explained they did not use a dependency tool as they based their ratio on knowing the needs of the people without this. They said there were always three staff on duty at night and some staff worked split shifts whereas others worked twelve hour days. However, our observations of care delivery showed, at times, people were having to wait and the deployment of staff was not always most effective. We recommend the registered manager regularly reviews staffing levels and adapts them to people's changing needs.

We looked at staff recruitment records and found appropriate checks had taken place. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at medication practice. One person said, "Don't talk to me about tablets, I must be on about 30 a day! I'm taking 8, 9, 10 at a time, but I'll say this, they [the care team] always get them for me and bring 'em to me on time, morning and evening. They know they've got to for things such as my diabetes and stuff." We observed medication being administered safely and people were supported patiently ensuring all medication had been swallowed before signing to say it had been administered. The medication room was kept locked with access only by permitted staff, and we saw the room and fridge temperatures were recorded and within required guidelines. Staff had had their medication competency checked at regular intervals by the registered manager and learning was shared from audits completed internally and externally.

Controlled drugs were stored appropriately and stock levels tallied with the records. Creams and other medication not dispensed from a dosette box had the date of opening recorded on it to ensure it was not used past its expiry date. The senior care worker responsible for medication fully understood the reason for the timing of specific medication, such as early morning medication to be taken before food. No one in the home was receiving any medication covertly. We did not see specific PRN (as required) protocols in place but when we questioned the registered manager they told us only one person was on PRN medication and they would resolve this immediately.

We saw all equipment had been checked in line with Lifting Operations and Lifting Equipment Regulations 1998 and other premises safety checks had been completed as necessary. However, when we looked at fire safety records we found much of these were incomplete and there was no evidence of any recent fire drills. One care worker had no understanding as to how to use the evacuation sledge. When we discussed this with the registered manager they said they had completed one fire drill since August 2016 but there was no written record of this. They did complete one in the period before the second day of our inspection to ensure all new staff were familiar with the process.

Hoyland Hall was cold on the first day of the inspection and we took the temperature in two places, one read 17 degrees centigrade in the dining room at 5.20pm and it was 18 degrees centigrade in the upstairs corridor at 5.40pm. People were observed sitting with blankets wrapped around them in the lounges and one person sitting in the dining room having breakfast on 6 November 2017 commented "It's cold in here." Mid-morning we heard one person say to their neighbour, "It's not very warm in here." Further comments were heard throughout the first day. One relative told us, "The only thing I would say is it could be a bit warmer." They had brought in a blanket for their relation as they were so concerned about the temperature. There were two convector fires in the lounges, one of which was blowing out cool air. The registered manager agreed to ensure the heating was turned up. On the second day of the inspection, it was much warmer in the home.

We saw a large part of the wall in the lounge had exposed plasterwork. The door between the kitchen and the dining room also banged very loudly and one person commented, "bang, bang, bang" while eating their dinner. We could not find any evidence these issues had been logged in a maintenance file.

We observed safe infection control practices including the use of personal protective clothing.

Requires Improvement

Is the service effective?

Our findings

We asked people if they felt staff were confident in their roles. One person said, "Overall I'm happy, no doubt about it. The staff know what they are doing." One relative told us, "The staff work well together and know [name] well, I've no grumbles."

Staff received an induction which included core training. We looked at supervision records and staff told us they had received sessions which they read and signed. The registered manager said, "Staff have supervision a month after they start and then two-three monthly afterwards. As many staff have been here a while some only have it every six months. They also have an annual appraisal." Staff received positive comments about their performance including, "[Name] leaves no stone unturned" and "Always informs staff of work required." We also saw evidence where particular issues had been identified, staff received targeted supervision to address these and they were monitored following this.

Staff spoke positively of the training they received which was thorough. One care worker told us they were currently completing a series of workbooks around infection control and they were interesting. Other topics included safeguarding and mental capacity. Staff had undertaken training in emergency aid, moving and handling, food safety, safeguarding, mental capacity and infection control. Not all staff we spoke with had completed fire training in regards to the use of the evacuation sledge or displayed understanding of how to support people living with dementia appropriately which showed in some of the interactions we observed between staff and people living in the home where people were not addressed directly during moving and handling transfers for example.

One person told us, "The food is good here and there's plenty of it." We saw portion sizes were sufficient. However, we observed poor mealtime experiences for people. During the breakfast period we saw two people given bowls of porridge without any explanation and this was left in front of them. They were not encouraged to eat it and no staff offered to support initially as they were occupied moving people into the dining room. Another person had three Weetabix in front of them and although a care worker sat down to support them to eat it, the person was not told what it was, the spoon was just placed near their mouth. In this person's care record it was recorded, 'staff need to sit at the side of [name] and inform them what is on their plate, and make sure their food is cut into bite-sized pieces'.

