J.E.M. Care Limited

Haylands Residential Home for Gentlemen

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on the on 25 and 26 July 2016. The first day was unannounced.

The service was previously inspected 4 February 2014 when it was found to be meeting all the regulatory requirements which were inspected at that time.

Haylands Residential Home for Gentlemen is a care home providing accommodation and personal care for up to 24 people living with dementia. It is a spacious, three storey building located in Urmston and situated near local amenities such as shops, a library and public transport links. There is a chair lift in place and communal facilities for cooking, dining, personal care, relaxing and leisure. The home has two lounges and one dining room.

At the time of the inspection there was a registered manager at Haylands Residential Home for Gentlemen. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

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.

During this inspection visit we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment and ineffective quality assurance and auditing systems. You can see what action we told the registered provider to take at the back of the full version of the report.

The manager was present during our inspection and engaged positively in the inspection process.

The manager was observed to be friendly and approachable and operated an open door policy to people using the service, staff and visitors. During the inspection we found Haylands Residential Home for Gentlemen to have a warm and relaxed atmosphere and overall people living in the home appeared happy and content.

Feedback received from people using the service we spoke with was generally complimentary about the standard of care provided. People living at Haylands Residential Home for Gentlemen told us the manager was approachable and supportive.

People were not always protected against the risks associated with the unsafe use and management of medicines. Appropriate systems were not in place for the recording, safe keeping and disposal of medicines.

The service lacked governance systems to assess the quality of the service. For example, effective systems to monitor medicines were not in place and auditing systems were not robust.

Some staff and people told us that activities could be limited at times. A part time activities co-ordinator was responsible for activities, however no activities were organised when they were not at work. This meant at times people lacked social stimulation.

We found that the home was properly maintained and ensured people's safety was not compromised. However, we felt the stair lift at the home required a safety guard in place to minimise any potential trip hazards.

Staff were supported through induction, regular on-going training, supervision and appraisal. A training plan was in place to support staff learning. There were however, gaps in some topics in particular food hygiene and health and safety training.

Consent to care and treatment was sought in line with legislation and guidance. Capacity assessments had been completed appropriately for people and were in their care records. Staff we spoke with understood the principles of the Mental Capacity Act 2005 which meant staff understood the importance of ensuring people's rights were protected.

People felt safe living at the home and their relatives were confident they were well cared for. If they had any concerns, they felt able to raise them with the staff and management team.

Risks to people's health and wellbeing were assessed and managed. There were sufficient suitably recruited staff to keep people safe and promote their wellbeing. Staff received training so they had the skills and knowledge to provide the support people needed.

Staffing levels were structured to meet the needs of the people who used the service. There were sufficient numbers of staff on duty to meet people's needs. However, we found the lunch time observation of our inspection was chaotic and lacked a sense of organisation to ensure this was an enjoyable meal time experience for people.

A process was in place for managing complaints and the home's complaints procedure was displayed so that people had access to this information. People and their relatives told us they would raise any concerns with the manager.

Staff were aware of the whistle blowing policy and they told us they would use it if required. Staff told us they were able to speak with the manager if they had a concern.

We have made recommendations to ensure people who are living with dementia are supported in an environment which is appropriate to their needs.

We also recommend that the provider ensures there are policies and procedures in place for the 'Mental Capacity Act 2005' and 'Deprivation of liberty safeguards', to ensure staff are familiar with the most up to date policies and procedures to follow.

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.

Medicines were not always being managed safely. A system to ensure the proper and safe management of medicines was not fully in place.

We found the safeguarding procedures had not been established to help staff understood how to safeguard people they supported. However, staff had access to the local authorities safeguarding policy and knew how to recognise and respond to suspected abuse.

Recruitment procedures provided appropriate safeguards for people using the service and helped to ensure people were being cared for by staff that were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements to the environment needed to be made, to make home more dementia friendly.

Staff received on-going training, supervision and support to ensure that they were competent and confident in their day-to-day work. However, we found there were gaps in some topics in particular food hygiene and health and safety training.

