Roche Health Care Limited

Hartshead Manor

Inspection report

817 Halifax Road
Cleckheaton
BD19 6LP
Tel: 01274 869807
Website: www.rochehealthcare.com

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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

Overall summary

The inspection of Hartshead Manor took place on 7 April 2015 and was unannounced. We also visited a second time on 9 April 2015, this visit was announced. We previously inspected the service on 29 September 2014 and at that time we found the provider was not meeting the regulations relating to respecting and involving people who use services, management of medicines and assessing and monitoring the quality of service provision. We asked the registered provider to make improvements. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Hartshead Manor is a nursing home currently providing care for up to a maximum of 55 older people. There were 43 people living at the home when we visited. The home is a converted property providing bedroom and communal areas on both the ground and first floor. The home has a section of the home which is dedicated to supporting people who are living with dementia. When we inspected Hartshead Manor there were 15 people living within this unit.

At the time of our inspection the home did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality

Summary of findings

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 who lived at Hartshead Manor told us they felt safe. Staff had received training in how to safeguard vulnerable people from the risk of harm and abuse.

People's medicines were stored and administered safely. Staff who administered people's medicines had all received training and an assessment of their competency had been completed.

We found recruitment practices were safe. Staff told us new staff had been recruited and the home was using less agency staff as a result. When we asked people if there were enough staff to meet peoples needs, feedback was mixed.

Feedback from people who lived at the home was positive about the meals they received. Lunchtime in the ground floor dining room was a positive experience for people. However, in the upstairs lounge/dining area we saw people were not always provided with adequate and timely support with their lunch time meal. Recording of people's dietary and fluid intake was inconsistent.

This demonstrated a failure to protected people from the risks of inadequate nutrition and dehydration. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a system in place to support new staff. We saw evidence to support staff had received supervision to monitor their performance, development needs and training.

The communal area for people who were living with dementia was not homely and items to engage people's attention were not readily available.

We saw a number of interactions between staff and people who lived at the home which were kind and caring. We heard staff explaining to people and offering them choices about what to eat, drink and where to sit. Staff were able to tell us about the actions they took to maintain people's right to privacy and dignity.

There was a regular programme of activity in the ground floor lounge, however, we did not see any form of meaningful activity in the upstairs lounge. There was a lack of information about people's life history in care records and care records did not consistently provide enough details to ensure peoples care and support was person centred.

This evidenced a failure to ensure that care and support was planned and delivered to meet the individuals need. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a system in place to monitor complaints although verbal and low level concerns were not logged.

When we asked people who lived at the home who was managing the home, they were not able to tell us. Staff told us the recent changes at the home had led to improvements at the service.

Audits were in place but audits of peoples care records had not been completed on a regular basis. We found people's care and support records were not always reflective of their current needs.

These examples demonstrate a failure to identify, assess and manage risks relating to the health, welfare of people who live at the home. This also demonstrates a failure to ensure accurate and complete records are maintained for each person. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular meetings were held with staff, people who lived at the home and their relatives. Quality feedback forms were due to be distributed following the commencement of the new manager.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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's needs were not always met in a timely manner.

There was a robust recruitment procedure in place.

People who used the service were protected against the risks associated with medicines.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were not always met in a timely and person centred manner.

We saw evidence that staff received training and new staff were supported in their role.

Staff had received training in the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Feedback from people who lived at the home and their relatives was that staff were caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who were living on the dementia unit were not engaged in meaningful activities.

People's care records were not always an accurate reflection of their needs.

The registered provider had a system in place to monitor formal complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home did not have registered manager in place at the time of our inspection.

Robust governance systems were not yet in place.

The service did not maintain accurate records.

Summary of findings

Meetings were held with staff and people who lived at the home.

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 first day of our inspection of Hartshead Manor took place on 7 April 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for an older person or a person living with dementia. The expert by experience on this occasion had experience in caring for elderly people, particularly those living with dementia. One adult social care inspector also visited on 9 April 2015, we telephoned the quality manager the day before this visit to tell them we would be visiting.

Before the inspection we reviewed all the information we held about the service including notifications and local authority contract monitoring reports. We had not sent the provider a

'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We also used the 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. During the inspection we spoke with six people who used the service and three relatives. We spoke with the quality manager, the training manager, a registered nurse, five care staff, two ancillary staff and the activity organiser. We observed how people were cared for, inspected the premises and reviewed care records for six people and a variety of documents which related to the management of the home.

