Care Quality Commission

Hallmark Care Homes (Brighton) Ltd

Maycroft Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Maycroft Manor on the 13 and 14 January 2015. Maycroft Manor provides care and support to people with personal care and nursing needs, many of whom were living with dementia. The home is arranged over three floors, offering residential and nursing care based on people's particular needs and requirements. One area is a specifically designed unit which provides an environment that supports people living with dementia. The home can provide care and support for up to 99 people. There were 63 people living at the home on the days of our inspections. Maycroft Manor belongs to a large corporate organisation called Hallmark Care Homes. Hallmark Care Homes provide residential and nursing care across England.

There was no registered manager in post. The home has been without a registered manager for approximately three months. However, a manager had been appointed and was due to start work at the home in February 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in August 2014, we asked the provider to make improvements in respect to the management of medicines and meeting people's

Summary of findings

nutritional needs. An action plan was received from the provider and we found that improvements had been made in the area of nutritional needs. However, we found further areas of improvement required in respect to the management of medicines and record keeping.

People's medicines were stored safely and in line with legal regulations and people received their medication on time. However, there were errors and omissions in the recording of administration of medicines and PRN medication (as required). We have asked the provider to make improvements in this area.

Care plans gave information on how people wished to be supported and daily records showed what care had been delivered. However some care plans and daily records contained gaps in their recording, or were missing information. We have identified this as an area of practice that requires improvement.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work with adults at risk. One person told us, "Yes I feel safe. We have good staff, they treat me very well". Staff were knowledgeable and had received training on safeguarding adults. Staff understood what action they should take if they suspected abuse was taking place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that staff understood when an application should be made and how to submit one.

Where people lacked the mental capacity to make a specific decision the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

Accidents and incidents were recorded appropriately and steps taken by the service to minimise the risk of similar events happening. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were encouraged and supported to eat and drink well. One relative said "The food tastes beautiful and visitors are always welcomed to come and have a meal". There was a varied choice of meals and people were able to give feedback and have choice in what they ate and drank. People were advised on healthy eating and special dietary requirements were met. People's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People could choose how to spend their day and they took part in activities in the home and the community. People told us they enjoyed the activities, which included arts and crafts, singing, exercises, films, opera, jigsaw, poetry, Sky sports, crosswords, jazz shows and pre dinner drinks and coffee and cake.

Staff had received essential training and there were opportunities for additional training specific to the needs of people. Staff had formal personal development plans, such as regular supervision meetings with their manager.

People felt well looked after and supported and we observed friendly and genuine relationships had developed between people and staff. One person told us, "It feels as if I have made friends straight away". Another said, "They just care, you are looked after well". Care plans described people's needs and preferences and they were encouraged to be as independent as possible.

People were encouraged to stay in touch with their families and receive visitors. Relatives were asked for their views about the service and the care delivered to their family members. Completed surveys showed families were happy overall and felt staff were friendly, welcoming and approachable. Residents' and relatives meetings were held and people said they felt listened to and any concerns or issues they raised were addressed.

People were involved in the development of the service and were encouraged to express their views. Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where management were available to discuss suggestions and address problems or concerns. The provider undertook quality assurance reviews to measure and monitor the standard of the service.

Summary of findings

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

Medicines were stored appropriately, but records used to show medicines people had taken contained errors and omissions.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care. People told us they felt safe. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work with adults at risk.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of peoples care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Staff received training which was appropriate to their job role. This was continually updated, so staff had the knowledge to effectively meet people's needs. They had formal systems of personal development, such as supervision meetings.

Is the service caring?

Good

The service was caring.

People felt well cared for and were treated with dignity and respect by kind and friendly staff. They were encouraged to increase their independence and to make decisions about their care.

Staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care.

Care records were maintained safely and people's information kept confidentially.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People were supported to take part in a range of recreational activities both in the home and the community. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People and their relatives were asked for their views about the service through questionnaires and surveys. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Several care plans and daily records contained gaps in their recording, or were missing information.

Staff felt supported by management, said they were supported and listened to, and understood what was expected of them. People were able to comment on the service provided to influence service delivery.

