Hestia Healthcare Properties Limited

Timperley Care Home

Inspection report

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31 August 2017
21 September 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place over three days on 30, 31 August 2017 and 21 September 2017. However, publication of this inspection report was delayed due to legal representations made to the Care Quality Commission (CQC) by the registered provider.

The first day of inspection was unannounced, which meant the service did not know we were coming. The second and third day was by arrangement. We were required to return to the service on the third day in order to gather additional information. This was due to circumstances beyond the control of the lead inspector or the service.

Timperley Care Home is a purpose built home in a residential area of Timperley, near Altrincham. There are bedrooms on two floors. Each floor has its own dining area and two lounges, there is a hairdressing salon situated on the first floor next to the passenger left. All bedrooms are single with their own en-suite shower facilities. There is an enclosed accessible, secure garden off one of the lounges on the ground floor.

Timperley Care Home is registered with the CQC to provide accommodation to a maximum of 56 people who require nursing or personal care. At the time of our inspection, 51 people were accommodated, one person was in hospital and the home had four vacancies. Ground floor accommodation is dedicated to people living a diagnosis of dementia. First floor accommodation is specific to people with more general nursing needs, but some people also live with dementia.

We last inspected Timperley Care Home on 23 and 25 January 2017. During that inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This resulted in an overall rating of 'requires improvement.'

In respect of this inspection, the scheduling of our return visit was brought forward as a result of information of concern received by CQC. This information related to the homes management of falls, staffing levels and the fact the previous registered manager had left.

During this inspection, we found three new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These related to the safe recruitment and selection of staff, staff training and meeting people's nutritional and hydration needs. You can see what action we have taken at the back of the full report.

Due to the nature of the service provided at Timperley Care Home, we were unable to gather the views of the vast majority of people who used the service. However, during the inspection we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with visiting relatives to ascertain their views on the quality of care being provided.

In response to concerns raised with CQC about how the service managed specific incidents such as accidents, incidents and falls, we reviewed a wide range of information including accident reports, risk assessments and quality assurance audits. Following this review, we were satisfied safe systems and procedures were operating in the home which sought to keep people safe.

With regards to staffing levels, we looked again to staff rosters, the dependency tool used by the home and we spoke with staff, management and relatives. On the basis of the evidence gathered, we were satisfied that staffing levels were sufficient to meet the needs of people accommodated at the time of our inspection.

We looked again at the homes approach to the safe recruitment and selection of staff and found this was not consistent. This meant the service was not able to consistently demonstrate the suitability of candidates to work with vulnerable groups before an offer of employment was made. This has resulted in a breach of regulation.

At our last inspection, we found people's medicines were not always managed safely. Since our last inspection, the provider had introduced a new and comprehensive system for managing people's medicines. The system, 'Wellpad', had a number of key features which sought to improve safety and reduce the likelihood for errors or omissions. We found medicines to be stored, administered, recorded and disposed of safely.

The service sought to protect people from abuse and we found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff we spoke with demonstrated a good understanding of the types of abuse and the procedure to follow if they suspected a person was at risk of or was being abused.

At our last inspection, we found staff supervision was not always completed. During this inspection, we found progress had been made. However, the timetable for completing staff supervision in a timely manner had been interrupted by the resignation of the registered manager. This meant the focus of those staff responsible for completing supervision sessions had been diverted to other key duties. Following discussions with the management team, we were satisfied the service had taken all reasonable steps to recover the situation and progress was continuing to be made.

Due to the nature of the service provided at Timperley Care Home, a significant number of people who used the service lived with a diagnosis of dementia. For some people, this also meant they would at times, present with behaviours that challenge. However, we found staff were not sufficiently trained and lacked the necessary skills and experience in this area. This has resulted in a breach of regulation.

During our last inspection in January 2017, we identified a number of issues related to the mealtime experience. Whilst improvements had been made in respect of the provision of appropriate equipment, other areas of concerns as identified in our last report had not been addressed effectively. For example, the mealtime experience on the ground floor unit was chaotic and people did not receive their meals in a timely manner. Deployment of staff was also not effective. This has resulted in a breach of regulation.

Staff demonstrated a working knowledge of the principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS).

