Roche Healthcare Limited

Hartshead Manor

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

We inspected Hartshead Manor on 4 and 6 April 2017. The inspection was unannounced on both days. The home was last inspected during May 2016 and there were no breaches of regulations at that inspection. During this inspection, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

This inspection was prompted, in part, by notification of an incident which had resulted in the unexpected death of a person living at the home. This incident is being reviewed by the Care Quality Commission (CQC) in line with our specific incidents policy. Therefore, this inspection did not examine the circumstances of the specific incident.

The information received by the CQC about the incident indicated potential concerns about the way the service managed risk to people. This inspection included an examination of how those risks were managed. We found, since the specific incident, the registered manager had been responsive and had introduced new systems and processes to improve their assessment and management of risks.

Hartshead Manor is a nursing home registered to provide care for up to a maximum of 55 older people. There were 49 people living at the home at the time of our inspection. The home is a converted property providing bedroom and communal areas on both the ground and first floor. The home has a unit which is dedicated to supporting people who are living with dementia.

There was a registered manager in post and this person had been registered with the Care Quality Commission since March 2016. 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 told us they felt safe living at Hartshead Manor. There was an up to date safeguarding policy and the registered manager and staff were aware of relevant procedures to help keep people safe. Staff had received safeguarding training and could describe signs that may indicate someone was at risk of abuse or harm.

Risks to people had been assessed and measures put into place to reduce risk. Since the specific incident, improved practices were in place to reduce risks. People's care plans contained information to enable staff to safely move and handle people and we observed this in practice.

Medicines were stored safely and administered in a kindly manner. However, although we observed people received support to meet their nutritional and hydration needs, records did not always indicate whether people had been given their prescribed drinks, such as those for people nutritionally at risk.

Staff told us they felt supported and had received appropriate induction, training and ongoing support and

supervision and the records we inspected supported this.

People were supported to have choice and control of their lives and we observed staff support people in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed staff to be kind and supportive and people told us staff were caring. We observed people's privacy and dignity was respected.

Care records were person centred and reviewed regularly. However, two care and support staff we spoke with were not aware of the content of care plans. Information was shared between staff to enable continuity of care but this posed a risk that staff were not always fully aware of people's care needs.

Staff told us they felt supported by the registered manager. Regular meetings such as staff meetings and residents' and relatives' meetings were held. Regular audits and quality assurance checks took place, although these were not sufficiently robust and did not identify some areas found during our inspection which required action.

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.

People told us they felt safe.

Records relating to the consumption of prescribed drinks were not always accurate.

Risks to people were assessed and measures were in place to reduce risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received appropriate induction, training, support and supervision to enable them to provide effective care and support to people.

Care and support was provided in line with the principles of the Mental Capacity Act 2005. However, some records of consent were signed by people without the appropriate authority to do so.

There were gaps in evidence to show people's nutrition and hydration needs were being met. Accurate and complete records were not always kept in relation to the care and support provided.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

Advocacy support was provided for people where this was appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans reflected people's needs, preferences, choices and personal histories but some staff did not always read people's care plans.

We observed people making their own choices relating to how they wanted their care to be provided.

Complaints were well managed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us they felt supported by the registered manager.

The registered provider had up to date policies and procedures in place.

Regular audits and quality checks took place. However, these required improvement to be fully effective in improving service provision.

Hartshead Manor

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 4 and 6 April 2017 and was unannounced. The inspection was carried out by three adult social care inspectors and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority contracts, commissioning and safeguarding teams as well as information we received through statutory notifications.

We used a number of different methods to help us understand the experiences of people who lived at the home, including observations and speaking with people. We spoke with 12 people who lived at Hartshead Manor, nine relatives, a healthcare professional, six care and support staff, the cook and the registered manager.

We looked at five people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at Hartshead Manor. One person told us, "Yes, I really do." Another person told us, "I don't need to lock anything away, everything's safe." A further person told us, "I don't have concerns."

A relative told us, "There are ups and downs. I'd have no problem with talking to the staff about concerns."

A member of staff told us, "I'd be happy for a relative of mine to live here."

We looked at how medicines were managed. Medicines were administered by a nurse and senior care staff who had been trained to administer medicines safely and they were administered in line with the registered provider's policy. Medicines training was refreshed annually.