Systems were in place to ensure accidents and incidents were reported and acted upon. Quality assurance was measured and monitored to help improve standards of service delivery.

Maycroft 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 13 and 14 January 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

Three inspectors and an expert by experience in older people's care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the three floors of the home. We spoke with people and staff, and observed how people were supported during their breakfast and lunch. We spent time looking at records, including seven people's care records, four staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation. We also 'pathway tracked' several people living at Maycroft Manor. This is when we followed the care and support a person receives and what is documented about their needs and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Some people had complex ways of communicating and several had limited verbal communication. During our inspection, we spoke with nine people living at the service, five visiting relatives, 15 care staff, the chef, two housekeeping staff, a registered nurse, the acting clinical care manager, the hospitality services manager, the regional manager and the clinical governance director.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. One person told us, "Yes I feel safe. We have good staff, they treat me very well". Another said, "Very safe no problems, always people about, I'm very thankful I came here". Although people told us they felt safe, we found areas of practice which were not safe.

At the last inspection in August 2014, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008. People were not protected against the risks associated with medicines, this was because the provider did not have appropriate arrangements in place in relation to the ordering and recording of medicines. Some improvements had been made, however we found further areas requiring improvement to the management of medicines.

We looked at the management of medicines. The registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). MAR charts are the formal record of administration of medicine within a care setting. We saw several MAR's contained omissions, or had been filled out incorrectly. For example, one person's required eye drops to be administered. The nurse working the night previously had administered the eye drops, but had not recorded this on the MAR. The nurse working the following day had no record that the eye drops had been given and tried to administer more, but the person would not allow it, and insisted they had been given by the night staff. This lack of recording placed this person at risk of a receiving the wrong dosage of eye drops, as despite informing the nurse on this occasion they had received their eye drops, they had a diagnosis of dementia and had dementia-related issues including memory loss. Another person required a night time dose of medication prescribed for mini-seizures. The nurse on duty did not know if this person had received their medication, and if it had not been given, the reasons why, as no record had been made. We saw a further 17 omissions in the recording of medication in eight separate MAR's.

People were at risk of not receiving PRN medicine (which is medicine taken as required) due to lack of guidance and risk assessments. PRN medication should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be given and the steps to take before administering it. For example, a nurse told us that one person might require pain killers for their arthritic shoulder. This information was not documented in their medicines care plan. The nurse knew which of this person's prescribed painkillers they found easier to take and most effective, but this was not documented. Another person required PRN paracetamol and morphine sulphate, plus Diazepam regularly at night and PRN at lunch time, but there was no PRN protocol recorded. We looked at this person's care plan, which contained no information of the type of pain they experienced, where on the body and what strength of painkiller would be advised according to the situation. Their care plan stated that Diazepam was to be given 'if needed' during the day – 'This is because [X] has been a lot more upset recently'. We spoke with a staff member, who told us that this person did not need Diazepam during the day anymore. They added that the person had been becoming tearful, but the Diazepam at night settled them. The person's care plan did not reflect this information, and had not been updated, meaning that other involved professionals, such as GP's could not be accurately informed. Maycroft Manor's policy on PRN states that PRN protocols must be drawn up where a person is prescribed, and that a manager must countersign. It also states that 'staff must ensure that the PRN form is competed and signed'. We did not see PRN forms in any of the records.

Inaccurate medicines recording places people at risk as they may not get the medicines they need, which may be vital to their health and wellbeing. Alternatively, staff may give the wrong medicine in error if there are gaps in the information. Clear records help to prevent drug errors. Everyone involved in looking after medicines for other people is responsible for keeping good records.

The above issues around medicines record keeping are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that requires improvement.

Despite the above concerns, people told us they received their medicines on time. Some people were enabled and supported to manage their own medicines. This promoted people to remain independent. One person told us, "I am

Requires Improvement

Is the service safe?

able to use the inhaler myself, as and when I need to. The staff do the drugs. I always get them on time". Another person said, "My medicine is supplied at appropriate times". We observed staff administering medicines to people. Staff were polite and made sure that people were comfortable and ready, and told people what they were taking.