We looked at the homes approach to end of life care (EoLC) and found the service was engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who we are nearing the end of their life, they

could choose to remain at the home to be cared for in familiar surroundings by people they know and could trust.

We looked to see how the service sought to promote the principles of equality, diversity and human rights (EDHR). We were satisfied the culture within was not discriminatory and the rights of people with a protected characteristic would be respected. However, improvement are required relating to how information is captured about a person's life history, their culture and who is important to them. We have made a recommendation about this.

We looked at improvements that had been made since our last inspection to create a dementia friendly environment. Whilst significant improvements had been made, further work was required to ensure consistency across the home in creating a dementia friendly environment. We have made a recommendation about this.

Throughout our inspection visit we observed a number of positive interactions between staff and people living at Timperley Care Home and we saw staff treating people with kindness and respect. Two people who used the service kindly showed us their bedrooms. We found their rooms to be personalised with individual items and were homely and welcoming. We observed staff being respectful of people's private spaces and knocking on doors before entering.

We spent a considerable amount of time speaking with the regional operations director and the service quality manager. This was important as we sought to understand some of the recent challenges the home had faced and aspirations for future success. Through these discussions, it was clear the management team had oversight of the key issues and we learnt of their plans for continuous service improvement. However, the three regulatory breaches identified during this inspection, demonstrated there was further work still to be done and improvements were not yet fully embedded. Furthermore, the effectiveness of the new home manager needs to be demonstrated through real, tangible, positive outcomes for people living at Timperley Care Home.

As this inspection represents a third consecutive rating of 'requires improvement' we plan to meet the provider and members of the management team to seek further assurance. Additionally, we will return to the home in due course to review progress.

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

Aspects of the service were not consistently safe.

Procedures for the safe recruitment and selection of staff were not consistently robust.

People's medicines were stored, administered, recorded and disposed of safely.

The service sought to protect people from abuse and there were appropriate safeguarding and whistleblowing policies and procedures in place.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff training to support people living with dementia and behaviours that challenge was not sufficient or did not exist.

The mealtime experience was chaotic and staff were not deployed effectively.

We made a recommendation for creating a dementia friendly environment that was consistent with nationally recognised best practice.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

The service was engaged with the NHS 'six steps' programme which meant people nearing the end of their life were able to choose to remain at Timperley Care Home and have their needs met.

We made a recommendation for ensuring equality, diversity and human rights is fully embedded in all aspects of care and support planning.

Is the service responsive?

Good

The service was responsive.

A new electronic care system had been introduced which meant the service was able to respond to people's changing needs more effectively.

Complaints were responded to a timely manner and records were maintained.

Enabling people to access person-centred activities remained a challenge for the service but plans were in place to address this issue.

Is the service well-led?

Requires Improvement

The service was not yet well-led.

At the time of the inspection there was no registered manager.

Plans for continuous service improvement were not yet embed.

The new home manager needs to demonstrate their effectiveness through real, positive, tangible outcomes for people living in the home.

Timperley Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place over three days on 30, 31 August 2017 and 21 September 2017. During day one of inspection, the inspection team consisted of two inspectors 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. One inspector returned for days' two and three.

As the scheduled inspection of this service was brought forward, we did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection, we reviewed information we held about the service, including communication with relatives, minutes of safeguarding meetings and notifications made to the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We liaised with Trafford Council and NHS Trafford Clinical Commissioning Group.

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

We were able to ascertain the views of three people who used the service and we spoke with four family members. We also spoke with the deputy manager, clinical lead nurse, regional operations director, service quality manager, operations manager's and 10 staff members including care staff, the administrator and domestic staff.

We looked at records relating to the service including electronic care records, staff recruitment files, electronic medicines records, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Due to the nature of the service provided at Timperley Care Home, we were unable to gather the views of the vast majority of people who used the service to ascertain whether they felt safe. However, comments from people who were able to speak with us included, "I've no concerns about my safety."; "The staff do their best to look after me."; "I feel safe at night and I like it here." During the inspection, we spoke with a number of visiting relatives. One person commented, "I don't feel [relative] is unsafe. If I had any concerns I'd raise it with the staff." Another said, "On the whole I think it's a safe home. I visit quite regularly and have no concerns at the moment." A third relative told us, "I feel [relative] is safe; [relative] can't go out alone. I know if I can't visit [relative] will be alright."