During the mid-morning drinks round on both days, people were given tea and no one was asked if they would like an alternative. Again, we observed people were given drinks but were not advised what they were or supported to drink them. We were told by a care worker two people had thickener added to their drinks to prevent choking, however, this was only recorded on the dietary requirements list for one person. When we checked one person's care record we found their nutritional care plan did not reflect the need for thickener in their drink. This was only recorded on a monthly review referring to Speech and Language Therapy (SALT) advice received at the time. Another person's dietary intake care plan written in 2015 did not evidence new advice received from the SALT team in June 2017 where it noted the person was to have only soft options.

People were taken to the dining room a long time before any food was served. People were encouraged to

move into the dining room at 11.40am and yet no food was served for a further 40 minutes. When we asked the cook why people were not being given food we were told, "We are waiting until more tables are full." One person who needed assistance with their meal was not given any food until 12.40pm and then they proceeded to eat with their fingers as no staff were around to support. Other people were not brought to the dining table until 12.50pm and then had to wait for support. The care worker did not tell people what was on their fork as they were assisting two people at the same time. One person pointed to two things on their plate and said, "I don't want those" to the cook and was told "You like mash. Eat what you want and leave the rest." This person was no offered an alternative. As with the beginning of the meal, people had to wait to move into the lounge after they had finished their meal as there were not enough available staff available to ensure safe transfers.

The three members of the care team focused on bringing people into the dining room and meals were served by the catering staff with little meaningful engagement. Initially it appeared that the only meal on offer was fish cakes, mashed potatoes, peas and white sauce. This was pre-plated and placed in front of people without any discussion or acknowledgement. People's preferences were not checked to see if they were happy with the meal choice and people with visual or cognitive impairment were not advised what was on the plate. We saw later there was also minced beef pie, boiled potatoes, peas and gravy on the menu which some people were given without any discussion. The pudding of sponge and custard was also placed in front of people without any comment.

One person called a member of the catering staff over and told them that they had had enough of their lunch, having only eaten a quarter of the portion. They said, "I'm still full from breakfast." This was because breakfast had not finished being served until 10am. We did not see people offered second helpings and the only drink offered was orange squash after the meal. Three people were given shandy but this was not offered to anyone else. Tea time was a similar experience with people not being offered a choice of drinks and sat in the lounge for over 25 minutes before any food was offered. One person who needed assistance with eating had been supported to the dining room before 4pm and left at a table. They did not did not receive assistance until 4.40pm.

We saw in the kitchen a list of the planned meals for the first day of the inspection, along with people's names, birthdays, type of diet and fluids, any allergies and dislikes and whether people liked to wear a clothes protector during meals. Where people need support with eating this was noted in terms of equipment needed such as plate guards or whether staff needed to assist. Staff were aware of who needed extra support and how to report any concerns regarding a person's nutritional intake. However, food and fluid charts only allowed staff to tick against a pre-completed amount such as ½, and did not indicate what or how much food was actually offered. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care as people's preferences and wishes were not evidenced and the dining experience was very task-focused.

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.

Where people lacked capacity to agree to take their medication we did not see any capacity assessments or best interest decisions. People did have decisions relating to 'understanding the necessity of 24 hour care' but some of these were dated from 2014 and people's capacity had not been reassessed. We found some evidence of consent discussions with people's appointed representatives where people were unable to

make the decisions themselves. However, these had not been regularly reviewed. Where people did have capacity this was recorded and their written consent recorded.

Staff had a working knowledge of how mental capacity may affect someone and knew who was able to make their own choices. One care worker explained, "I always explain and ask them simple questions to offer choice." As the staff team was stable they knew people well and how their decisions may be communicated such as pushing food away if they have had enough.

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

Staff's understanding of DoLS was mixed as some told us they focused on making decisions in people's best interests whereas others were aware of the restriction on people's liberty. The registered manager advised there were six authorised DoLS in place with a further two applications awaiting decision. However, they were unable to state who had conditions attached. We looked at the DoLS file and found very little evidence of the necessary paperwork to ensure the service was meeting any DoLS conditions. One DoLS had been granted in April 2017 but there was no corresponding paperwork and yet the previous DoLS had conditions attached. The registered manager advised us they had not received this and yet we could see no evidence this had been followed up with the supervisory body. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as the registered manager was unaware who had a current DoLS condition and therefore could not evidence they were compliant with these.