Medicines were stored appropriately and securely. Medicines which were controlled under the Misuse of Drugs Act 1971 (controlled drugs) were appropriately double locked within a medicines cupboard. These drugs were listed and logged in a controlled drugs register. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly.

There were systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments which were specific to their needs. The assessments outlined the benefits of the activity, the associated hazards and what measures could be taken to reduce or eliminate the risk. We spoke with the acting clinical care manager and the regional manager about the need to balance minimising risk for people and ensuring they were enabled to try new experiences. The acting clinical care manager said, "We carry out pre-assessments with people to determine risks. Some residents don't want to be involved in their care planning, so we involve their family. We promote independence and encourage people to take risks. This is detailed in their care plans and details discussed with staff in handover meetings".

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff and people knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, staff safety and welfare. There was a business continuity plan. This instructed staff on what to in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Staffing levels were assessed to ensure people's safety. The acting clinical care manager told us, "I feel that there are enough staff in the home. We use a system calculated on a dependency screening for residents to determine how many staff we need over a five week rolling rota". They added "We have a lot of bank staff [Bank staff are employees who are used on an 'as and when needed' basis] and have good team cover. Plus full time staff cover as well. We use agency staff if need be and use regular agency nursing staff". Feedback from people indicated they felt the service currently had enough staff and our own observations supported this. In respect to staffing levels and recruitment, the acting clinical care manager added, "We set our rotas four weeks in advance, we have just changed the staff rotas which has helped a lot. We continually recruit and we are looking to get the right people in, with the right skills, not just bodies through the door". Documentation we saw in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs.

Records showed staff were recruited in line with safe practice. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Good

Is the service effective?

Our findings

People told us they received effective care and their needs were met. One person told us, “The staff help to keep you clean, they always bring me my meals, and they are very cheerful.” Another said, “They listen to me, staff are very interactive here, they listen and respond accordingly”

At the last inspection in August 2014, we found the provider was in breach of Regulation 14 of the Health and Social Care Act 2008, as people were not protected from the risks of inadequate nutrition and dehydration. We found that improvements had been made.

People were complimentary about the meals served. One person said, “Soup and dessert excellent, main course 7 out 10”. People had an initial nutritional assessment completed on admission. Their dietary needs and preferences, such as food allergies, diabetic, pureed and fortified food were recorded and catered for. Where a need for a specialist diet had been identified we saw that this was provided. For example some people were on a soft or pureed diet due to problems with swallowing. We saw that staff recorded the food eaten and any observations about people during the meal. Staff told us that how much people drank was discussed at every handover meeting, and those with a low intake were monitored more closely. People’s weight was regularly monitored. The staff we spoke with understood people’s dietary requirements and how to support them to stay healthy.

We observed breakfast in the residential dementia unit (Clement Way). People were encouraged by staff to choose where they wanted to sit and what they would like to eat and drink. Staff told us that us that everyone was encouraged to come to the dining area, however if they wanted to stay in their own room they were able to do so. Staff prepared the breakfast for residents in the kitchen of the dining area. Staff had a detailed understanding of each person’s dietary needs and their preferences. One person was struggling to decide what to have, so a member of staff asked “Would you like us to cook your favourite today?” The person smiled their affirmation in response. The breakfast was served and eaten in a relaxed atmosphere. There was a lot of chatter and laughter between people whilst they waited to be served. One person moved freely among the tables joking with others and staff, creating a friendly atmosphere.

We also observed lunch in the in the residential dementia unit (Clement Way) and the nursing unit (Bardon Lane). People were considerately supported to move to the dining areas, or could choose to eat in their bedroom. The menu was displayed for people and showed the options available that day. We saw staff giving a menu individually to everyone, so that that they were aware of the choices of food on offer. Staff assisted residents to make their choice. Food was delivered in heated trollies via a separate lift to all floors of the home, so that people received hot food in a timely manner.