However, some medication administration records (MARs), relating to prescribed drinks and shakes, were not completed fully. We counted the number of remaining drinks, which indicated they had actually been given, as prescribed. However, the staff member administering medicines was unable to explain why the records were not completed. We highlighted this to the registered manager.

We observed people were supported to take their medicines by a member of staff in a kindly, reassuring manner. We saw, if people became agitated or refused their medicines, the member of staff appropriately moved away and returned to the person later. Good infection control practice was observed, such as hand-washing.

MARs contained photographs of each person, which reduced the risk of medicines being given to the wrong people. We observed staff complete the MARs appropriately, once medicines had been administered.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and the drugs that were required to be logged in the register were recorded as such. We checked a sample and found the amount of medicine remaining was correct, according to the register. This showed controlled drugs were managed appropriately.

Some people were given medicines in a covert manner, for example hidden in food. Appropriate steps had been taken to ensure the medicines were safe to administer in this way, in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Medicines were stored safely and securely. Unused medicines were disposed of appropriately and any sharp objects were disposed of safely in an appropriate receptacle, which was kept secure.

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. The registered manager was aware of their duty to report incidents of safeguarding. The staff we spoke with were

aware of the whistle-blowing policy and told us they would report any suspected abuse and escalate their concerns if they felt they were not acted upon. This helped to keep people safe because staff had knowledge of appropriate action to take if they had concerns anyone was at risk of abuse or harm.

Risks were identified and assessed and measures were put into place to reduce risks to people. This was done in a way which enabled people to maintain choice, control and independence, whilst reducing associated risks. For example, self-medication assessment tools were used, in order to determine whether people could safely administer their own medicines. Where people were not able to do this, appropriate decisions were made in line with the principles of the Mental Capacity Act 2005. Where a person was identified as safe to manage one particular aspect of their medicine routine, associated risks had been assessed and the person was supported to be as independent as possible.

Risks in relation to falls were assessed and factors such as a person's history of falls, their medication and cognition were given consideration. These were regularly reviewed. Care records contained moving and handling instructions. Where equipment was used to assist people to move, the type of equipment and associated sling were detailed as well as information relating to the method of application. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely. We observed staff assist people to move, using equipment, in a confident, safe and efficient manner

Records showed a malnutrition screening tool was used and updated monthly in order to consider those people at risk of malnutrition. We saw evidence people were weighed monthly. Recognised assessment tools were completed monthly which considered risks relating to skin integrity. When care staff assisted people to move from their wheelchairs to seats, or from seats to wheelchairs, staff ensured pressure cushions were in place, which helped to ensure safe pressure relief was provided.

Some people had bed rails in place, to stop them falling out of bed. Records showed consideration had been given to the associated risks and the least restrictive options had been considered. These were regularly reviewed. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

We viewed a person's care plan who had epilepsy. The plan contained a detailed personal protocol for staff to follow, should the person have a seizure. The plan included signs to observe, individualised treatment and care and when to call emergency services.

The registered manager had subscribed to the principles of the Herbert Protocol and details were contained within people's care plans. The Herbert Protocol is a national scheme, which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing and to allow for early intervention. This further demonstrated the registered manager had taken steps to reduce risks to people.

We reviewed records relating to the risks associated with choking. Since the specific incident, a dietary needs sheet had been introduced for each person. This contained information such as whether the person was diabetic, coeliac, required food supplements, the person's cultural needs, specialist advice such as consistency of food, likes and dislikes and whether the person required assistance. These dietary sheets were available to kitchen staff and care staff and we saw all staff refer to these prior to assisting people at mealtime. People were observed to be served the meal consistency as documented on their dietary needs sheet. A team leader we spoke with was clear about which type of support and type of diet people required. They told us, "I make it my business to know."

Some people required thickened fluids to reduce the risk of choking. Information was available to staff which showed clear directions as to how much thickener to add to the fluid. We observed staff refer to this information.

We examined records for a person who had moved to Hartshead Manor, and who was at risk of choking. Records showed the person had been referred to a speech and language therapist since arriving at the home. Following the assessment, associated risks were clearly documented and appropriate information was made available to staff.

The registered provider's policy indicated there would be a trained first aider, 'On the staff rota at all times,' although not all staff were trained in first aid. The team leader on shift during our inspection had completed first aid training. There were 61 staff listed on the training matrix and the registered manager confirmed 18 staff were first aid trained.