In response to concerns raised with CQC about how the service managed specific incidents such as accidents and falls, we looked in detail at this area. We found the provider had implemented a new electronic care records system - Person Centred Software (PCS). This new system featured both desktop and handheld device applications for nursing and care staff. We reviewed five care records and associated risk assessments via the new PCS system. A suite of assessments of need and risk assessments were in place including pain scale, aspects of daily living, bed rails, pressure sore risk, continence, eating and drinking (choking risk), falls, moving and handling and nutritional risk assessments. Where applicable the system prompted the user to write a care plan for the identified need or risk. We saw that one person had a personal risk and behaviour assessment in place and associated behaviour management strategy. The use of handheld devices meant that important information could be accessed at the point of care and records could be updated in real time. We saw risk assessments had been reviewed and updated and that the PCS system indicated when they were next due to be reviewed.

We looked at accidents and incidents and saw how reporting of such events was also integrated into the new PCS system. Staff were able to record an event on the electronic record and this triggered further management actions to demonstrate what remedial actions had been taken to reduce the likelihood of such events occurring again in the future. Where appropriate, we saw that referrals were in a timely manner to other health professionals such as GP and community falls team.

Quality assurance audits and reports linked to safety and risk were also accessed via PCS and we saw how oversight was maintained both locally within the home, and at regional management level. In view of this, we were satisfied safe systems and procedures were operating in the home which sought to keep people safe.

In response to concerns about staffing levels, we spoke with staff, management and relatives and looked at a sample of rosters to determine current staffing levels. Our discussions with staff and relatives provided mixed feedback. One member of staff told us, "I don't think there is enough cover during the night." Another member of staff commented, "We manage but no two days are the same. Some days it feels staffing is OK, others it feels like were doing just enough." One relative told us, "You can come in some days and it appears no one is around but I understand the staff might be behind closed doors giving care to people." Another said, "I think staffing is OK. I can't see any real cause for concern."

We looked at staff rosters and found that typically there was always one nurse on each floor of the service, along with either four or five care staff on each floor. Overnight we saw there was a nurse on each floor along with two carers and an additional carer between the floors as necessary. We spoke with a member of the management team and saw how the service used a formalised dependency tool for assessing staffing numbers against the needs of people who used the service. This was also linked to people's individual electronic care records. We also reviewed how the service ensured the registered nurses who worked at the service maintained their registration. We saw the service kept a record of the nurses Nursing and Midwifery Council (NMC) pin numbers and when their revalidation was due. Records showed all the registered nurses who worked at Timperley Care Home were registered and had a valid pin.

On the basis of the evidence gathered, we were satisfied that staffing levels were sufficient to meet the needs of people accommodated at the time of our inspection.

We reviewed the homes approach to the safe recruitment and selection of staff. We looked at a sample of six staff files, which included staff recently recruited and we reviewed records relating to registered nurses. Whilst we found evidence of standard good practice in respect of obtaining proof of identity, completed interview notes and checks with the disclosure and baring service (DBS), we found inconsistencies in other areas of recruitment. For example, in the six records we reviewed, unaccounted employment gaps were present in four records. We also found evidence that character references had been obtained but that references from previous employers had not been consistently obtained.

On day three of the inspection, we raised this concern with members of the regional management team who were present at the home. Initially, it was indicated to the lead inspector that CQC were not sufficiently 'prescriptive' about such matters. However, following a telephone consultation with a HR manager, one of the regional managers acknowledged current practice was not robust enough. This meant the service was not able to consistently demonstrate the suitability of candidates to work with vulnerable groups before an offer of employment was made.

This is a breach of Regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 with regards to fit and proper persons employed.