Staff were appropriate in their encouragement for people to be independent with eating, and where needed, staff were observed offering support and assistance for example chopping food into smaller portions, or getting extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. We saw one person who liked to eat with their fingers and this was supported by staff. After lunch staff encouraged people to move into the lounge area and have coffee or tea, whilst watching an old black and white film on television. One person being assisted from the table commented, “I enjoyed that” and the staff member responded with encouragement saying, “You have done well today”.

The staff knew individual likes and preferences and offered alternatives. For example, we observed one person became agitated during their meal and started throwing their food on the floor, as they didn’t want to eat it. A staff member remained very calm and patient and offered several alternative choices. The staff member suggested that the person may prefer to go to the lounge where there were less distractions and they agreed. The person was encouraged to try some toast, and when they tasted and rejected this, the member of staff prepared some scrambled egg which the person ate and stated was their “favourite”.

People told us they could have a drink at any time and staff always made them a drink on request. Short order menus were available and snacks were available at all times with juice and water available on all floors. Food forums took place every four months, where residents could discuss the menu with the chef. One person told us, “I have a hearty appetite and would sometimes like more vegetables. We discuss the meals at residents meetings and have been able to bring in some changes”.

Good

Is the service effective?

Staff had received training that was specific to the needs of people, for example in food hygiene, fire evacuation, health and safety and equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experience members of staff until they were deemed competent to work unsupervised. They also received training which enabled them to provide effective care, for example around the care of people with dementia. People felt staff were well trained. One person told us that staff were having training on the day of our inspection and said, "I feel the staff are well trained, they are often having refresher courses". Staff received ongoing support and professional development to assist them to develop in their role Staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns. We saw there were on-line and paper copies of supervision records, and any concerns identified were recorded and actioned by management.

Staff told us they explained the person's care to them and gained consent before carrying out care. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures in place to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The provider was meeting the requirements of DoLS. The regional manager and acting clinical care manager knew how to make an application for consideration to deprive a person of their liberty should they not have the capacity to make certain decisions, and there is no other way to look after them safely. One decision to deprive somebody of their liberty was in place, and the home was consulting regularly with the Local Authority to keep this person safe from being restricted unlawfully. This person lived on a floor of the home that was locked, with entry gained via a coded keypad. They often wished to leave the home, however it would not be safe for them to do so alone. We saw that staff ensured they took regular trips and walks out of the home and around the gardens to support this person in the least restrictive way.

Care records showed when there had been a need, referrals had been made to appropriate health professionals. One person told us that when they moved to the home they were very poorly, they said, "I had one or two concerns and the staff arranged a doctor to visit. The staff are very helpful. I have also had a chiropodist came and look at my feet" they added, "If you get something it's dealt with straight away by the staff". Another person said "If I am not feeling well, staff are very good at getting the doctor to visit". We also saw that if people needed to visit a health professional, such as a dentist or an optician, then a member of staff would support them.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "It feels as if I have made friends straight away".

Interactions between people and staff were positive and respectful. We saw one person in a wheelchair being assisted into the dining area. We heard the staff member explaining and talking to the person about what they were doing and asking them where they would like to be seated. We also observed a staff member being kind to a person who was sitting slanted on a sofa and did not look comfortable. The staff member politely suggested they might like to stand up, so they could get straight on the sofa. They agreed and the staff member guided them on how to stand independently. The person found this very funny and started giggling, and the staff member joined in laughing. After a few attempts, which were slowed due to the person giggling, they managed to stand and sit down in a more comfortable way. The support for manual handling was performed safely and appropriately and the member of staff was kind and considerate throughout. They then offered the person a drink when they were comfortable.

People looked well cared for and were relaxed when staff supported them. Staff supported people in doing what they wished, such as sitting in the lounges or going to their room. There was a friendly and relaxed environment, where people were happy and engaged in their own individual interests, as well as feeling supported when needed. We noticed that staff engaged with people at every opportunity and that people responded in a positive way. People were happy with the care and support they received and were complimentary about the staff. One person told us, "Staff are very nice here, I'm very happy here". A relative said, "Generally the carers are very good".