Regular safety checks took place throughout the home in relation to, for example, bed rails, nurse call bells, fire alarms and emergency lights. Tests such as gas safety and portable appliances had been completed. This helped to ensure the safety of premises and equipment.

We saw some first floor windows were fitted with window restrictors but these were of a chain mechanism and were not suitably robust to prevent vulnerable and determined adults from forcing them open beyond 100mm, as outlined by the Health and Safety Executive. We highlighted this to the registered manager. On the second day of our inspection, the registered manager confirmed that solid, robust window restrictors had been ordered and were being fitted.

Records showed equipment was examined regularly, such as wheelchairs and slings. We saw slings were replaced when this was identified as necessary and repairs were made to wheelchairs where this was highlighted as required. Records showed wheelchairs were cleaned monthly. Regular servicing of equipment took place such as fire extinguishers and lifting equipment for example.

Personal Emergency Evacuation Plans (PEEPs) had been devised for each person living at the home. The plans detailed the level of assistance required and the evacuation route to use, for each person and this related specifically to the room number where the person slept. However that meant the plan would only be valid, in terms of evacuation routes, if the person was in their own room at the time of the fire. The plan did not indicate which routes should be used should people be in another room such as communal areas or bathrooms. Furthermore, we highlighted the plans could be improved by including information such as the person's ability to understand instructions, whether the person would hear alarms, be able to interpret emergency signs and the level of reassurance that may be required for example. The registered manager was receptive to this and agreed to consider this further.

We looked at records of accidents and incidents. We found these were recorded appropriately and evidenced actions taken following any incidents. Analysis took place which helped to identify any trends. We saw a falls diary was kept for a person who was at risk of falling. The date, time, circumstances and outcome of falls were recorded so this could be analysed and falls reduction measures put into place where necessary.

The registered manager told us they used a dependency tool in order to help determine the required staffing levels. We saw this included details of people's needs in relation to, for example eating and drinking, continence needs, mobility, hygiene and daily activities and the tool helped to calculate the number of staff required, based on this information. Our observations were that people's needs were met in a timely

manner during our inspection.

All of the staff we asked told us they felt there were enough staff to provide safe care for people. However, one member of staff said, "Sometimes we could do with an extra pair of hands, if busy." Staff told us there was always a member of staff in communal areas and we observed this. Another staff member said, "Staffing numbers are adequate but it could always be better." One relative felt there were sufficient numbers of staff in the home and told us, "Yes there are. They never seem short staffed." However, some other relatives felt more staff were required. Comments included, "There are never enough staff," and, "There are not enough staff downstairs." One person told us, "I call for staff and they come if I need them," and another person told us, "I might wait for a couple of minutes if I press it [nurse call bell]."

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

There was a 'staff concerns meeting log' which was kept by the registered manager. This showed, where staff conduct had fallen below that which was expected, a meeting had been arranged and this had been addressed where necessary. This is an important aspect of a registered manager's responsibility, in ensuring staff are aware of the expectations placed upon them.

The home appeared visibly clean and was free from malodours. Staff were seen wearing personal protective equipment (PPE) at appropriate times. All of the staff we asked told us they had access to adequate supplies of PPE. This helped to prevent and control the risk of the spread of infection. The people we asked told us the home was kept clean. One person told us, "It's clean and well looked after. The cleaner takes pride." A relative told us, "I think it's lovely and clean."

Requires Improvement

Is the service effective?

Our findings

We asked people whether the staff were skilled and effective. One person told us, "They know what they are doing," and another person said, "Yes, I do think so. They know what they are doing and they do it properly." A person who lived at the home, whose occupational background was health and social care, told us staff were skilled and said, "I'd know if they were not doing their job."

A relative told us, "This place was recommended. The staff are very good." Other comments from relatives included, "They are there straight away if there is any incident," and, "They're very competent and on top of things."

A relative told us they felt confident staff had the skills and abilities to provide effective care. We were also told, "There's continuity of staff. You know who they all are, mostly."