Requires Improvement

Is the service safe?

Our findings

During our visit we asked people whether they felt safe in the home. Everyone whom we spoke with told us that they did. One person we spoke with said, "I find that it's being safe at night that I like. That and the way they look after us. They are concerned about everybody". Another person told us, "The best thing here is the feeling of security. It's just a general feeling, like having someone's arms wrapped round you." Relatives we spoke with also told us they felt their relative was safe, one visitor said, "I'm sure (relative) is safe".

Our inspection on 29 September 2014 we found the provider was not meeting the regulations relating to management of medicines. On this visit we checked and found improvements had been made.

We saw people's medicines were stored safely. Temperature checks were recorded daily for the room where medicines were stored and the medicines fridge. Photographs to enable staff to clearly identify people were in place for nine of the ten people's medicine records we looked at. We checked one person's boxed medicines and found the stock tallied with the number of recorded administrations. We also checked two medicines which were stored in the controlled drugs cupboard. The stock tallied and each entry was completed and checked by two staff. We also saw the staff completed a weekly stock check of the medicines stored in the controlled drug cupboard to ensure that all the stock was accounted for. This meant there was a safe system in place for managing medicines.

We saw one person was prescribed 'as required' (PRN) medicine. The quality manager told us protocols were currently being implemented for people who were prescribed 'as required' medicine. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We asked a team leader how topical medicine (cream) was recorded. They showed us the records for one person who was prescribed a cream. We saw a record was kept in the person's room which recorded the name of the cream and when and where staff were to apply it. The team leader told us the care staff completed these records where people were prescribed regular creams. They said when people were prescribed a short course, for example, a steroid cream, then a member of staff who was trained in administering people's medicine would be responsible for administering the cream.

Medicines were administered to people by either registered nurses or team leaders. The training manager told us all staff who administered medicines received appropriate training and had an annual assessment of their competency completed. We saw documented evidence that the team leaders who administered people's medicines had all had a competency assessment. This meant medicines' were only administered by staff who were appropriately trained.

Each of the staff we spoke with told us they had received safeguarding training and they would report any concerns to the team leader or the nurse. One staff member said, "You would report if staff are not doing proper care, even if it was your friend". This showed that staff recognised their personal responsibilities for safeguarding people using the service.

Risk assessments were in place in each of the care records we looked at. For example, falls, moving and handling, falls, skin integrity and weight. We saw where people were identified at risk of falls, equipment had been put in place, for example, low beds, crash mats and, where appropriate, bed safety rails. This meant equipment was provided to reduce risks to people's safety and welfare.

We saw that accidents and incidents were recorded, monitored and analysed so that lessons could be learned and the risk of repeat minimised.

When we asked people about staffing in the home, feedback was varied. One person said "I think there are enough", "Normally there are enough staff. I think they manage well. I used my call bell after I fell in my room, they came quickly". However, one person said, "Sometimes people have to sit and wait for help and they shout for attention". Comments from the two of the visitors we spoke with were, "I'm not sure there are enough staff at times, people are often kept waiting for things. There has been an improvement recently, people aren't left in there (the upstairs lounge) on their own anymore", "There isn't enough staff, but I don't think there are at any home. Sometimes they're rushing here and I feel sorry for them".

The registered provider and the quality manager told us that staffing for the home was reviewed weekly to ensure

Requires Improvement

Is the service safe?

the staff team could respond to people's needs. Staff we spoke with told us the staffing had improved recently. One staff member said new staff had been employed at the home and the use of agency staff had reduced. Another member of staff told us the management were trying to get a small number of staff who worked regularly on the dementia unit. They said this was to enable people who were living with dementia to be supported by staff who had the knowledge and skills to provide their care and support. Staff told us the three staff who worked on the dementia unit each day were supposed to provide activities for people. They explained this was difficult to achieve due to a number of people who needed two staff to support them, supporting people who may want to walk and completing their other duties.

On the day of our inspection, people who were sat in the ground floor lounge and dining room had their needs met in a timely manner. However, the experience was not always echoed in the upstairs lounge/dining room. This was evident from our observations, for example, at 10.05am seven people were sat at the dining table although everyone appeared to have finished their breakfast. At lunchtime we saw two people were seated for 20 minutes at the dining table before they were served anything to eat or drink. This meant there may not be enough staff available to meet peoples assessed needs in a timely manner.