Staff knew people well and had a good understanding of their preferences and personal histories. One staff member told us, "I knew that a resident used to like drinking Dandelion and Burdock, because we talk quite a lot. I'd never even heard of it, but I got her some today on my way to work and she loves it, she's nearly drunk it all already". One person told us, "Staff have got a lot of patience. They listen and really pay attention. Sometimes I cannot get out the words, they don't rush me and they give me time to get out what I want to say". A visitor added, "Staff get to know the residents very quickly and make sure that they are clean and feel well cared for".

Throughout the day we saw and heard staff working and in a way that was respectful of people's privacy and dignity. We observed staff knock on people's doors before they entered. Staff told us that they would always ensure that doors were shut and curtains closed during personal care and that people were covered appropriately. One relative told us "Privacy is respected and wonderful. The staff always close the door when they are doing personal care. Staff are very nice and very kind when with the residents." When staff passed people in the corridor they would address each other by their first name and stop and have a chat. Staff told us they helped people to have choice and maintain their independence. For example they encouraged people to make decisions about their clothes and to dress and wash themselves, and would support them if required.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. We saw that regular meetings took place for residents and relatives and were recorded, with minutes being made available to residents and staff. We saw that changes were made to the service in light of feedback received at these meetings. For example, around the frequency of care plan reviews and staffing allocations. People's care plans contained personal information, which recorded details about them and their life. This information had been drawn together by the person, their family and staff. Most people we spoke with confirmed that they had been involved with developing their or their relative's care plans. Care records were stored securely, information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of confidentiality and had received training which enabled them to respect and promote people's confidentiality.

Visitors were welcomed at the home and we observed many visitors coming in and out of the home throughout our inspection. Relatives told us they could visit at any time and they were always made to feel welcome. One visitor told us, "This bistro is a great place to meet and eat, a

Good

Is the service caring?

brilliant place to bring a guest and have coffee". Another visitor said, "When my friend moved here, he couldn't have gone to a better place. It feels like a home here, it's a homely and welcoming place".

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, “They listen to me and see me right”.

There was regular involvement in activities and the service employed a ‘lifestyle’ team whose role it was to manage this. One person told us they had been taken out on trips to the theatre and gardens and said “It’s more fun living here than at home”. Another person said, “I like my own company and I generally keep to my own room, but if there is anything going on, if you want to join in, there is never any pressure to do so”. Activities were organised in line with people’s personal preferences, for example a bridge club attended the home to play bridge with one particular resident, and this now included other people living at the home who were interested in participating. We saw a varied range of activities on offer, including, arts and crafts, singing, exercises, films, opera, jigsaw, poetry, Sky sports, crosswords, jazz shows and pre dinner drinks and coffee and cake. During the inspection we observed people participate in a gentle exercise class and a talk about the gardens. One person showed us a card they had on display which they had painted in the craft class. Another person said, “I like the music and poetry activities. It fills the room, this helps to create friendships”. We also saw a singing session with people with dementia. During this session staff were engaging on a one to one level with people, and were encouraging them to sing and play musical instruments, which people were enjoying. The home has its own mini-bus and the regional manager told us, “We ask people to give us suggestions about trips out in the mini-bus. We spend a large amount of time on activities and food, we’re selling a lifestyle with care”.

The home supported people to maintain their hobbies and interests. We saw that one person had moved their grand piano into the home and was seen playing it each morning. They told us, “I enjoy musical events, singing and playing my piano. I was able to bring my grand piano here and sometimes accompany the musical sessions”. Another person wished to attend a local church and we saw that this had happened. The regional manager told us, “We listen to what people want to do. We have one resident who was an engineer, so we have got them a motor that they can tinker with and repair”. The home also encouraged people to maintain relationships with their friends and families. We saw that the home supported one person to visit their brother in another care home.

Care plans were reviewed monthly or when people’s needs had changed. People were involved in the reviews of care. Most people we spoke with told us that they were aware of their care plan and had told staff their likes and dislikes. A visiting relative told us, “We regularly meet with the nurse and clinical manager when they were here to discuss the care.