At our last inspection, we found people's medicines were not always managed safely. Since our last inspection the provider had introduced a new and comprehensive medicines management system. The system, 'Wellpad', had a number of key features which sought to improve safety and reduce the likelihood for errors or omissions. For example, each person who used the service was allocated a unique barcode. When scanned, a list of their medicines would be displayed. When administering medicines the individual medicine was scanned. The system could be programmed around the frequency of which medicines were required so staff were only prompted to give these on the agreed day of the week. If the scanned medicine was not required, the system would alert staff. We also saw how medicines were re-ordered and received through the system by scanning the barcode on the box of medicines and the status of the order could be seen on a handheld device.

Medicines that required refrigeration were stored in a medicines fridge located in the treatment room. Daily temperature checks were recorded in line with guidance. Controlled drugs (CD's) were stored appropriately and in line with legislation. The CD cabinet was not overstocked and the keys were in the possession of a registered nurse. As part of the transition from paper based records to electronic, we saw hard copies of key medicinal charts were still in use. For example, cream charts and transdermal patch charts. This ensured that until all staff were trained on the electronic systems, appropriate records were maintained. A dual system was also in use for medicines that could be administered 'as and when required.'

We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff we spoke with demonstrated a good understanding of the types of abuse and the procedure to follow if they suspected that a person was at risk of or was being abused. We asked staff about whistleblowing and people told us they would not hesitate to use the policy and identified internal reporting protocols. For example, informing head office if they did not feel their concerns were being taken seriously.

We checked to ensure everyone living at Timperley Care home had a personal emergency evacuation plan (PEEP) in place, which provided details about the support they would need in the event of an emergency. We saw equipment which may be required during an emergency was stored in an accessible place and was checked regularly.

Health and safety and building maintenance records were examined and found to be in order. Up to date certificates and checks had been completed in respect of gas and electrical safety, fire safety, communal hot water temperatures, waterborne viruses and portable electrical appliances. Upper floor windows were compliant with safety regulations and suitable window restrictors were in place. Equipment used for moving and handling people had been serviced and maintained in line with regulations.

We looked at how well people were protected by the prevention and control of infection. We saw the home had policies and procedures in place related to infection control and staff were observed to be following good practice guidance. For example, hand washing was carried out routinely and items deemed for 'single use' were disposed immediately after use. We found the home to be visibly clean and well presented.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found staff supervisions were not always being completed. During this inspection, we saw progress had been made. However, the timetable for completing staff supervision had been interrupted by the resignation of the registered manager. This meant the focus of those staff responsible for completing supervision sessions had been diverted to other key duties. We spoke at length with the regional operations director and service quality manager about this and saw how plans had been implemented to recover the situation. This included a review of who will take responsibility for ensuring supervisions were completed. For example, nurses to complete supervision with their direct reports and senior support workers to complete supervision with their direct reports. On this basis, we were satisfied the service had taken all reasonable steps to recover the situation. However, we will review progress at the next inspection.

We looked at induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. We saw that newly recruited staff completed an induction period which included job observation, mandatory training and completion of an induction booklet. Staff we spoke with gave a mixed response when asked about the quality of induction. One person told us, "My first day was great, second day not so good and the third day was terrible as I was on shift with an agency nurse who didn't know people so couldn't provide me with any guidance." A second member of staff commented, "Everyone was very supportive during my induction and I got lots of opportunities to shadow more experienced staff, including the registered nurses." A third member of staff told us, "If I could change one thing it would be the use of e-learning during induction. I don't think it's very effective, I learn better with face-to-face training. We looked at training records maintained by the service and saw training was a combination of online e-learning and classroom sessions. Topics covered via e-learning included infection control, health and safety, fire safety and food hygiene. Classroom based training topics included the mental capacity act, safeguarding and basic life support. Registered nurses were able to maintain clinical skills through access to training opportunities specific to their role.

Due to the nature of the service provided at Timperley Care Home, a significant number of people who used the service lived with a diagnosis of dementia. For some people, this also meant they would at times, present with behaviours that challenge. For example, episodes of aggression or an unwillingness to accept care and support deemed in their best interest. Prior to our inspection, we had received information of concern that indicated the service was not always dealing effectively with people who presented with behaviours that challenge. Therefore, during this inspection, we sought to understand the reasons behind this. A key area we looked at centred around staff training. We found that whilst 'dementia awareness' formed part of an e-learning module, no class room based training was offered. Staff we spoke with lacked underpinning knowledge around dementia care which meant the e-learning module was not effective. Furthermore, we found challenging behaviour training had never been provided. We concluded there was a direct correlation between this and the homes increased level of resident-on-resident altercations and increased dissatisfaction and complaints from relatives around managing behaviours that challenge. This was because the provider had failed to ensure suitably qualified, competent, skilled and experienced staff were deployed to meet the needs of people using the service.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014: Staffing.