We looked at two staff files and saw that procedures had been followed to make sure staff employed at the home were suitable to work with vulnerable people. We saw staff members had completed an application form, references had been sought and they had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. We also saw the registered provider had checked with the Nursing and Midwifery Council (NMC) to ensure that a recently appointed nurse was registered to practice.

The home was clean and odour free. We saw liquid hand soap and paper towels were available in toilets and bathrooms and instructions for thorough hand washing were on display throughout the building. In the reception area we saw a poster which advised people not to visit if they thought they have signs or symptoms of an infectious ailment. The majority of flooring was cushion flooring, a member of staff said, "It's a pleasure to clean now, all the floors have been replaced and the rooms refurbished".

Requires Improvement

Is the service effective?

Our findings

We asked people if they enjoyed their meals. One person said, "The food is nice, we get good meals." Another person said, "The food isn't bad, you can more or less choose. Sometimes it's things that I don't like, they'll bring me something else." A visitor said, "The food looks quite good, I don't think I'd have a problem eating it."

The cook told us they had a rolling monthly menu. They showed us where they recorded each person's likes, dislikes and allergies. The cook was knowledgeable about people who had specific dietary needs for example soft or liquidised diets.

We saw evidence people had a range of options for breakfast, this included, cereals, porridge, toast as well as cooked choices.

Staff told us they had recently implemented two sittings in the ground floor dining room. They explained this was to protect the dignity of people who required support to eat. In the ground floor dining room we observed five people who required support to eat and they were assisted by four staff. There were twelve people on the second sitting and three staff. We observed the atmosphere to be calm and relaxed with friendly conversation throughout both sittings.

On the dementia unit there was only one sitting for lunch. We observed a person who had finished their meal before the two people they were sitting with had been served with either food or drink. We observed one person who did not communicate verbally, the staff member who was supporting them made very little attempt to interact with the person. On a number of occasions the staff member was either looking away or engaging with other people and did not focus their attention on the person they were supporting. In contrast, we saw another member of staff supporting another person, they remained attentive and conversed with the person while they were supporting them. People were not provided with adapted cutlery or crockery. We saw one person who was eating independently but was using their fingers to push food on to their fork. Another person only had the use of one arm and was eating with a knife instead of a fork. We heard staff ask people if they would like staff to cut their food up for them.

At lunch time people were offered a choice of two main courses, however the vegetables and gravy that accompanied the meals were already on the plates meaning people were not able to personalise these selections to their taste. We noted one person did not eat their meal despite encouragement from staff. The person said they did not want the meal and asked for sandwiches, which were provided.

People told us they could ask staff for drinks or snacks throughout the day. We saw jugs of juice and glasses in the downstairs lounge, the upstairs lounge/dining room had a kitchenette area which enabled staff to provide drinks for people. In the afternoon people were not offered a mid-afternoon drink in the upstairs lounge/dining room until 3.30pm. This meant people may not be receiving adequate amounts of fluid throughout the day.

We looked at one person's diet charts for a 14 day period, from 23 March to 5 April 2015 and found the recording was inconsistent. For example, there was no record of a mid-morning drink on three days, no record of a mid-afternoon drink on six days and supper was not recorded for eight days. We also noted that staff did not consistently record how much of the food and drink that were offered to the person, had been consumed.

This demonstrated a failure to protected people from the risks of inadequate nutrition and dehydration. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence in each of the records we looked at that people had access to GPs, optician, chiropody and, where appropriate, the district nurse and speech and language therapist.

However, when we looked at one person's records we saw this person had suffered a high number of falls over the previous months but a referral to the falls team had not made until April 2015. This meant this person may not have received the additional support required for meeting their care and support needs.

During our visit we asked people who lived at the home and visitors whether they felt staff had the skills to care for them or their relatives. People's comments included, "Even the young ones are sensible and know what they're doing", "They're not so bad", "The staff seem to know how to look after people, they check with you if they're not sure. Even the young staff seem to have mature heads on their shoulders". Two of the visitors we spoke with said, "I think

Is the service effective?

the staff here now know people well enough to provide their care", and, "There is a mix of expertise; the older ones seem to know how to smile more, how to exaggerate it so that (my relative) responds in kind".