We observed people received support to meet their nutritional and hydration needs on the days of our inspection. However, records in relation to nutrition and hydration, such as food and fluid charts, were not always fully completed and in a timely manner. We saw staff completing food and fluid charts a day later than their observations. A member of staff told us, "I know it's important to keep the records up to date but sometimes we just can't." Records we reviewed showed gaps. For example, the first day of our inspection was 4 April 2017 and we saw one person's food records only showed breakfast and mid-morning entries for 3 and 4 April 2017. Nine people's food records for 3 April 2017 showed no entries until a drink at suppertime. This meant accurate, timely records were not being kept. We shared our findings with the registered manager in order for them to be addressed.

Furthermore, there were gaps in records relating to whether prescribed drinks had been consumed. For example, during the month of March 2017, records for one person who was prescribed a specific drink three times a day showed they had not had their drink in the afternoon on six different days. Records for another person, who was also prescribed the drink three times a day, showed they had not had their prescribed drink in the afternoon on five occasions during March 2017. A further person's record, who was prescribed a specific drink twice a day, showed they had not had their prescribed drink at all on two days during March 2017. The above examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because accurate, complete and contemporaneous records relating to the care and treatment of each person were not kept.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager and the staff we spoke with demonstrated they understood the principles of the MCA and when DoLS would be required. The records we sampled showed mental capacity assessments had been completed and, where people lacked capacity and were being deprived of their liberty to receive care and treatment, appropriate DoLS authorisations had been sought.

The staff we spoke with were clear of the principles of the MCA and demonstrated they were aware of the importance of assuming people had capacity to make their own decisions. We saw evidence decision specific mental capacity assessments had been undertaken, when this was required and the principles of the MCA were followed. Where people were deemed to lack capacity, decisions were made in their best interests, taking into account the person's and other relevant person's views. This showed the principles of the MCA were followed.

We observed staff ask people for consent, prior to providing care and support to people and, if people refused, this was respected by staff. We noted care records contained consent forms and some had been signed by people living at the home and others had been signed by relatives, but in the files we sampled there was no evidence the relatives held Power of Attorney for health and welfare. We highlighted to the registered manager that, although it was important to consult relatives if a person lacks capacity to consent, a relative may only consent to care on a person's behalf if they have the appropriate Power of Attorney to do so.

We recommend the registered provider seeks guidance to ensure only people with the appropriate power provide consent on behalf of others.

Records showed staff had completed training in areas such as fire safety, safeguarding, infection prevention and control, nutrition and hydration, moving and handling and equality and diversity. The staff we spoke with told us they had experienced, during their training, what it felt like to be moved using a hoist. This helped staff to understand the experiences of people living at the home when they were being assisted to move.

Staff told us if they felt the need for further training, they would feel able to ask for this with confidence and it would be provided. A member of staff told us they had a particular interest in dementia and said they had been supported to undertake training in this area. Staff told us, and records showed, staff received regular supervision and appraisal.

Records showed staff had received a thorough induction. This included training and shadowing more experienced members of staff. Records showed the registered manager had requested a member of staff repeat a particular aspect of their training where they felt this was necessary. A member of care staff told us, "The team are a good support, yes." This showed staff received appropriate induction prior to commencing their caring duties.

We spoke with a member of staff who was new to care and who was currently working towards the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

There were instances on the dementia unit where people showed signs of agitation, sometimes towards

other people. Staff were effective and swift to act in order to divert people's attention. This helped to diffuse any situations that may otherwise have escalated.

Drinks and snacks were offered throughout the day. We observed a mealtime experience. Choices of two meals were offered at lunch time and a range of drinks were on offer. We saw a person being provided with a meal that was not on the menu but which they had asked for. Staff encouraged people to eat their meals. People were asked if they would like more, before their plates were taken away. This helped to ensure people's nutritional needs were met.

At mealtimes, people were offered napkins or aprons, to protect their clothing. We noted, on the dementia unit, people were not asked whether or how much gravy they would like, as this was served already plated. People were given the choice whether they wished to remain in their seats or move to the dining table at mealtimes.

A person said they would like, "A bit of both," when they were given choices for a meal. Staff brought the person what they had asked for. Despite this, the person did not eat much of their meal. Staff were observant of this and brought the person a fresh meal.

Staff encouraged people to eat and prompts were given. We saw, on the dementia unit, there was a menu board which included pictures. Having a pictorial board helps people with dementia to make their own choices.

Comments from people in relation to food included, "Very good. Well cooked. They asked us what our favourite meals were." Another person told us, "The meals are alright. They ask you what you want."

