Coveleaf Limited

Hope Manor Residential Home

Inspection report

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Greater Manchester
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12 June 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Hope Manor Residential Home on 07 and 12 June 2017.

Hope Manor is a residential care home located in Salford, Greater Manchester and is owned and operated by Coveleaf Limited. Hope Manor is an older building with accommodation set over two floors. The home is situated off a busy main road and close to local amenities. Parking facilities are available at the front of the home which also facilitates wheel chair access. Hope Manor is registered with the Care Quality Commission (CQC) to provide personal care and accommodation for up to 26 people. At the time of our inspection there were 23 people living at the home.

The home was last inspected on 23 and 24 March 2016, when we rated the service as 'requires improvement' overall and identified two breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person-centred care and staffing.

At this inspection we found the service had made improvements and was now meeting all regulatory requirements. We did not identify any current concerns with the care provided to people living at the home.

At the time of the inspection the home had a registered manager. '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.'

We found the home to be clean with appropriate infection control processes in place. Three housekeepers were employed and worked on a rota system to ensure daily input was provided. We saw detailed cleaning schedules in place to ensure bedroom, bathrooms and communal areas were cleaned regularly.

All the people we spoke with told us they felt safe and loved living at Hope Manor. Relatives were similarly positive about the safe care and treatment provided to their loved ones. The home had appropriate safeguarding policies and procedures in place, along with instructions on how to report safeguarding concerns to the local authority. All staff had been trained in safeguarding adults and knew how to identify and report any safeguarding or whistleblowing concerns.

Staffing was organised based on people's dependency levels, with assessments of need being completed every month. We saw enough staff had been deployed to support people effectively and people living at the home told us they were happy with the number of staff on shift and any requests for assistance were met quickly.

Both the registered manager and staff we spoke with demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which are used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within

the principles of the MCA and had followed the correct procedures when making DoLS applications. The home had implemented DoLS care plans to ensure any recommendations or conditions listed on the DoLS authorisations had been addressed.

We saw medicines were stored, handled and administered safely and effectively. All necessary documentation was in place and was completed consistently. Staff responsible for administering medicines were trained and had their competency assessed annually. The home completed daily, weekly and monthly medicines audits, to ensure administration and recording had been completed accurately.

Staff spoke positively about the training available and we saw the home had links with the local college. All staff completed an induction upon commencing employment, which included a flexible period of shadowing experienced staff. We saw staff had been enrolled on the care certificate and on-going training was provided to ensure skills and knowledge remained to date.

Staff told us they received regular supervision, which along with the completion of monthly team meetings, ensured they were supported in their roles.

Meal times were observed to be a positive experience, with people able to choose where they sat and what they ate. Meal options were provided at point of service, with additional options being readily available for those who did not like what was on offer. Staff supporting meal times were attentive, ensuring people had drinks, were served promptly and dishes cleared after eating. The home had monitoring charts in place to record people's food and fluid intake, with nutritional care plans in place for those with special dietary requirements.

Throughout the inspection we observed positive and appropriate interactions between staff and people living at the home. Staff were kind, caring and treated people with dignity and respect. Staff were knowledgeable about the people they cared for, which was commented upon by the people we spoke with. Both people who used the service and their relatives were complimentary about the standard of care received and said they would be happy to recommend the home to others.

We looked at four care files which contained detailed and personalised information about the people who used the service and how they wished to be cared for. Each file contained a range of care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. Alongside standardised care plans, individual plans had been implemented to address specific issues.

The home employed an activity coordinator who oversaw all activities and outings facilitated in the home. Everyone we spoke with was positive about the options available and complimentary about the coordinator. We saw a mix of activities were organised throughout the week which catered for all interests and abilities along with regular outings and visits from entertainers. The home had three lounges, which meant that people who did not wish to take part in activities had somewhere they could sit and either read, watch television of chat to others.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a weekly, quarterly and annual basis and covered a wide range of areas including medication, care files, nutrition, activities, training, health and safety and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People we spoke with told us they felt safe living at Hope Manor.

Staffing levels were appropriate to meet people's needs and re-assessed on a monthly basis.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff who had their competency assessed on a regular basis.

Is the service effective?

Good

The service was effective.

All staff spoken with had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the service was working within the principles of the MCA.

Staff were positive about the training provided and along with regular supervision meetings; this enabled them to carry out their roles successfully.

People's nutritional needs had been assessed with appropriate care plans in place.

The service worked closely with other professional and agencies to ensure people's health needs were being met.

Is the service caring?

Good

The service was caring.

During the inspection we observed positive interactions between staff and people living at the home. Staff members were kind and respectful and knew the people they cared for and how they wanted to be treated.

Both people living at the home and their relatives were positive about the care and support provided.