We spoke with two staff who had been employed for less than six months. They both told us they had received training and support when they commenced employment at the home. They also told us they shadowed a more experienced member of staff for a number of shifts. We looked at the induction records of one of the new staff we spoke with. We saw a record of the induction they had received at the home. This demonstrated that new employees were supported in their role.

We spoke with eight members of staff about the training and support they had received. They all told us they received regular training and supervision. The training manager showed us a matrix where they logged the staff supervisions' sessions, they said this ensured they kept up to date with all staff supervisions. We looked at the registered provider training matrix and saw that staff received regular training in a variety of topics including moving and handling, fire, food hygiene and infection control. We noted that all staff had completed fire training, however, of the 54 staff listed on the matrix only 41 staff were recorded as having attended a fire drill within the previous twelve months. This demonstrated the registered provider had a system in place to ensure staff received regular training and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The quality manager demonstrated an understanding and knowledge of the requirements of the legislation. They told us two people who lived at the home were subject to a DoLS authorisation in regard to aspects of their individual support needs. This process is carried out if the service needs to make a decision on someone's behalf and ensures the decision involves the relevant professionals and is made in the person's best interests.

We saw that staff had received training in MCA and DoLS, we asked them how this legislation applied to the people they supported. One staff member said, "If someone refuses personal care, we would go back three times and if they still refused we would document this. It means people can make own choices". Another member of staff told us about the people who had a DoLS authorisation in place and the risk assessments which had been put in their care plan. This showed that staff were aware of their responsibilities under this legislation

The quality manager told us they had looked at current research and guidance when they determined the décor for the unit which supported people who were living with dementia. We found the bedroom doors were in a contrasting colour to the walls and handrails in the corridors were also in a bright colour to make them more visible to people. The walls had pictures and relevant newspaper articles, for example, the sinking of the Titanic. A woodland mural was at the end of a corridor and memory boxes were outside each person's room.

The lounge dining room of the dementia unit was a large space with plenty of windows and natural light. The room was practical and functional but did not appear homely. For example, the easy chairs were arranged around the edge of the room with a number of dining tables in the middle of the floor. There was no focal point in the room and the room was not homely. There was an absence of items to engage people in activity or social interaction. Providing an appropriate environment for people living with dementia can greatly enhance people's quality of life.

Good

Is the service caring?

Our findings

Our inspection on 29 September 2014 we found the provider was not meeting the regulations relating to respecting and involving people who use services. On this visit we checked and found improvements had been made.

We asked people who lived at the home and visitors whether they felt that staff were caring. People told us, "Even the younger ones are caring. If someone is sat on their own then someone will go and talk to them", "The staff are kind, I can't fault them" and "They all have a nice temperament, they must be well selected". One person told us stories about their past life, we asked if the staff knew these things, they said, "No, not to my knowledge". We asked visitors if they thought their relatives were cared for by staff who knew them well. One visitor said, "I think they do now. There used to be a lot of agency staff, and they never got chance to know someone well. They would always have to run around after the regular staff members to ask them things". Another visitor said, "(Relative) used to be quite aggressive when people tried to give personal care. Now they can manage (relative) better".

A staff member said, "I look after them like they were my mum or dad". Another member of staff said, "You have to care. Some people may not have capacity, but you don't treat them with less respect".

Throughout the inspection we observed interactions between staff and people who lived at the home which were caring, person centred and patient. For example, during a quiz the activities co-ordinator ensured they interacted with and included all the people who were seated in the lounge, patiently repeating questions and encouraging answers.

In the unit dedicated to supporting people who were living with dementia we heard a member of staff explain to a person they were going to move the chair they were sat in before they moved it. We saw a person being transferred in a hoist, staff explained their actions to the person and provided reassurance. However, at lunchtime we also observed one person who was eating their lunch using a knife, staff walked past this person on a number of occasions but failed to notice they were not using their cutlery appropriately.

We overheard staff supporting people to make simple lifestyle choices. For example we heard staff ask one person where they would like to sit, we also saw some of the staff show people two choices of juice to enable them to choose which they preferred. One staff member we spoke with said, "We give them a choice. If they can speak they will tell us. Like dressing, we hold up the clothes and then they choose. With (name of person) I hold up five or six items before they decide what to wear".