We looked at the layout of the home. The registered manager told us they were planning to include a photo board of staff members in reception. This would help people to identify staff. A calendar displayed the correct date and time. Menu boards displayed the correct menu for the day. Effective signage was placed around the home to help people to navigate. Boxes were placed outside people's rooms, containing personal items and photographs and this would further help people to identify their rooms. Corridors were brightly coloured with appropriate pictures and contrasting doors. All these features helped to create an appropriate environment for people living at the home.

Concerns had been raised following a specific incident that people may not be receiving appropriate health care support. Records showed referrals were made to appropriate health care professionals such as doctors, district nurses, community psychiatric nurses, occupational therapists, speech and language therapists and care home liaison team. Care home liaison team is a liaison service which offers care home staff support in their care planning to enable them to better meet the needs of their residents, improve their well-being and minimise risks. We spoke with a healthcare professional, following our inspection, who told us they felt the staff and registered manager were receptive to their input and acted upon their advice. This showed people living at the home received additional health care support to meet their care and treatment needs. A relative we spoke with confirmed the registered manager had made referrals and sought advice from other health care professionals.

Good

Is the service caring?

Our findings

We asked people and relatives whether staff were caring. Comments from people included, "Most are nice and kind," and, "All nice and kind, they chat for a few minutes," and, "They treat me with respect."

Relatives' comments included, "They are caring and know [name] and treat them sensitively," and, "They are very good," and, "Some are lovely and nice and give the time [name] needs." One relative told us, "Some of the younger staff talk to each other over the person instead of talking to the person. Others are good." A further relative told us, "Staff do their absolute best." They told us their loved one was always clean shaven and this was important to them.

A person living at the home told us, "I used to be professional and to be fair, I can't fault the staff attitude."

We heard a person say to a member of staff, "We're good mates aren't we?" and the staff member agreed.

We observed staff approached people gently, for example when asking people if they wished to partake in activities or look at books. We observed gentle hand stroking and appropriate touch. We saw staff chatting and interacting with people and looking at personal photographs and talking about family members and the person's life story.

Some people approached staff for hugs and staff responded appropriately and affectionately. Throughout the inspection we heard lots of talking between people and staff, for example about people's histories and bygone eras. People appeared comfortable in the presence of staff. When relatives visited, they also chatted with staff in a familiar way. This showed people and their relatives knew staff.

Staff were discreet when necessary, such as when they identified a person required assistance with continence care. This helped to ensure people were treated with dignity.

During our inspection, a GP visited the home to see a person during lunchtime. Staff respectfully requested the GP wait until the person had finished eating. The person was not rushed in any way by staff. We observed a person on the dementia unit being supported by a member of staff on a one to one basis to eat their meal. Staff interacted well with the person in a patient and caring manner and the pace of support was appropriate to the person's needs. This demonstrated staff gave people the time they needed and people were not rushed.

We observed a family member attended the reception area during our inspection, in order to pay some fees for their relative who lived at the home. The reception area was busy at the time and the staff member behind the reception desk asked if the family member would prefer some privacy, and provided this. This demonstrated an ethos of respecting people's privacy.

We saw people had accessed an advocate when this was appropriate. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing

so, for themselves.

People were encouraged to maintain their independence. One person told us, "I'm very independent and they [staff] let me be." We observed a member of staff assisting a person to eat some toast. The member of staff placed the toast in the person's hand and guided them to their mouth. They helped the person to retain a level of independence, whilst offering the required support.

We also observed a member of staff assisting people to their seats. This staff member took their time and showed patience. They encouraged people to walk and move within minimal assistance, whilst ensuring appropriate support was available. This further showed staff tried to ensure people maintained their sense of independence where possible.

People made their own choices throughout the inspection. For example, when people were assisted to the lounge area, they were asked where they would like to sit.

When staff were assisting people to move using moving and handling equipment, people appeared at ease. Staff spoke to people throughout and reassured people at a time when they could otherwise feel vulnerable. We observed staff sing a song to one person, as they were lifted up in a hoist. The person responded positively.

No-one living at the home was receiving end of life care during our inspection. We asked the registered manager how people's end of life care wishes were taken into account. The registered manager told us they discussed people's end of life wishes upon admission to the home. However, some people did not wish to discuss this and their opinion was respected.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they were involved in their care planning and we looked at whether the care provided was responsive to people's needs. One person told us, "They [staff] tell it how it is. They involve me. I like that."