Regular meetings were held to enable people to receive information and have input into the running of the home and the care being provided.

Is the service responsive?

Good

The service was responsive.

Care plans were regularly reviewed and signed off, with involvement from the person themselves, their family or other representative clearly documented.

Assessments of people's needs were completed and care plans provided staff with the required information to enable them to support people in a person centred way.

People we spoke with were positive about the activities available in the home. The coordinator was enthusiastic and encouraged people to take part, whilst respecting the wishes of those who chose not to.

The service had a robust complaints procedure in place. The complaints policy was clearly displayed and people we spoke with knew who to talk to if they had any concerns.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people living at the home and staff working there felt that the home was well-led and managed and they felt supported by management.

Team meetings were held to ensure that all staff had input into the running of the home and made aware of all necessary information.

Hope Manor Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 07 and 12 June 2017 and was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC) and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the course of the inspection we spoke to the registered manager, activity coordinator and five care staff. We also spoke to seven people who lived at the home and two visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included five staff files, four care plans, Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Hope Manor. All seven people we spoke with said they did. One told us, "It's way safer than other places I know, staff are doing a good job." Another said, "I am as safe as I can be here." Whilst a third stated, "I didn't like this place when I first came, I felt like I was losing myself, but after a couple of weeks I felt really safe because staff did everything they could to make me feel at home." We asked relatives visiting the home for their opinion, one told us, "The home is safe… they have got nothing to hide, that's why we feel it is a safe place for [relative] to be."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained local authority guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully. A matrix was also in place to monitor and log all referrals, which included sections for outcomes and lessons learned. We saw the correct forms had been submitted to the local authority for any concerns identified and each referral was filed separately, which made it easy to cross reference between the matrix and the completed documentation.

We asked all staff we spoke with about safeguarding adults. Each member of staff confirmed they had received training in this area which was refreshed annually. The staff all demonstrated a good understanding of what to look out for and how to report concerns. One staff member told us, "If I discover something happening and I consider it unsafe for the resident, I will go to the manager and if it is not sorted I will report it to CQC."

The homes recruitment procedures ensured people who used the service were protected and staff had the necessary skills and experience to meet people's needs. We looked at five staff personnel files and found robust recruitment checks had been completed before new staff began working at the home. The files included proof of identity, at least two references, full work or educational history and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets contained hand washing guidance with liquid soap and paper towels available. Personal protective equipment (PPE) such as gloves and aprons were situated outside bathrooms and toilets. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. We saw detailed cleaning schedules were in place for the domestic staff to follow, including weekly deep cleans of all bedrooms. The home was in the process of completing refurbishment and re-decoration work, however this was being done sensitively to minimise the level of disruption for people living in the home.

The home completed dependency assessments for all the people who used the service; which were reviewed monthly, and used a dependency screening tool to determine the number of staff needed to meet people's needs. We looked at the data from the last four months and saw enough staffing hours had been

employed to meet people's needs. We also noted that according to the tool, in both April and May 2017, the number of staffing hours provided had exceeded needs.

We asked the registered manager about staffing levels and were told that during the day the home ran with at least one senior and three carers, as well as the activities coordinator who started work at 8.00am to assist the care staff. An additional staff member worked between 2.00pm and 6.00pm. At night the home ran with two staff members, a senior and a care assistant.

People living at the home told us there was enough staff on duty and they were well looked after. One said, "I press the buzzer when I need them, they come, they are always there." Another stated, "I never want for anything, there is always staff when you need them." A relative told us, "Every time I am here visiting, there is always staff about, they always seem busy though."

We asked staff for their current views on staffing levels and ability to meet people's needs in a timely manner. The staff we spoke with stated they were able to meet people's needs, especially since staffing levels were increased for the afternoon shift, however some felt they could do with more in the morning, to increase the quality of care being provided. One said, "It would help to get an extra staff in the morning, although we are coping very well at the moment." Another told us, "We could do with one extra in mornings, because there is more care activities in the morning, we could respond to the buzzer and attend those who need toileting more quickly and promptly." A third said, "I think we are doing alright, we can respond to buzzers pretty much straight away, unless we are busy with personal care." A fourth stated, "The work is manageable with the numbers we have, we can meet people's needs."

Over observations over the course of the inspection indicated people's requests for support were met in a timely manner. Staffing levels were sufficient enough to allow staff to have breaks, including leaving the home to visit the local shop.

We looked at how accidents and incidents were managed at the home. The home had a file in place which contained detailed guidance on the actions to take in the event of either an accident or incident. The file also contained a log, onto which all issues had been recorded. The log included sections on whether 24 hour observations had commenced, if an accident or incident was falls related, whether the risk assessment had been updated and if a body map had been completed. We noted the accident book and associated records tallied with the information on the accident/incident log. Copies of any accident or incident forms were also stored in the person's care file.