Staff were able to tell us how they protected people's privacy and dignity. They told us they closed bedroom doors and ensured personal care was done in bathrooms or bedrooms. One staff said, "I always knock first if doors are shut. When I hoist someone, I put a blanket over (them)". Another member of staff said they asked people quietly if they needed the toilet. One person told us staff knocked on their bedroom door before they went in. This showed staff were aware of the importance of respecting people's privacy and dignity.

We asked if people had access to the advocacy service. The activities coordinator said no one had an advocate. When we asked the quality manager they told us people who lived at the home had relatives involved and there was no-one who currently required the support of the advocacy service. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

One staff member told us people were encouraged to be as independent as possible, they said, "We encourage people to wash and dress. With one person they were assisted to start with but now they can do this themselves and we monitor. In one of the care plans we looked at we saw this recorded, '(name of person) is able to wash their hands and face'. Encouraging people to be independent can improve people's quality of life.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home about what was available to engage them during the day. One person said, "There's always something different going on", another person said, "(Name of activity organiser) helps the day go along, we have quizzes, trips out. We've been down the canal and went out for lunch".

The activities organiser told us they provided a regular activity programme for people but did not get involved in the day to day activities for people in the upstairs lounge. They said they regularly had trips out and the home had recently adopted a donkey. During our inspection we saw the activities organiser engaging with people in the ground floor lounge.

People who sat in the upstairs lounge did not appear engaged in any form of meaningful activity. Music was played for a period of time and the television was on. We saw people were seated in chairs or walking about the unit. We observed a person who required a member of staff to walk with them. This person stood up a number of times and staff either walked with them or encouraged them to sit back down. Another person became agitated and made frequent requests for staff attention, while, on the whole staff responded, no attempt was made to engage either person in any form of occupation.

A staff member we spoke with told us about a person who liked to sweep up and another person who enjoyed reading. However, we did not see anyone being offered or supported to engage in these activities. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

In each of the care records we reviewed we found minimal information about people's life history.

When we discussed this with the quality manager they told us they had plans to implement 'this is me' style document. They told us one had already been completed for one person who lived at the home. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences, it can also aid staffs' understanding of individuals' personalities, behaviours and enable staff to have meaningful conversations and encourage social interaction and communication.

The care files we looked at did not demonstrate that care was always planned in a person centred manner. For example, one record detailed the person was not able to verbalise their needs or worries and instructed staff to 'give choices', but did not indicate how staff should offer choices and how the person would indicate their preferred option. Their eating and drinking care plan recorded 'staff will assist' but there was no detail recorded as to the level of assistance required.

This evidenced a failure to ensure that care and support was not planned and delivered to meet the individual's need. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were not consulted in the planning or delivery of the care and support they received. People told us, "I don't know anything about that", "Maybe they might ask questions about it in general conversation. I don't know what a care plan is". Another person said, "I've heard about my care plan", however, they were not able to tell us how they had been involved in a review. Visitors we spoke had not attended any formal reviews of their relatives care. The training manager told us they had begun to review people's care plans. They showed us evidence of one person's care plan which had been reviewed, we saw the care plans had been re-written and had been signed by the person's relative. They told us they had plans in place to review further care plans over the coming weeks.

We asked people if they were happy with the care that they received. One person said, "I love it here. The main thing is the way that we are catered for. It's like a happy family". Another person said they were happy, they said, "It's not like an old people's home". Visitors also said they were happy with the care that their family member received. One visitor said "(Relative) always says they are happy here." However, another visitor said, "Whenever I come (relative's) clothes are always dirty. I know they spill food but they could do something to smarten (relative) up."

We asked people what they would do if they wished to make a complaint, they told us would report concerns to 'the staff'. A visitor told us they had recently raised a concern regarding their relative's laundry items. We looked in the home's complaints file and could not see evidence this concern had been logged. The quality manager told us they had not received any formal complaints since June 2014. They said verbal complaints were not currently

Requires Improvement

Is the service responsive?

logged however, they were aware of the matters raised regarding this person's laundry and the action which was being taken to resolve the issue. This meant we were unable to evidence that where people raised a concern they would be listened to and their concerns acted on.

Requires Improvement

Is the service well-led?

Our findings

Our inspection on 29 September 2014 found the registered provider was not meeting the regulations relating to assessing and monitoring the quality of service provision. On this visit we checked to see if improvements had been made. While we found a number of improvements had been made to address our concerns, there was not enough evidence to demonstrate that robust governance systems were yet in place.