Systems were in place to assess people's capacity to consent to their care and treatment. However, the provider did not have organisational policies and procedures in place to provide guidance to staff.

Is the service caring?

Good

The service was caring.

People were cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately.

Staff were polite and friendly in their approach. They had a good understanding of how each person communicated, their wishes and emotions.

Staff we spoke with were able to show that they knew people who used the service well. Staff demonstrated a commitment to providing person-centred care.

Is the service responsive?

Good

The service was responsive.

Care files contained the relevant and person-centred information regarding people's background and history to help ensure the staff had the information they needed to support the person safely and effectively, and to respect their preferred wishes, likes and dislikes.

We saw few activities taking place during the inspection. The activity co-ordinator was off work and staff had relied on this support for activities.

People told us they would be confident to raise a complaint if they felt this was necessary. We saw appropriate actions had been taken to investigate complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although some auditing systems were in place, it was evident that there were gaps in the home's quality assurance systems and significant scope for improvement.

The provider had systems in place for gathering the views of people who used the service and their relatives.

Staff felt supported and were able to discuss any concerns with the registered manager.

Haylands Residential Home for Gentlemen

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 26 July 2016. The first day was unannounced.

The inspection team consisted of one adult social care inspector 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.

We sought feedback prior to the inspection from the local authority commissioning and safeguarding teams, the clinical commissioning group (CCG) and Healthwatch. Healthwatch is the national consumer champion in health and care.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked at all communal areas, bathrooms, the kitchen, store rooms, medication room and the laundry room.

As part of the inspection process, we observed how staff interacted with and supported people at lunchtime and throughout the two days of our visit in various areas of the home. We used the Short Observational

Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eleven people who use the service and three relatives. We also spoke with the home manager, deputy manager, administrator, two care staff members, the activities co-ordinator, one cook and one domestic member of staff.

During the two days of inspection we looked at a range of records including: three care plans; four staff files; staff training; minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and audit documents.

Requires Improvement

Is the service safe?

Our findings

We asked the people living at the home what made them feel safe. One person said, "The staff are great here; they help me with everything. I feel safe, not like the other place" and "I feel there are enough staff around."

We checked the arrangements for medicines at Haylands Residential Home for Gentlemen. We were informed that only the registered manager and senior staff were authorised to administer medicines and had completed medication training along with an annual medication competency assessment.

The medicines were stored in one medication trolley in a small lockable room within the home. We noted this trolley was not secured to a wall in this room, due to the room in question also being used as a storage room which was cluttered with other items, such as people's belongings that had previously left the home. The registered manager explained that the medication trolley was previously secured to the wall in the dining room, however the manager was advised by the infection control team that the trolley needed to be stored in a room that had a wash basin available. We noted no room temperatures had been recorded by the staff responsible for medicines at the home. During the inspection we viewed the laundry room that was located in the cellar of the home. We saw a large bag of medicines stored in this room that were due to be returned to the local pharmacy. We noted that this room was unlocked and we were informed by the registered manager that the room was not locked due to the laundry staff requiring access to store clean linen. We discussed the potential risk hazard with the registered manager of the unsafe storage of returned medicines.

We could not be assured that medicines were stored safely due to the lack of recordings of room temperatures and the unsafe storage of returned medicines. A system to ensure the proper and safe management of medicines was not fully in place.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The controlled drugs medicines were stored in a locked room in the cellar of the home that was only accessible to staff. We checked these arrangements for the storage, recording and administration of control drugs and found that this was satisfactory.

We saw a list of staff responsible for administering medication, together with sample signatures was available for reference and photographs of the people using the service had been attached to medication administration records to help staff correctly identify people who required medication.
We checked that there were appropriate and up-to-date policies and procedures in place around the administration of medicines and noted that a medication policy was in place for staff to reference. We noted that protocols for the administration of PRN (as required medication) were also in place.