People received care which was personalised to reflect their needs, wishes and aspirations. Care plans showed that assessments had taken place and that people had been involved in the initial drawing up of their care plan. These plans also provided information from the person’s point of view. They provided information for staff on how to deliver peoples’ care. For example, information about personal care and physical well-being, communication, mobility and dexterity. One person’s care plan stated they would like a bath every day and wanted to be well dressed and wearing their earrings. We spoke with staff and the person in question and saw that this had happened. Another person had requested in their care plan that they wanted to stay in bed until late morning. We spoke with this person’s family who confirmed that their relative always ‘liked having a lie in’.

People were treated as individuals and their care needs reflected personal preferences, for example people were getting up at the times they wanted. Staff were able to tell us why some people were still in bed. For example, one person had just received a pressure relieving cushion and were waiting for it to inflate, another was on bed rest due to an ongoing condition. Staff told us that they checked people’s preferences, for example, a staff member told us they would mention to the nurse if it was unusual for a resident to stay in bed, so that the nurse could check on them. Staff showed they were knowledgeable of the people they were caring for. We saw in a care plan that staff were concerned a person was ‘acting strangely’ and may have a urinary tract infection (UTI). Staff responded to this by testing the person’s urine and confirming there was an infection and ordering antibiotics.

Records showed comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes

Good

Is the service responsive?

and learning recorded. Staff told us they would support people to complain. We also saw an example of the service making changes following compliments received. In light of feedback, the home now puts a plant and a card in people's rooms prior to their admission. The procedure for raising and investigating complaints was available for people. One person told us when they moved in they weren't sleeping very well as the bed was not comfortable for their size and build. They said "As soon as I complained to staff my complaint was dealt with immediately and they adjusted the bed end straight away". Another person informed us that when they had made a complaint it was sorted out quickly, and they had weekly meetings with management until the complaint was resolved. The regional manager said, "We look at complaints as a positive thing and take learning from them".

Meetings were held regularly for people at which they could discuss things that mattered to them and people said they felt listened to. Meeting minutes showed that somebody had fed back that they menus were too small for them to see, so they had been made larger. A suggestions box was also available for people to use. A service user and relatives' satisfaction survey had been completed in September/October 2014. Results of people's feedback had been used to make changes and improve the service. For example, in light of comments received the daily menu was displayed on the television screen in the bistro area.

Requires Improvement

Is the service well-led?

Our findings

Comments we received from people indicated they felt the home was well led. One person told us, “The home is pretty well managed. I know the staff in charge”. However, we found areas of practice which required improvement.

At the last inspection in August 2014, we found the provider was in breach of Regulation 14 of the Health and Social Care Act 2008. As systems for monitoring people's fluid intake were not completed consistently. Improvements had been made, however further areas requiring improvement to the recording of fluids and other records were identified.

Food and fluid charts were completed indicating a good intake of food and drink for people and we observed staff updating charts. However, on the Bardon Lane nursing unit, people’s fluid charts were not totalled and information on the amount of fluid they should be drinking was missing. We also saw one chart that showed a person had only 350ml of fluid in a day, and no indication as to why this person’s fluid intake was so low. This lack of information meant that it was not possible to determine if this person was at risk of dehydration.

The acting clinical care manager informed us that care plans were reviewed every month and that records were regularly checked to monitor for any inaccuracies or missing information. However, in three of the care plans we looked at we found inaccuracies or missing information. For example, one person was assessed as being at very high risk of pressure ulcers. We saw that the wound care plan was very clear and easy to follow. However, the wound care plan evaluation sheet contained omissions, and we could not see evidence that the wound had been dressed for six days, despite the registered nurse on duty confirming that it had. Another person who was assessed as being at risk of pressure ulcers required regular turning to minimise the risk. Their turning chart contained several omissions and it was not possible to evidence that the care had taken place.