In respect of the above, during feedback at the end of day two of our inspection, the regional operations director agreed with our findings. At the start of day three, this was echoed by the service quality manager. In the intervening period since our inspection concluded, we acknowledge the provider had moved swiftly to commission and implement a full and comprehensive revised training programme, delivered in collaboration with an external training provider and an NHS trust. This included training centred on dementia and behaviours that challenge.

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 that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that there were correct assessments in place in relation to people's capacity and decisions to restrict someone's liberty were being followed. Where people lacked capacity to make specific decisions about their care and support, we saw that due process had been followed and relevant people consulted. For example, records demonstrated whether people had capacity or whether there was someone holding Lasting Power of Attorney (LPA) for Health and Welfare as well as Finance . A person designated an LPA has legal status to make decisions that are deemed in a person's best interest. When required, we also saw people had access to the local advocacy service and had been supported to access their services if they had no other family to support. This demonstrated the service ensured people's views were considered before decisions were made.

The service maintained hard copy records and an electronic matrix of DoLS applications which had been made to the local authority, information about who had an authorisation in place and whether this was a standard authorisation or not. We reviewed a sample of these records and found all was in order.

During our last inspection of Timperley Care Home in January 2017, we identified a number of issues related to the mealtime experience. This included issues around maintaining people's safety, dignity, lack of appropriate equipment to promote independence and the deployment of staff to meet people's needs. This resulted in a breach of regulation for meeting nutritional and hydration needs. Following our last inspection, we required the registered persons to submit an action plan to CQC to demonstrate how they would rectify these issues. In the action plan, information was only provided with regards to the provision of new height adjustable tables. We confirmed these were now used for people who chose to eat their meal in the lounge area and were satisfied this aspect of the breach had been acted upon. However, other areas of concerns as identified in our last report had not been addressed effectively.

On day one of our inspection, we completed observations during lunchtime service on both the ground and first floor. We did this by completing a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Lunchtime on the ground floor was not well organised. Two people who used the service were observed to be walking around and being told to 'move away' by other people who were already seated. We saw a nurse

attempt to encourage these people to leave the dining room and come back later but they refused. We saw one member of staff was left in the dining room with eight people; they were also serving the food to be taken to people eating in the lounge or their rooms. This meant two people sat with food in front of them for 20 minutes before they could be supported to eat, and then only briefly before the staff had to move away and do something else. One of the individuals we observed walking around the dining room did eventually sit at a table and was given soup and sandwiches. They ate the soup but then had to wait 20 minutes for their desert. Staff spoke to this person on two separate occasions stating they would get their desert but on each occasion the staff member became distracted with other tasks. We then saw how this person ended up using their spoon to get orange squash out of their glass.

On the first floor, the mealtime experience was less chaotic and staff appeared to be deployed to their duties more effectively. However, only seven of the 23 people accommodated on the first floor were present in the dining room and they were seated across five separate tables. This did not necessarily promote a convivial, sociable mealtime experience. All the staff were attentive giving whatever help was needed with care and empathy but leaving residents to feed themselves as much as they were able, encouraging them to eat and finding alternatives if the dishes ordered were not wanted. Across both dining rooms we saw that cutlery and crockery matched but there were no coloured plates to give better contrast with the food or special cutlery for the benefit of those with dementia or dexterity problems. Pictorial menus were also not in use.

We asked people about the mealtime experience and we received a mixed response. One person who used the service told us, "The food is not cold but not quite warm, that was the only thing wrong with it." Another commented, "You choose your meals the day before. If you don't want anything on the menu you can always have, say, cheese on toast. They'll cut the food up for you, but I can swallow." A third person who used the service told us, "Food's not too bad. It's not like being at home. I like fish and chips, from the fish shop." We also spoke with a number of visiting relatives, one person told us, "The home don't seem to individualise menu options to suit people's likes and dislikes. For example, there is no point giving [relative] Italian food or anything with spices, as they have never eaten this. I wish more homely traditional choices were available." Another relative commented, "My [relative] has a good appetite and the portions seem to be generous. They prefer to eat in their own room and sometimes have to wait but I can see the staff are pushed."