We saw evidence health and social care services were requested for people. People had access to the GP, district nurses, opticians and chiropodists when needed. Staff were able to explain effective pressure relief care techniques. No one had a pressure sore and staff told us how they would report any concerns. We spoke with a visiting health professional who told us, "Staff are helpful. There are no problems at all. Staff know people well and it's usually the same staff on duty." They also said staff followed any advice given and they were called to the home only when appropriate. One relative also confirmed, "If needed, the GP is called promptly."

Some rooms were personalised with photographs. The lounges were not particularly welcoming as doors were left open and the open alcoves meant noise carried between rooms. Some people in the lounge were looking at a wall as chairs were lined up round the outside of the room and when the doors to the patio area were opened it meant the rooms lost their heat very quickly.

Good

Is the service caring?

Our findings

One person said, "It's great. They look after me really well. I've been smoking since I was 16 and I'm 81. Someone always wraps me up and stays with me when I go out for a quick one." Another person told us, "They are kind, they look after me... If I want owt they get it for me, they're always popping by to check on me and have a chat." One relative also told us, "They are quite prompt at caring for you if you do need anything." Another relative spoke highly of how staff had made significant efforts to get to know their relation. They stressed how staff had worked at the person's pace in terms of involvement in the home rather than forcing events on the person.

People were able to receive visitors at any time. One person visiting the home told us, "I visit [name] every week and we sometimes take them out in their chair. Their relative comes sometimes as well, and we've already got it planned; in a couple weeks we'll go down to the cenotaph cos it's Remembrance Sunday." Another relative said, "Staff are always polite and friendly."

It was one person's birthday on the second day of the inspection and they were brought a cake with candles and everyone sang to them. There was a nice atmosphere of celebration. We found staff were caring, patient and kind when talking to people.

Staff demonstrated in-depth knowledge about people's wishes and lifestyle choices. They told us no one had specific cultural or religious needs at present although there were visits from a local church every couple of months for those who showed an interest. One care worker told us about people's different interests including crochet, knitting and reading. The registered manager discussed the Equality Act in regards to both staff and people living in the home, and said they focused on people as individuals, and sought to meet their needs as best they could. The protected characteristics were embedded in the service's policies and procedures.

We observed staff routinely knocking and waiting to be invited into people's rooms before entering, and then engaging in conversation once they had gone in. One person told us, "They always knock on the door before they come in." One care worker said, "We get close to them and whisper. Close doors and windows if they can wash themselves. We let them do what they can for themselves."

Requires Improvement

Is the service responsive?

Our findings

We asked people if there was enough for them to do and one person said, "I'm quite happy with what I get here. I don't need a lot of support, but I go down for my meals, I have a lovely view from my room and I can read and watch my TV. I'm not a fan of bingo, but the things I do like; I choose to join in with." Another person told us, "There's not a lot of activities here, but I have my crochet and my knitting and stuff. It's all piled up in this corner, so I keep myself busy."

However, one visitor said, "They could do with more in the way of activities for them." We saw a flyer advertising a coffee morning although it did not contain a time. One relative we spoke with was aware of it. The TV was on in the first lounge on the first day but no one could hear it as the volume was too low. People were not engaged with the programme. Records relating to activities were sparse; one person's file had the last entry dated December 2016. There was a list of daily activities on the lounge door but the last date was 4 August 2017. One care worker did play with an inflatable ball with people but they were often called away to deal with other issues.

The registered manager was aware of the limits of activities. They explained options had been discussed with people, some of whom had requested trips and bingo. However, when such activities were arranged they said people did not engage in them. The registered manager had recently undertaken some reminiscence activity which people had engaged with.

We saw a newsletter advertising a forthcoming 'Glam 'n Glitz' evening and also celebrating people's birthdays. One care worker discussed the party evening engaging with one person, "Your [name] will like that as they enjoy dancing."

We looked at care records and found most were written in a person-centred manner. The registered manager completed detailed pre-admission assessments to obtain information about people's needs. For example, in one person's record it was recorded, "[Name] hears when spoken to as they try to acknowledge this by nodding or attempting to speak." Where people were able to contribute their comments were noted and written on the care plan. This included people's life histories which provided care staff with significant information about previous occupation and interests to help them form relationships. Care plans included information about people's mobility, nutritional needs, pressure care, communication needs, personal care regime and medication support.

As with the risk assessments although care plans were reviewed on a monthly basis, this provided little value as the needs were not considered in full and information remained the same. One person's nutritional care plan and risk assessment had been scored but this had not changed for over a year and yet their needs presented quite differently from the care plan document. The care plan explicitly stated "One member of staff should sit at the side of [name] and inform them what the meal consisted of." We did not observe this at any meal time with this person.

Daily notes recorded minimum detail about people's mood, activities and wellbeing and reflected task

based support only. We saw a 'bath book' which showed people only had showers on a weekly basis. This was reflected in people's care plans where we saw it recorded, "Requires help of two staff to maintain weekly shower. Unable to help themselves wash or dress." It was unclear whether a weekly shower was the person's preference. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records did not always reflect people's current need.