We looked at how the home protected people deemed to be at risk of falls. Falls risk assessments had been completed and provided good detail about the level of risk presented to people and actions staff needed to follow. The assessments had been reviewed and updated each month to ensure the information was still relevant. Observation charts were in place and people monitored every hour for 24 hours following a fall, with their body map also updated. Assessments had also been completed to establish if bed rails were required to keep people safe. Where a need had been identified, we saw these were in place.

We looked at the processes in place to maintain a safe environment for people who used the service, their visitors and staff. We found health and safety checks such as water temperature monitoring and legionella prevention were carried out on a regular basis. Fire risk assessments had been completed along with a record of fire systems, emergency lighting and fire alarm checks. Contingency plans were in place detailing steps to follow in the event of emergencies and failures of utility services and equipment. Records also showed arrangements were in place to check, maintain and service fittings and equipment, including the nurse call system, lifts and hoists.

We found there were safe systems in place to manage medicines. Medicines were stored safely and securely and there were records which accounted for all medicines ordered, received, disposed of or returned. We looked at a sample of ten medicine administration records (MAR) and found these were generally well completed with no gaps. Codes and a written explanation had been used to explain any anomalies, such as if a person had refused their medicine, or not been given a sleeping tablet, due to being asleep at the time of administration. Detailed information about each individual was kept with the MARs which included the person's name, date of birth, photograph and allergies. Arrangements were in place to make sure people who required their medicines to be given at set times received them correctly, with the home using a colour coded system on the MAR to distinguish administration times. Similarly protocols were in place for 'as required' (PRN) medicines, which explained the name of the medicine, how it was to be taken, the dosage, the time between doses, the maximum dose in a 24 hour period, the reason for taking and any side effects. This ensured PRN medicines were being managed and administered safely.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We checked the controlled drug (CD) cupboard and saw this was locked with the key held safely by the senior. We checked the stocks of three different medicines for three people and found these tallied with the CD register. The register was well maintained with two signatures recoded for each administration as required.

Staff told us they had received training in medicines, which was refreshed annually and had their competency to administer medicines assessed every six months. People living at the home were complimentary about how well the staff managed their medicines. One told us, "Don't have any problems, staff are making sure I get all my medications, I don't know how they get it right, but they do, they always give it on time." Another said, "I get every medication from staff, it's different medication for different aches and pains of old age." A relative told us, "Staff did a brilliant job finding the right medication for my Mum."

Good

Is the service effective?

Our findings

People living at the home told us they enjoyed the food and got enough to eat and drink. One said, "Staff give me exactly whatever option I said I prefer, no complaints at all about food." Another stated, "Food is great, oh yes, I love the food and I love the staff for making sure that there is always plenty." A third told us, ""Food is plenty, always enough food and enough drinks." A visiting relative said to us, "There's plenty for everyone, the residents are always eating when I am here."

We observed the meal time experience on both days of the inspection and found this to be positive. Tables had been nicely set out containing a table cloth, napkins, cutlery, glasses, vase of flowers and a daily menu. A larger menu was also situated at the entrance to the dining room. The menu design was in big font with coloured pictures and also contained information about allergens. People were able to sit wherever they wanted and the unobtrusive music being played along with the conversations being held, gave the sense that meal times were a social event.

The home had a protected meal time policy in place, with clear notices explaining this. Relatives were encouraged not to visit during meal times, however could do so if they chose. One relative told us they visited regularly at meal times and assisted their Mum to eat. This was supported by the home.

People were offered a choice of meal at the point of service. A staff member told us, "We used to go around in the morning to ask residents to choose what they would like to eat for dinner or for tea, however by meal time, most of them had forgotten their choices, as result we now ask residents their menu options when they are ready to eat, the chef prepares enough of both menu options." We saw two main options were available for both lunch and evening meal, with alternatives being provided if people did not like either option. We observed one person ask for a 'banana butty', which was made and provided without question. Staff were supportive and attentive during meal times. We saw one person refuse to have lunch, consistently shouting, "I don't like the food, leave me alone." Staff took turns to persuade the person to eat something, offering different options, including going to buy them something from the 'chippy', before the person finally agreed to try what was on offer, which they ate all of.

We found there were effective systems in place for monitoring people's food and fluid intake and making sure people received sufficient amounts to eat and drink. People's care plans provided detailed information about their dietary requirements, including nutritional risk assessments, as well as any food or drink preferences. Food and fluid charts were in place which listed what the person had eaten or drank and the amount, indicated by circling one of five options; nil, quarter, half, three quarters or all. Nobody living at the home required a soft or pureed diet, though seven people required a fortified diet. There was detailed information in place, including dietician guidance on how to ensure food was fortified, including the provision of milkshakes at set times during the day. We observed these being provided, however noted the recording of these on monitoring sheets was not consistent.