The issues identified during mealtime service on the ground floor demonstrated that insufficient progress had been made to consistently ensure people's nutritional and hydration needs were being met.

This is therefore a continued breach of Regulation 14(1)(4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014: Meeting nutritional and hydration needs.

We looked at improvements that had been made since our last inspection to create a dementia friendly environment. We saw a great deal had been done in the corridors both to help peoples' orientation and to stimulate their memories. Some of the features on bedroom doors were more regimented than personalised. Different colour schemes were used helpfully to differentiate different parts of the home; throughout the corridors there were good handrails, painted in colours contrasting with their backgrounds. In bathrooms there were handrails but toilet seats and other bathroom 'furniture' were white rather than coloured to make them stand out from backgrounds. Floor covering throughout the home was chosen to suit those with dementia.

To aim for consistency in providing a dementia friendly environment, we recommended the provider consult national guidance from the Social Care Institute for Excellence (SCIE) for dementia-friendly environments.

Good

Is the service caring?

Our findings

We asked people who used the service that were able to speak with us, if they thought the service continued to be caring. One person told us, "I'd rather be at home but they look after me wonderfully well." Another person said, "The staff do their best for me and I've no complaints." A third person commented, "Most of the staff are caring." Comments from relatives included, "On the whole I think the staff are caring but sometimes it feels they are rushed and can't spend much time with [relative]. Another commented, "Staff have been very kind; the home has been very good for my [relative]. The staff know my [relatives] needs and how to care for them. The staff phone me straight away if there are any changes in [relatives] health."

Throughout our inspection visit we observed a number of positive interactions between staff and people living at Timperley Care Home and we saw staff treating people with kindness and dignity For example, we observed a person who used the service had become upset whilst sat in the lounge area. A member of staff responded by sitting next to this person, holding their hand and offered reassurance until they calmed down. A cup of tea was also provided which appeared to cheer this person up.

We looked to see how the service sought to promote the principles of equality, diversity and human rights (EDHR). At the time of our inspection visit the service did not support anyone who identified as lesbian, gay, bisexual or transgender (LGBT) and the home considered everyone who used the service to be of white heritage. Through talking to staff and members of the management team, we were satisfied the culture at the home was not discriminatory and the rights of people with a protected characteristic would be respected. However, further work was required to embed EDHR into everyday practice across the home. For example, improving how information is captured about a person's life history, their culture and who is important to them. However, we saw that people's pastoral needs were being met through good links with local faith groups and the provision of regular communion.

We recommend the service consults CQC's public website and seeks further guidance from the online toolkit entitled; Equally outstanding: Equality and human rights - good practice resource.

We looked at the homes approach to end of life care (EoLC) and found the service was engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who we are nearing the end of their life, they could choose to remain at the home to be cared for in familiar surroundings by people they know and could trust.

We reviewed how people were involved with planning their care and support and we saw that where possible, people who used the service and their family members or people who knew the person well, had been consulted. Records demonstrated whether people had capacity or whether there was someone holding Lasting Power of Attorney for Health and Welfare as well as Finance. When required, we also saw people had access to the local advocacy service and had been supported to access their services if they had no other family to support. This demonstrated the service ensured people's views were considered before decisions were made.

We looked at how information was shared with people who used the service and their relatives and found that a regular programme of resident and family meetings was taking place. This was evidenced through minutes of meetings being recorded. We could see that a variety of topics were discussed during these meetings and that people were able to share their views and experiences. However, attendance at such meetings was variable with some well attended and others no so.

During our inspection, two people who used the service kindly showed us their bedrooms. We found their rooms to be personalised with individual items and were homely and welcoming. We observed staff being respectful of people's private spaces and knocking on doors before entering.

Good

Is the service responsive?