People we spoke with told us they would know what to do if there was an issue of concern. One person told us, "Look, I've no complaints about the staff, the cleanliness, the food or anything. I'm happy and settled here." Another person said, 'I'd go to the top, there's no point being worried about something and keeping it to yourself. If it was more minor, I'd just speak to one of the carers, they're all very good and helpful." One relative said, "I'd go to the manager, or [name] is always around and very helpful." Another relative who had not had any cause to complain said, "If there are any problems they sorted straight away."

We were advised by the registered manager no complaints had been received as "we get on well with everyone." However, we did find evidence of one which had been dealt with thoroughly. The provider's complaints policy was displayed in the reception area along with a large number of thank you cards. One visitor said, '"Look at all those cards; they're all thank you cards you know, so they must be doing something right."

Requires Improvement

Is the service well-led?

Our findings

People were happy in Hoyland Hall and knew the registered manager and names of the staff, speaking positively of them. One relative said, "I'm very happy my relation is here. I know they are settled and are well looked after. This home cares about people." Another relative stated on a recent survey, "I have peace of mind. They are well looked after."

We found minutes of regular meetings with people who lived in the home. Discussions had included the provision of meals, activities and upgrades to the bathrooms into wet rooms. We saw people and relatives had completed a questionnaire asking a range of questions about the care at Hoyland Hall. Comments included, "I am very happy with the care and respect the staff have for my relative," "warm, clean home, lovely girls," and "staff always nice and friendly to me. Help me shower. Give me good food." One relative told us, "The manager's door is always open. They will talk about anything and are always very receptive."

Staff spoke well of each other, stressing how they worked well as a team. One care worker said, "There is a handover morning and night between each senior who then tells us what we need to know." Another care worker said, "The staff team are good. I come and try and do a good job. They will tell me if I have any faults." A further care worker told us, "I'm very aware this is people's home and we try to offer the best service we can."

The registered manager was also spoken of highly of by staff. One care worker said, "They are good. If they are any problems they deal with them. The provider comes in most days. If we need anything we just tell them and then they get it." Another care worker said, "Yes, I feel listened to." The registered manager endorsed this view saying, "The director visits daily and there are never any cutbacks. Nothing is frozen or pre-packed, everything is prepared fresh." We saw evidence of regular provider visits which referenced conversations with people in the home and a walk-around the premises to identify any concerns. They also looked at supervision and training records to ensure these were up to date.

The registered manager explained staff meetings were not always recorded as they caught staff "10 minutes here and there" and as they were a small staff team this seemed to work. We saw minutes of staff meetings which had discussed care plan recordings, amendments to DoLS legislation, training updates and how to engage better with people in the home while acknowledging the time constraints on staff to do this.

We asked how the quality of service provision was reviewed and the registered manager advised, "Through questionnaires which people and visitors complete, and also when we speak to families." Some of the comments from visitors and health professionals included, "Staff are great, friendly and helpful," "This is a really nice care home," and "All staff are accommodating, welcoming and aware of people's needs." Some suggestions for improvements were made such as ensuring people were offered a choice of where to sit and activity boards to be on display. One care worker when asked how they knew they were doing a good job told us, "By my appraisal and I would be told if I needed to improve anything."

There were no other formal auditing tools in use which meant the registered manager was unable to

evidence how they knew their care delivery was safe and effective.

The registered manager was keen to state people did not have keyworkers as they felt this meant people became reliant on specific staff and this was to their detriment. Instead, all care workers were responsible for reviewing three care plans every month to ensure they were up to date, and these were then audited by the registered manager. We did not see evidence of any auditing paperwork which meant the quality of these evaluations had not been addressed. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were no systems in place to assess, monitor and improve the quality of service provision.

We asked the registered manager what their vision for the home was and they said, "To get everything sorted and finished" in relation to the premises' improvements. In regards to care they stressed they wanted people to be 'safe and comfortable in their latter years and to have good relationships with all services they came into contact with." They felt their key achievements were, "a good relationship between staff and outside agencies." They felt all staff were very friendly and were hospitable with any visitors.

Hoyland Hall had its rating and report on display on the reception area of the home.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's preferences and wishes were not evidenced and the dining experience was very task-focused.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager was unaware who had a current DoLS condition and therefore could not evidence they were compliant with these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were being placed at risk of harm by unsafe methods of transfer and inconsistent practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were insufficient to mitigate the risks to people in the event of a serious incident. Records did not always reflect people's current need. There were no systems in place to assess, monitor and improve the quality of service provision.