The registered manager informed the inspection team she undertakes regular checks within the home to ensure the environment is safe. However, we found these checks had not been recorded. During the

inspection we noted that the stair lift at the home did not have a safety guard at the bottom of the stairs to minimise the potential of someone tripping over the rail. The registered manager acknowledged this potential hazard and informed the inspection team they would ensure the stair lift company was called out to look at the stair lift and in the interim to find a way to minimise any potential risk of people tripping. Since the inspection, we have contacted the registered manager who has advised us the stair lift company came out on the 27 July 2016 to assess the stair lift. However, they were unable to offer any solution. The registered manager went on to say the home will get their maintenance person to put up a warning barrier in the forthcoming days. We will review the stair lift at our next inspection.

Equipment checks were undertaken regularly and safety equipment, such as fire extinguishers and alarms, were also checked regularly.

An accident book was in place to record incidents, accidents and falls and to maintain an overview of incidents. This information captured did not provide any evidence of lessons learnt and actions taken to minimise the potential for reoccurrence. The manager acknowledged this observation and assured us she would update records so this information was included to ensure best practice.

We saw that care records contained risk assessments to identify any potential risks to people's health and wellbeing and plans were in place to safely manage those risks. We noted risks of falls were being managed and referrals to external professionals were made if required. We saw people had their walking aids close to hand throughout the day. We saw several occasions when staff reminded people to use their walking aids before mobilising and staff walked with people to ensure they remained safe. We heard one staff member say to a person they were supporting, "You need to take your walking stick with you." Staff we spoke with understood the risks associated with people's individual care needs and their knowledge of people and their risks, helped keep people safe because they knew what support they needed.

At the time of our inspection Haylands Residential Home for Gentlemen are registered to provide accommodation and personal care to 24 people, some of whom are living with dementia. There were 22 people living at the home at the time of our inspection.

The registered manager said staffing levels supported people's needs, especially as the home was not at full occupancy. We saw people's dependency had been assessed. However, the registered manager we spoke with told us there was no dependency tool or other way of reviewing the combined dependency of people supported by the service to help determine staffing requirements. The manager said if occupancy increased, staffing levels would be reviewed. From 08:00am to 3:30pm there were two care staff plus one senior staff member on duty. In the evening time from 3:30pm to 11:00pm there were two care staff plus one senior staff member on duty. During the night, staffing levels were two care staff from 11:00pm to 08:00am. The senior staff were responsible for managing the shift, medicines and supporting staff alongside the registered manager. In addition, there was one cook, a part time activity co-ordinator and housekeeping staff. The registered manager said they had bank staff to rely on when unexpected absences occurred, plus they stepped in to help out.

No concerns were raised regarding staffing levels at the time of our inspection from people using the service or staff. We observed that staff were able to respond to call bells quickly and had time to spend with people as well as providing care.

We saw that an emergency plan had been developed to ensure an appropriate response in the event of an emergency. The plan contained contact details for various emergency evacuation places and contact numbers for staff and contractors in the event of a gas, electric, plumbing, nurse call or other emergencies.

We noted that personal emergency evacuation plans (PEEPS) had also been produced for people using the service. PEEPS provide a clear contingency plan to ensure people are kept safe in the event of a fire or other emergency.

The Care Quality Commission (CQC) had received one whistleblowing concern since the last inspection in February 2014. This was in relation to a lack of staffing during one shift in January 2016. We found this concern to be unfounded as the registered manager was able to explain this matter in detail, along with evidence of the rota concerning this allegation. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. We spoke to staff about the principles of the whistleblowing policy and it was clear they had a good understanding of the policy and who they would notify if they had concerns. Staff also knew to be vigilant about the possibility of poor practice by their colleagues and they knew how to use the home's whistleblowing policy.

The manager and staff we spoke with demonstrated a good awareness of their duty of care to protect the people in their care and the action they should take in response to suspicion or evidence of abuse.

Discussion with staff and examination of training records confirmed that the majority of the staff team had completed safeguarding vulnerable adults training. We noted three staff members were in the process of completing this training via e-learning.

During the inspection we asked to view the registered provider's 'Safeguarding Adults' policy and procedure. We were informed by the registered manager that the service did not have a policy in place. We were informed by the registered manager that the service referred to the local authority's policies and procedures. We found these local authority's policies and procedures were available for staff to view.