Our findings

We asked people and their relatives if they thought the service was responsive to their needs. One person who used the service told us, "I can walk with help. I would like to do more. I don't see anybody most of the day. They come at meal times and cut my food. I would like to go to the dining room sometimes, not all the time." Another commented, "There is nothing really for us to do, it can get a bit boring." A relative told us, "Things have got better recently, I feel the staff listen to me when I raise a concern. The deputy manager is lovely so I tend to speak with them the most if I have an issue." Another relative commented, "On the whole the team here are responsive. Communication can get a bit messy sometimes but if I raise an issue it tends to get sorted one way or another."

During this inspection, we reviewed progress in respect of the lack of activities identified at our last inspection. Whilst we saw some progress had been made, this had been hindered by the fact the activity coordinator had been absent from work for an extended period of time. Prior to their absence, we saw the activities coordinator had been engaging people in a variety of activities and records had been maintained to evidence when this had taken place. However, the continued absence of the activities coordinator meant opportunities for people to participate in meaningful person-centred activities remained limited.

We spoke at length about this with the regional operations director and the homes deputy manager. We accepted the service had taken all reasonable steps to address the lack of activities by employing a dedicated member of staff to fulfil this role. It could not have been foreseen that this person would then be absent from work. The management team gave a high level of assurance that a real concerted effort and continued commitment would be maintained to ensuring everyone living at Timperley Care Home had access to meaningful person-centred activities. We will review progress in this area at the next inspection and we expect tangible supporting evidence to be provided.

A significant development at the home since our last inspection was the introduction in May 2017 of a new electronic care records system - Person Centred Software (PCS). This new system featured both desktop and handheld device applications for nursing and care staff. PCS provided a robust system for maintaining accurate records. Staff used a hand held device to record people's daily care and activities and this was then uploaded onto an electronic system. The electronic care planning system enabled the management team to monitor if people were not weighed regularly, did not eat well, or if their weight or fluid intake dropped out of an appropriate range for their height, age and health condition. The system prompted staff to make sure support was provided as identified in people's care plans. Staff told us they regularly used the care plans to understand people's needs and that these care plans were regularly updated. There was a hospital section which could be downloaded so that it could be taken to hospital with the person; this sought to ensure a person's transition between services was safe.

From the sample of electronic records we reviewed and by talking to staff and management, it was clear the PCS system was still being embedded across the home. Staff we spoke with agreed this advancement in technology was a significant positive improvement but a number of staff felt the introduction of two new electronic systems within quick succession, for care records and medicines, had been challenging. Several

members of care staff acknowledged it had taken them slightly longer to embrace the new technology but additional support had been provided to them.
Whilst embracing the advantages of new technologies, the provider must ensure capturing true person-centre information about the person is fully integrated into the new PCS system. This includes ensuring information focuses on people's likes, dislikes, personal preferences, people who are important and cultural, social and recreational preferences.

During our inspection, we spent time talking to one person who used the service and their loved one. During this discussion, a number of issues were raised with us but a primary concern centred on daily routine and personal preferences. As these concerns had not previously been raised with the management team at Timperley Care Home, we raised them on the family's behalf and asked for a response. During day three of inspection, the service quality manager provided us with feedback with regards to progress that had been made. We learnt the service had met with this person and their family and entered into open and honest dialogue. This enabled all parties to reach a common agreement about achievable goals and what aspects of care and support could be delivered effectively and in a timely manner. We saw how this process had been hugely beneficial for everyone involved and translated into a more positive experience overall.

We looked at how the service managed complaints and saw a complaints policy and associated procedures were in place. The policy clearly explained the process people could follow if they were unhappy with any aspect of the service. Information about how to raise a concern was readily available in communal areas of the home and displayed on notice boards. The home maintained a complaints log which detailed the nature of the complaint, outcomes and actions taken. However, feedback from relatives' was mixed when asked about their experiences of making a complaint. One relative told us, "Things have got better but I don't feel the previous (registered) manager took complaints seriously. I had an occasion to go into the office but I felt I was fobbed off." Another commented, "I would always raise any concerns with the deputy manager. I felt they listened."