The care plans we reviewed were person centred and they contained sufficient information to enable staff to provide appropriate care and support to people. Care plans included a photograph of the person and contained information relating to each person's needs, for example in relation to maintaining safety, communication, breathing, dietary requirements, personal care, mobility and activities.

Records showed care plans were evaluated monthly and reviewed annually, or more frequently if needs changed. The registered manager had written to key family members, where this was appropriate, and asked how often they would like to be involved in reviewing their relatives' care plan. A relative we spoke with told us they had been involved in developing their family member's care plan.

Some care plans contained detailed information in relation to different aspects of the person's care and support needs. For example, in relation to communication, one plan indicated the person had loss of sight in their right eye and therefore staff should stand on their left side. However, when we asked a member of care staff whether they were aware of this, they confirmed they were not aware and they confirmed they did provide support to the person. We highlighted to the registered manager that, although care plans contained detailed information relating to people's needs, it is essential that care staff access this information. We had asked two members of care staff whether they read people's care plans. One staff member shook their head and told us, "It's just getting the time," and the other told us they knew what care and support to provide to people by, "Word of mouth and handovers." We shared this with the registered manager as this meant staff were not always fully aware of people's care needs and this posed a risk of inappropriate care delivery.

Staff deployment included a 15 minute paid handover period, during which the qualified nurses would share information regarding people's needs. This information was then disseminated to staff in a written and verbal format. We looked at handover records which showed appropriate information was shared between staff and this enabled continuity of care when staff changed.

There was a full activities programme such as bingo, music entertainers, ball games, quizzes, church services, reminiscence sessions, dominoes and trips out for example to a local restaurant, local stores or boat trip. The people we asked were enthusiastic about the range of activities. A person we spoke with told us, "We go on outings, boat trips and coach trips." Another person said, "We went to the railway museum and a boat trip. I like getting out and about." A relative told us there was a good range of activities.

In the afternoon on the first day of our inspection, we observed a singing entertainer in the home. People were encouraged to join in and we observed staff danced and sang with people. A person who was not able to stand and dance was given attention and staff jiggled with the person in their chair, in time to the music.

People appeared to very much enjoy the session.

A hairdresser visited the home twice a week. We observed, during a game of bingo, the numbers were being selected and read out by a person who lived at the home. They appeared to be very much enjoying the session.

We looked at records of two people's activities. Both people tended to stay in their rooms. Records showed both people had participated in an activity on only two days each month for January, February and March 2017. The care plan for one of these people indicated, 'Staff to encourage [Name] to join in all activities provided by the home and make friends with other residents.' We did not observe this and there was no evidence in the activity recording to show staff had done this. We shared this with the registered manager, who advised sometimes people do not wish to partake in activities. However, records did not show people had always been asked or encouraged, despite their care plan stating this was required. Another person's care record did not indicate they had joined in any activities, although the 'work and play' section of their care plan stated, 'Enjoying drinking whilst socialising, darts, doms, bowling, snooker, fishing, horse racing.' We could find no evidence of person centred activity planning to explore whether this person could continue to enjoy their previous hobbies. This meant, although there was a range of activities in place, for some people, records showed opportunities for person centred activity planning were missed for some people.

A relative told us they could visit the home whenever they wished. This helped to ensure they could maintain contact with their loved one. We were told, "They always ring me and keep in touch."

We observed people were offered choices throughout the day, such as what they wanted to do and food and drinks choices were offered. We noted one person changed their mind about which meal they would prefer, after the meal had been served. The person was provided with an alternative. This showed people were able to make their own choices.

A member of staff told us, "At handover we're told who's down for a bath or shower, but they can choose, if they want one or don't want one." We asked what would happen if a person requested a bath or shower on a different day and were told, "That's never happened to be honest." A person we spoke with told us they could choose when to have a shower.

People's rooms contained personal items, such as photographs, teddy bears, flowers and items of sentimental value. We overheard a member of staff advise a family member that it would be useful if they could bring in some photographs that could be placed on the person's wall. This showed staff encouraged people to make their rooms personalised to their own tastes and interests and included families in this when appropriate.