Examination of individual safeguarding records confirmed the provider had taken appropriate action in response to incidents. In some instances the provider had been asked to undertake an investigation having reported the concern to the local authority safeguarding team. We looked at records of some of the investigations and could see actions had been identified where required to help ensure people were kept safe. Staff spoken with demonstrated a good awareness of their duty of care to protect the people in their care and the action they should take in response to suspicion or evidence of abuse.

Through discussion with staff and the examination of records we received confirmation that there were satisfactory recruitment and selection procedures in place which met the requirements of the current regulations.

We looked at a sample of four staff records for staff recently recruited. In all four files, we found that there were application forms; references, medical statements; disclosure and barring service (DBS) checks and proofs of identity including photographs. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We were satisfied that the service had appropriate recruitment systems in place to help ensure staff employed were fit to work with vulnerable people.

We saw domestic staff cleaning the premises and viewed schedules in place to make sure all areas of the home were kept clean. We saw that staff wore aprons and plastic gloves when they were cleaning. The home was clean and free from any malodours during our visit.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service and their representatives if they found the service provided at Haylands Residential Home for Gentlemen to be effective.

People we spoke with told us that their care needs were met by the provider. Comments received from people included: "I shout for staff and they come and help me", "It is very good here; staff are very kind to us. I admire them; never heard staff get angry or shout at people", "Staff are understanding when people are not happy or shout or something" and "It warms the cockles of my heart to see their kindness."

One relative told us, "Staff, [manager's name], keep us informed about how (relative) is doing. We come to see (them) maybe three or four times a week. They phone us up if needed. That is very reassuring for the family."

Haylands Residential Home for Gentlemen is a care home providing accommodation and personal care for up to 24 people living with dementia. It is a spacious, three storey building located in Urmston and situated near local amenities such as shops, a library and public transport links. There is a chair lift in place and communal facilities for cooking, dining, personal care, relaxing and leisure. The home has two lounges and one dining room.

We found there were some basic adaptations to make the environment at Haylands Residential Home for Gentlemen more accessible to people living with dementia. There were pictorial signs for rooms such as the toilets and the dining rooms, and there was limited use of colour schemes that would help people living with dementia orientate around the home and recognise where bathrooms and toilets were. There were no photos or other distinctive indicators in place that would help people recognise their bedrooms and promote people's independence. There are ways to modify buildings to better accommodate those living with dementia in residential care, for example, picture signage, the use of wall and floor colour to aid navigation and memory boxes
to stimulate memory and promote discussion.

We discussed the environment with the registered manager who informed us they had begun to work on areas in the home to make the premises more 'dementia friendly', however this work was still on-going. A dementia friendly environment is an environment which takes into consideration the needs of people living with dementia and allows them to find their way around the home safely and This would have a positive impact on people's emotional well-being dignity and independence.

We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

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.

We saw mental capacity assessments and best interests decisions were documented and in place regarding decisions for treatment and care. For example, we saw one person's ability to make decisions regarding their diet had been assessed and another person's capacity had been assessed in regards to their mobility and fluid intake.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 was being met.

We saw the registered manager had made DoLS applications which were appropriate and they demonstrated they were aware of their responsibilities under this legislation.

The staff we spoke with had variable knowledge regarding MCA and DoLS. However, they demonstrated that they understood the importance of consent, offering choice, and helping people to make decisions. During our inspection we witnessed this in practice as we saw staff checked people's consent to the care they were providing. One person told us staff always ensured they knew what staff were doing and said, "I've never done anything I don't want to."

We found the provider did not have organisational policies and procedures for the MCA and DoLS. The registered used current guidance available whenever they needed to refer to the MCA and DoLS process.

We recommend that the registered provider implements their own MCA and DoLS policy and procedure, which will provide staff with guidance on how to follow the MCA process.

The provider had established a programme of induction, mandatory, qualification level and service specific training for staff to access. This was delivered via a range of methods including face to face and on-line training.

New staff were subject to a structured induction process. This led to them gaining the Care Certificate. The Care Certificate is provided by the Skills for Care organisation and is the start of the career journey for staff and is only one element of the training and education that will make them ready to practice.