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection of Timperley Care Home, the previous registered manager had resigned. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new home manager had been recruited to Timperley Care Home and at the time of our inspection they were working their notice period with their previous employer. Since our inspection, the new manager has started in post and would be applying to CQC to become the registered manager.

We asked people how well-led they considered the home to be and we received a mixed response. However, through talking to staff, relatives and people who used the service, many of the issues appeared to be historical and could be attributed to a previous management regime that did necessarily promote positive relationships. One relative told us, "Communication was poor and I felt there was a barrier between us as relatives and the previous (registered) manager." A second relative told us, "The home is a lot nicer to come into now, there's a better atmosphere." A third relative commented, "I'm very confident to go to the deputy manager or clinical lead" A person who used the service told us, "I know the other manager has left, I think there is a new manager but I'm not sure." During the inspection we spoke with a range of staff and comments included, "Things have got much better over the last few weeks. Staff are being listened to now and more involved in aspects of the service." Another commented, "I'd say things were pretty rubbish before, everyone works really hard but there was little recognition. Things are definitely getting better now though."

In the absence of a registered manager, we saw how the deputy manager was maintaining continuity and day-to-day oversight of the home. The deputy manager was also very well supported by the clinical lead nurse. Staff and relatives were particularly complimentary about their respective roles. One relative told us, "[deputy manager] is fantastic. Very approachable and kind." Another said, "The deputy is wonderful. Very visible and always happy to spend time to talk." A member of staff commented, "[clinical lead] is amazing. Works really hard and cares passionately about the people living here." Another told us, "[clinical lead] is so helpful. Always encourages us to learn and nothing is too much trouble." The local management team were also supported by members of wider regional management team. This included the operations director, service quality manager and several regional operations managers. Support was provided over a number of days per week and we saw that members of regional team had assumed responsibility for key aspects of service improvement such as quality assurance and staff training.

We reviewed the homes approach to audit, quality assurance and questioning of practice. We saw how the new Person Centred Software (PCS) system was allowing for a more robust system of audit, which enabled oversight at both local and regional level. By looking at electronic records, we saw a wide range of audits had been completed. For example, audits related to medicines, the home environment, health and safety and care plans. Where issues had been identified, records demonstrated the remedial action that had been taken. This included an effective system for tracking and monitoring of accidents, incidents and falls and

strategies that sought to reduce the likelihood of such events occurring again in future.

We asked for a variety of documents to be made available throughout the inspection. We found documentation was kept securely in locked offices and the offices were organised enabling the documentation requested to be accessed promptly. We found all the records we looked at were structured and organised which assisted us to find the information required efficiently. This made information easy to find and would assist other staff if they were required to find information quickly for themselves.

In the absence of a registered manager, the management team understood their responsibilities with regards to notifying CQC of significant events in line with the requirements of the provider's registration. Information relating to notifiable events was sent to CQC via a statutory notification within a timely manner. For quality assurance purposes, the operations directors maintained oversight of all notifications submitted to CQC.

It is a requirement of the regulations that providers display the rating they received at their last inspection, within the home and on their website if they have one. The rating of 'requires improvement' from our last inspection was clearly on display in the foyer to the service and also on the providers website. This showed the service was ensuring people who used the service or were considering using the service, had access to the most recent report.

During our inspection, we spent a considerable amount of time speaking with the regional operations director and the service quality manager. This was important as we sought to understand some of the recent challenges the home had faced and aspirations for future success. Through these discussions, it was clear the management team had oversight of the key issues and we learnt of their plans for continuous service improvement. However, the three regulatory breaches identified during this inspection, demonstrated there was further work still to be done and improvements were not yet fully embedded. Furthermore, the effectiveness of the new home manager needs to be demonstrated through real, tangible, positive outcomes for people living at Timperley Care Home. As this inspection represents a third consecutive rating of 'requires improvement', we plan to meet the provider and members of the management team to seek further assurance. Additionally, we will return to the home again in due course to review progress.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The mealtime experience was chaotic and deployment of staff was not effective. This meant people using the service did not have their nutritional and hydration needs met in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks centred on the safe recruitment and selection of staff were not consistent. Inappropriate references had been obtained and gaps in employment were not always accounted for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not adequately trained to meet the needs of people living with dementia and behaviours that challenge.