The complaints procedure was displayed within the home. We looked at how complaints were managed. They were investigated and records showed actions were taken. Of the few complaints that had been received, records showed the registered manager had taken action and written to complainants to offer an apology. People and the relatives we spoke with told us they would feel able to complain if they felt the need. We spoke with two relatives who had previously had reason to complain. They told us their complaints were dealt with and, "Followed up."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been managing the home since April 2015 and had been registered with the Care Quality Commission since March 2016.

The registered manager told us they had raised with the registered provider that a deputy manager was required and this had been approved. The post had been advertised but had not yet been filled. Once this post was filled, this would provide additional support to the registered manager.

People and relatives told us they felt the home was well led. A family member told us, "I'd say it's well led. I'd say the manager is very on the ball." This relative told us they felt able to raise any concerns they had with the registered manager.

The staff we spoke with told us they felt the home was well led. One staff member said, "I think there's enough equipment. The manager is good. I tend to go to the team leaders if I need support." We asked whether the registered manager was visible throughout the home and a member of staff told us, "I've seen the manager speaking with people and interacting." Another member of staff said, "We have a good home. Everyone's happy."

A member of staff told us they felt the home was well run and said the managers supported staff in their work. We were told by a staff member the registered manager was, "A manager, as opposed to hands on," but they added the registered manager supported staff when necessary.

A member of staff told us, "The manager has an open door policy. We can go to her any time. We've a supportive team. We can always go to the manager and area manager and the owner.

We asked the registered manager whether they were supported in their role. We were told they accessed peer support through managers of other homes within the registered provider group and a quality manager visited the home regularly.

Residents' and relatives' meetings were held quarterly and we saw these were advertised. Records showed items discussed included the Care Quality Commission inspection, occupancy levels, staffing levels and ideas such as a photo board of staff. The registered manager told us this was being considered.

Records showed staff meetings took place with different groups of staff such as kitchen staff, team leaders, care staff and domestic staff. Issues discussed included recording information, inspections and visits, policies and procedures and safeguarding and whistleblowing procedures. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

The previous inspection ratings were displayed at the home and on the registered provider's website. This showed the registered manager was meeting their requirement to display the most recent performance

assessment of their regulated activities.

Care plans were audited monthly and records showed these checked the plans were completed correctly and that daily records were up to date. We saw evidence action was taken where audits identified areas for improvement. However, the audits did not identify the areas for concern we found during our inspection.

Medication audits were completed monthly. These identified where some records were incomplete, such as medication administration records not being signed. Staff were addressed and action was taken. However, these audits failed to identify some people's prescribed drinks had not been recorded as administered. The registered provider told us this would have been identified during the next monthly audit.

Other audits, for example in relation to the environment and equipment, took place regularly. Pressure cushions and mattresses were examined and we saw evidence these were replaced where this was identified as necessary.

Water temperatures had been regularly tested. The documentation stated, 'The acceptance criteria – hot within 2 mins max. 43°C.' However, we saw the water temperature in a person's room had been recorded as above this temperature consistently, that is, for the last four months. We highlighted this to the registered manager. On the second day of our inspection we were assured this had been rectified. Although the water temperature remained within the safe limits, as advised by the Health and Safety Executive, the temperature limits were not within the registered provider's own policy and this had not been identified through any auditing.

We saw records of 'Manager's daily walkabout.' These showed the registered manager checked, for example, whether the home was clean and clutter free, the treatment room was clean and well organised, equipment was stored appropriately, the home was free from odours and daily records were completed. Where actions were identified we saw evidence to show these had been followed up.

A compliance manager visited the home monthly in order to undertake audits. Areas audited were in line with the Care Quality Commission's key questions of whether the service was safe, effective, caring, responsive and well led. We saw these audits resulted in action plans, which were shared with the registered manager. These audits considered care plans, health needs, social needs, sensory needs, personal care, falls risks, moving and handling assessments, Mental Capacity Act compliance, life history and daily notes.

The registered provider had up to date policies and procedures in place, for example in relation to safeguarding, fire safety, data security, MCA and complaints. These were reviewed at regular intervals and this helped to ensure the registered manager and staff were aware of current guidance.

Although regular audits were undertaken to help drive improvements at the home, these audits were not sufficiently robust to identify some areas which were highlighted during the inspection, such as water temperatures being consistently higher than the registered provider's tolerance levels and some prescribed drinks not being recorded appropriately. This demonstrated a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service.

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not effectively assess, monitor and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records relating to the care and treatment of each person were not always kept.