At the time of our inspection, training records were not up-to-date. The registered manager arranged for an up-to-date training matrix to be forwarded to the inspection team upon completion of the inspection. The training matrix received following the inspection confirmed that staff had completed key training in subjects such as first aid; moving and handling; fire safety; safeguarding; medication; control of substances hazardous to health; infection control; and dementia awareness. Staff we spoke with confirmed they had annual refresher courses. However, we found gaps were noted for some topics in particular food hygiene and health and safety training MCA and Dol's. The registered manager explained it was the staff responsibility to complete this training via e-learning, as the training is available to staff. The registered manager went on to say this was something the she is looking to address with the staff team at the next team meeting to remind the staff of the importance of completing this mandatory training.

Additional training courses such as national vocational qualifications / diploma in health and social care were available for staff to undertake.

We noted that team meetings had been coordinated for staff to attend throughout the year and that staff had access to annual appraisals and supervisions every two months. Staff spoken with confirmed they felt valued and supported in their roles.

A four week rolling menu plan was in operation at Haylands Residential Home for Gentlemen which offered people a choice of menu and was reviewed periodically.

There was a record of any special diets required and we saw there were plentiful supplies of fresh, frozen, dried and canned foods. This included the option of fresh fruit. The kitchen had been awarded the five star very good rating at the last environmental health inspection which meant the cook followed safe food hygiene practices. Each person had a nutritional assessment in their plans of care and we saw that people had access to dieticians if they needed more support.

We received mixed comments from the residents regarding the food. One person said, "I have been here six weeks, yes, very nice food here." Another person said "It is patchy, during the week it is not bad, but at weekends it goes to pot; meals are hit and miss then." A third person told us, "I like the Sunday roast; you can have something else if you do not like it."

We observed the lunchtime meal on the first day of our inspection in the dining room. The décor of the dining room had not been updated for some time and would benefit with updating. We noted some tables had tablecloths and napkins while others did not.

Throughout our observation the staff on duty appeared to be rushed. Although the large majority of people did not require assistance we found the meal time experience was chaotic and lacked a sense of organisation to ensure this was an enjoyable meal time experience for people. We observed many people still eating their meals of bacon and scrambled eggs, while a dessert for other people were being served. We observed one person tell a staff member they did not like bacon. We heard the staff member say they would see if there was an alternative choice in the kitchen. This staff member never returned and the expert by experience person encouraged the resident to eat the scrambled egg instead before it went cold.

We discussed our observations of the mealtime experience with the registered manager during feedback. The manager said they would look to address this problem and ensure the meal time experience for people was not rushed.

People were weighed monthly and appropriate action was taken if people lost weight, for example, they were referred to the dietician, therapist or GP. We saw that referrals had been made to dieticians, the SALT team, occupational therapists and district nurses when required.

Good

Is the service caring?

Our findings

We asked people using the service and their representatives if they found the service provided at Haylands Residential Home for Gentlemen to be caring. People we spoke with told us that they were well cared for and treated with respect and dignity by the staff at Haylands Residential Home for Gentlemen.

Comments received from people using the service included: "My six grandchildren have visited me here and I can go home to my daughters if I want to", "Visitors can come any time. Last week my friends picked me up and we went for a pub lunch; I liked that" and "I get support from staff; the staff work hard, we do alright, we all get along well."

Comments received from people's relatives were also positive, "(Relative) is comfortable here. We used to take him out at the beginning but, (relative) just wants to get back to the home now so we stopped taking (them) out. The staff here keep you updated. When (relative) had to go into hospital the family were kept informed" and

"[Name of resident] had a stomach bug. Staff phoned us and kept us updated on how (relative) was doing. Best place on earth here."

Care records we reviewed included information regarding people's interests, their family and social history. This should help staff form meaningful and caring relationships with the people they supported.

During the inspection, we observed staff supporting people at various times and in various places throughout the home. We saw that staff communicated in a kind and caring way and were patient and respectful. We observed staff being affectionate and tactile with people and we saw this often helped to reassure people when they were unsettled.