At the time of our inspection Hartshead Manor did not have a registered manager in post. The quality manager told us they were overseeing the day to day management of the home, along with the registered provider's training manager. They told us a new manager had been recruited and would be commencing employment once all their pre-employment checks had been completed.

During our visit we asked people if they knew who was managing the home. People who lived at the home and the visitors we spoke with did not know the identity of the people who were currently managing the home. One visitor said, "There have been numerous managers."

Staff we spoke with were aware of the names of both managers who were overseeing the management of the home. Staff comments included, "We have a new manager coming on 20 April. (Name of quality manager) and (name of training manager) are very good. They are here till we get a new manager", "Management have listened. Before there was no team work, now it is a good culture, a nice team" and "This place has turned around, such as training and working hours. Team leaders are supportive and approachable".

We asked the quality manager how they knew the service was providing care and support in line with good practice guidelines. They told us accessed a variety of references to support good practice within the home. They said this included the National Institute for Clinical Excellence (NICE) guidelines, Nursing and midwifery council (NMC) guidelines and they had also had input from a company who specialised dementia care. The training manager also told us the registered provider was accredited with Investors in People (IIP). This is a nationally recognised award for supporting and managing people who work for the organisation.

We looked at the audits which were completed by staff. We saw an audit of people's medicines had been completed in December 2014, February and March 2015. We saw issues identified in the December audit were recorded as having been actioned in the February 2015 audit. The quality manager said audits were completed to ensure mattresses on people's beds were clean and functioning correctly. We looked at the audit completed on one person's mattress and saw it had been completed on a regular basis.

Audits of people's care records had not been completed regularly. We saw two audits, one dated August 2014 and a second dated February 2015. When we looked at peoples records we found the records were not always reflective of people current care and support needs For example, one person had not been weighed since December, despite losing six kilograms since September 2014. The record detailed this person was 'end of life', however, on the day of the inspection they were sat in the lounge. Some people's records did not provide clear guidance for staff, for example, one person's care plan recorded 'weekly or four weekly weights to be recorded'. This meant people were not protected from the risks of unsafe or inappropriate care and support because accurate and appropriate records were not maintained.

The quality manager told us a management report was submitted monthly which provided key information regarding a number of topics, including, pressure ulcers, falls and safeguarding. We asked the quality manager if this was completed for Hartshead Manor. They told us it was not as there was not a manager in post. We asked the quality manager how they ensured they had an accurate oversight of the home, they told us they 'knew' as it was 'all in their head'. However, they also said that in the absence of a manager at the home both themselves and the training manager had been involved with the home on a daily basis. This included attending shift handovers and supporting staff in their role.

These examples demonstrate a failure to identify, assess and manage risks relating to the health, welfare of people who live at the home. This also demonstrates a failure to ensure accurate and complete records are maintained for each person. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

The commercial manager visited the home on a regular basis, they recorded the reason for their visit and actions they had taken. For example, addressing matters relating to the kitchen and maintenance of the home.

We asked people if they attended resident meetings. One person said, “Two or three of us are on the committee, we meet once a month or when anything happens and they call a meeting.” This person was not able to tell us what was discussed at the meetings or if anything had happened as a result of the meeting. A visitor told us, “I didn’t know anything about meetings until I saw a notice saying that a meeting was cancelled.” We saw a notice in the corridor, this recorded resident meetings were held on the first Wednesday of the month. We saw minutes from meetings held in January and February 2015.

We also saw staff meetings were held on a regular basis. These detailed the names of those who attended and the topics discussed. We saw meetings were held with different staff groups, for example team leaders and the catering team.

None of the meeting minutes we looked at recorded if any action was required as a result of the issues raised or recorded the progress of any action needed.

The quality manager told us quality surveys were to be sent out to people when the new manager commenced employment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Assessments of people's needs did not take into account all of their needs. Care and support was not person centred and did not reflect their personal preferences.** **Regulation 9 (1) (3) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People were not protected from the risks of inadequate nutrition and dehydration.** **Regulation 14.**

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 **Governance systems did not robustly assess and monitor the quality of service provision. People were not protected from the risk of unsafe or inappropriate care and support due to accurate and complete records not being maintained for each person.** **Regulation 17 (1) (2) (a) (b) (c).**