Records that contain omissions, or are completed incorrectly can undermine patient care. Accurate record keeping forms the basis for planning peoples’ care and treatment, obtaining feedback on their progress and suggesting actions for prevention and health promotion. Accurate records provide written evidence that a service has been delivered, and provides information for clinical management, resource management, self-evaluation, clinical audit and quality assurance. We have identified the above issues around record keeping as an area of practice that requires improvement.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are ‘registered persons’. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The home had been without a registered manager for approximately three months. They had recruited a manager, but they were not yet in post. The regional manager told us, “We have management staff on duty seven days a week from all departments on a rolling rota”. Day to day charge of the home was taken by the acting clinical care manager, the hospitality services manager and the regional manager, to provide consistent management cover until the new manager was in post.

People were actively involved in developing the service. For example, we saw that more one to one activities had been put in place for people in light of feedback received. We also saw that people were involved in the development of the gardens at the home and that they had been entered into a competition.

We discussed the culture and ethos of the service with the regional manager. We were shown a document called the ‘Hallmark Care Homes Charter’. This document contained information to guide and explain the values and purpose of the home. Statements in the charter included ‘We are dedicated to developing quality environments and high standards of care, which enable residents to enjoy life to the full, as individuals, in happy, comfortable and safe surroundings’. The regional manager told us, “We provide the Hallmark Charter for all staff to read. It explains what we aim to do, what we expect from individuals and why we are here. We remind staff of the charter at workshops”. In respect to staff, the regional manager added, “We share information with staff and want their feedback. The managers have a good understanding of the day to day culture of the home and have an open door policy”. We were shown an example whereby as a result of feedback from staff, the weekly shift pattern and rota had been changed. A staff member confirmed this and said, “There is less agency staff now and we have a good team. Managers’ try to find out our likes regarding the shift changes with

Requires Improvement

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trials of different rotas. It has been very positive since last summer and it is a completely different home". Another commented, "There has been an influx of staff and new rotas and this is working much better".

Staff said they felt well supported within their roles and were happy in their roles. One staff member told us, "This is the best place I have ever worked". Another said, "I love working here, the residents make me want to come to work". A further member of staff added, "The team leaders are helpful and we get a lot of support". Staff were encouraged to ask questions, discuss suggestions and address problems or concerns with management. One member of staff told us, "Management are really approachable now". Another said, "Manager's walk the floor every day, they are more responsive and involved". A staff member told us they had an issue with a member of staff, and that this had been dealt with by head office satisfactorily. Further comments included, "It's getting much better and we know exactly who to go to" and "Management is supportive and there is more of a management presence".

There were good systems of communication within the service, and staff knew and understood what was expected of them. Handover meetings took place between shifts in order for staff to discuss matters relating to the previous shift. A daily quality meeting took place with senior staff, and team meetings were held at which staff could discuss aspects of people's care and support, and work as a team to resolve any difficulties or changes. Staff told us they could raise any issues of concern and these were documented with actions taken. An example given was that requests for equipment for people were responded to quickly by management.

Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future. For example, after analysis of an incident, a person had an assessment for the use of bed rails.

Staff knew about whistle blowing and said they would have no hesitation in reporting any concerns they had. They reported that manager's would support them to do this in line with the provider's policy. We were told that whistle blower's were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

The provider undertook quality assurance audits to help ensure a good level of quality was maintained. For example, an audit of training highlighted which staff required further training or updates to existing training. The regional manager also told us that in light of the analysis of previous concerns at the home gained through feedback, complaints and safeguarding information, they had slowed down the number of people they had admitted to the home. They said, "We slowed down the admissions rate to help us manage people's expectations. We wanted to get the culture of the home embedded, keep ahead with recruitment and training and create team work". Questionnaires were sent out regularly to families and feedback was obtained from people, staff and involved professionals. Returned questionnaires and feedback were collated, outcomes identified and appropriate action taken. The information gathered from regular audits, monitoring and the returned questionnaires was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. The regional manager informed us they were supported by the owners and directors of Hallmark Care. They attended regular management meetings to discuss areas of improvement for the home, also to review any new legislation and discuss good practice guidelines within the sector.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.