Through our discussion and observation, it was clear that that there was effective communication and engagement between the people using the service and staff responsible for the delivery of care.

The registered manager and staff were seen to enjoy friendly banter between each other and the people using the service. The home had a warm atmosphere and people were seen to respond to this interaction positively and appeared happy, content and relaxed.

From our discussions with care staff, it was clear they knew the people living at Haylands Residential Home for Gentlemen very well. Staff were able to tell us about people's interests, preferences and the most effective way to support them.

We saw that the people living at the service looked clean and well presented and were dressed appropriately for the weather on the day.

During the inspection, we observed one resident becoming upset in the lounge area of the home. The

registered manager was quickly on hand to speak to the resident and sat with them until they were feeling better. The registered manager explained that this person in particular could sometimes become upset throughout the day and they told us staff were always readily available to reassure them.

People with spiritual needs were supported, the local church attended the home regularly to provide a prayer service to people with religious beliefs. A person's religious needs were recorded in plans of care. There were no people who had any ethnic or other religious needs on the day of the inspection.

The provider told us no-one living at the home was receiving end of life care at the time of our visit. We asked if there was a specific approach or model of end of life care that the home would provide should anyone be approaching the end of their life. The registered manager told us they were previously following the 'Six Steps' end of life programme, but training records confirmed that there had been no specific end of life training at Haylands Residential Home for Gentlemen to follow up this end of life programme. The registered manager explained this was something they would be looking to address in the near future.

Good

Is the service responsive?

Our findings

We asked people who used the service and their representatives if they found the service provided at Haylands Residential Home for Gentlemen to be responsive to their needs. People we spoke with confirmed that the service was responsive to their individual needs.

Comments received included: "The staff are first class here, they know when you are feeling down" and "I had sore gums for a while but the staff soon sorted that out and made a dentist appointment for me. I now have new dentures."

One relative reported, "(Relative) can change by the minute; (they) can be okay but then becomes aggressive putting (their) fists up to you when you go to speak with (them). The staff are good with (them) though; they are patient. We feel staff will work with (relative); they adapt to his changing needs."

As part of the assessment process, the provider asked the person's family, social worker or other professionals who may be involved to add to the assessment if it was necessary at the time. We looked at the pre-admission paperwork that had been completed for people currently living in the home and we could see that the assessments had been completed.

The three care files we looked at contained the relevant information regarding people's histories to ensure the staff had the information they needed to respect the person's preferred wishes, likes and dislikes. For example, food the person enjoyed, preferred social activities and social contacts, people who mattered to them and dates that were important to people. We saw that the provider
tried to obtain consent to care from the person themselves; if this was not possible because they had been assessed as not having capacity then they would ask the person's family or representative regarding the person's best interests. We saw the care plans had been regularly reviewed and updated. Staff told us that they were informed of any changes in a person's needs at the daily shift handovers.

This helped ensure the staff had the information they needed to meet people's needs.

We saw little meaningful activity taking place during our inspection. The television was on in the lounge and we saw some people sat reading newspapers.

Comments received from people regarding activities and recreation included: "There is not a lot going on; I read the papers when I can get one", "I like it here but I am bored", "There is activities happening here if you wish to take part" and "The last home I was in, the large cellar was set up so we could play darts, snooker, and table tennis. It is good to keep active. The basement will be big here, why can they not clean it up, get rid of the rubbish and have a games room."

The home employed an activity co-ordinator who worked on a part time basis at the home. The activity co-ordinator was extremely motivated about the activities provided and was always looking to introduce something new at the home. On the second day of our inspection we looked at the activity file with the

activities co-ordinator. This file evidenced that activities had been taking place only on the days the activity co-ordinator was in work. We viewed evidence of a recent boat trip for the residents and other indoor activities such as painting, crafts, coffee mornings, dog therapy, massage, puzzles, music and one-to-one reminiscence time. We noted the provision of activities had been reliant on the activity co-coordinator and as such had dropped off in their absence.

We discussed the activities further with the registered manager. The manager confirmed she would look at improving the frequency of activities and ensuring activities still took place when the activities co-ordinator was not available.

We saw there was an up to date complaints policy that contained details of organisations external to the provider that people could contact if they were not satisfied with the handling of their complaint. People we spoke with told us they would feel confident to raise a complaint should they feel this was necessary. We looked at the provider's record of complaints and we saw complaints had been investigated, and actions taken to resolve complaints.

Residents' meetings had also been coordinated throughout the year. The last meeting was in April 2016. These meetings allowed residents to air their views and opinion's concerning the home. Activities were discussed at these residents meetings and people's suggestions were recorded. The activities co-ordinator commented; "We are always looking to organise trips out for the gents, we have recently been on a boat trip, we did two trips so nobody missed out."

Requires Improvement

Is the service well-led?

Our findings

We asked people who used the service if they found the service provided at Haylands Residential Home for Gentlemen to be well led.

People we spoke with confirmed they were happy with the way the service was managed.

Comments from relatives included: "I have no complain about the staff because they know what they are doing", "The manager is great here. (They) know (their) job very well, top marks", "The staff and manager are good here" and "The carers have been here a while so I know them all."

The registered manager and the deputy manager were both present throughout our inspection. Both managers were observed to be helpful and responsive to requests for information and support from the people using the service, staff, visitors and the inspection team.

During our inspection, we observed that people and their visitors felt able to approach the registered manager directly and the manager communicated with them in a friendly and caring way. People were observed to refer to the registered manager by their first name which reinforced that there was a friendly yet professional relationship between them.

The registered manager told us they carried out quality assurance checks on the service provided. The registered manager told us they also carried out informal checks on the care plans, safety of the home and observing the competencies of staff. However there were no written records of these checks for us to review. The registered manager said they would often do unannounced spots checks of the home; however these were not recorded.

We did see the registered provider had recently developed infection control audits within the home that had been carried monthly since April 2016. These audits at times lacked detail and needed to be more robust ensuring all areas of the home had been audited for example. The home had an infection control audit carried out by Pennine Care Trafford division in March 2016. Areas were highlighted in this audit that needed addressing by the provider. The registered manager confirmed all actions had been addressed.

We noted that care plans audits had also recently been introduced to the service and these were carried out by the senior staff at the home. We saw these audits identified areas within the care plan that needed to be reviewed, for example, we saw the registered manager completed a monthly medication audit. However, we questioned how robust these audits were given the shortfalls we have found during our inspection of the home's administration of medicines. We noted the registered provider did not have a clear overview of accidents and incidents at the home, due to there being no overview record established to capture any evidence of lessons learnt and actions taken to minimise the potential for reoccurrence. Furthermore, we found the registered provider had not established their own organisational policies and procedures for safeguarding adults, MCA and DoLS, to ensure the most relevant and up to date guidance was available for the staff to follow.

Although some auditing systems were in place, it was evident that there were gaps in the home's quality assurance systems and significant scope for improvement.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we were shown an action plan of areas the registered provider were looking to improve. In discussion with the registered manager they confirmed the owners were visiting regularly to assist with areas that were highlighted in the action plan. We noted the main area of this action plan was to create an environment which was safe and stimulating to people living with dementia. We will check the progress of this work at our next inspection.

The quality assurance process for Haylands Residential Home for Gentlemen involved seeking the views of the people using the service or their representative periodically. We were informed by the registered manager that questionnaires had recently been sent out and they were awaiting the results.

We checked a number of test and / or maintenance records relating to the fire alarm, fire extinguishers, gas installation, electrical wiring, portable appliance tests, water quality checks and hoisting equipment. All records were found to be in satisfactory order. We noted that meetings with staff and people using the service or their representatives had been coordinated periodically to share and receive feedback on the service provided. This meant people, their representatives or relatives and staff were given the opportunity to give their views about the service to help make improvements.

The manager is required to notify the CQC of certain significant events that may occur at Haylands Residential Home for Gentlemen. We noted that the registered manager had kept a record of these notifications. This meant that the registered manager was aware of and had complied with the legal obligations attached to their role.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has not ensured the proper and safe management of medicines was not fully in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has not ensured effective systems were in place to monitor and improve the quality of service provided.