Each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. In the four care files we looked at, we

noted these had been completed consistently. People's weights were closely monitored and referrals made to relevant professionals, such a dieticians, if weight loss was detected.

We looked to see how the service managed people's pressure care. We saw Waterlow scores were consistently monitored, with referrals made to the district nurse for pressure relieving equipment, when people had been identified as 'at risk'. We saw equipment to provide a reduction in pressure on vulnerable areas such as heels and the sacrum, for example; air flow mattresses and pressure relieving cushions was in place. Positional change records were in place, with codes used to indicate the person's position before and after turning. These had been completed consistently and at the frequency contained in the care plan, for example every two hours.

People living at Hope Manor told us they had access to healthcare services such as a general practitioner (GP), chiropodist and optician whenever there was a need. One said, "The last time I was not well, staff got the GP for me." Another stated, "When I am not feeling well, staff ring the GP." Our review of people's care records showed the service worked closely with other professionals and agencies to meet people's health needs. For example we saw referrals had been made to a dementia clinical nurse specialist, due to an increase in a person's anxiety and agitation, another had been made to the community dental service, due to a person reporting pain when they brushed.

We looked at how the home sought consent from people who lived there. People told us staff asked for their consent before providing any care, and we observed this taking place during the course of the inspection, with staff asking people if they would like to take part in activities, come through for lunch and take their medicines. Each care plan contained a consent form covering a range of areas including consent to care and treatment, which had been signed by either the person themselves or their representative, such as next of kin and Lasting Power of Attorney (LPA).

We asked people living at the home if they thought the staff were well trained. Everyone we spoke with told us staff knew what they were doing and provided good care. One said, "If you are asking if the girls are looking after me well, then the answer is a big yes." A visiting relative told us, "I am very impressed with staff, they know how to manage every one, they treat them all like it's their own parents.. they know [my relative] doesn't like company so they give her space, all her needs are met."

Staff were also complimentary about the training provided, telling us they were up to date with all mandatory training and had completed NVQ's in health and social care, which had been facilitated by Salford City College. We looked at staff training documentation which was stored both electronically and in staff's personnel files. Staff training was monitored via a matrix, which was colour coded to indicate each staff members job role. The matrix showed that all staff had completed training in key areas such as moving and handling, safeguarding, fire awareness, infection control and dementia awareness. We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One staff member told us, "It relates to making sure that we support those residents who are unable to make safe choices for themselves." Another said, "It's about seeking permission to care for them in the way that ensures their best interest."

The home has a DoLS log in place, which was used to monitor all applications. The log contained each person's name, the date of referral, date application authorised, expiry date, date for re-referral, date of any hospital admissions and date of death or discharge. At the time of inspection, fifteen people had a DoLS in place with a further three awaiting assessment. Within people's care files we saw that any potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention being utilised. People also had DoLS care plans in place which specified any conditions listed on DoLS and how these were to be met.

The staff we spoke with said they received regular supervision from their line manager. A supervision schedule was clearly displayed in the staff room, which included each staff members name and their supervisor. The home also used a matrix to monitor completion of supervision. We saw staff were scheduled to complete supervision bi-monthly, with the matrix listing both planned dates for the year and actual dates for completion.

We saw some consideration had been given to ensuring the environment was 'dementia friendly'. Corridors were light and airy with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. Large pictorial signage was in place on all bathrooms and toilets and reminiscence items were on display around the home, such as old pictures of the local area and other places of interest.

Good

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One told us, "Staff do talk to me about one or other things all the time. I have a keyworker, she does lots of things for me, such as give me a bath or do my hair." Another said, "Me and my family are happy about the care I receive, its top notch. I am well looked after."

We asked people who lived at the home if staff treated them with dignity and respect. All confirmed that they did, with one telling us, "The girls are all very good people, always being respectful and showing they care." A visiting relative said, "Staff treat my mum the way I would like her to be treated, they know her very well by now." Each staff member we spoke with was aware of the importance of dignity in care. One staff member said "It is about treating them the way I would like to be treated." Another stated, "Dignity in care is about knowing what is important to an individual resident, and showing respect for their choices and preferences and we do this by reading their care plans."

We saw the home employed a keyworker system, with every member of staff having the responsibility for a small group of people. We asked staff about this process, one stated, "As a key worker you have a responsibility to get to know what your residents like and dislike, for instance I know that one of my residents likes to have a chippy tea every once in a while, whilst another one prefers a bath rather than a shower." Another staff said, "When you get to know your residents, you also get to offer them options so they are able to make a choice, all you do is direct them the right way."

People we spoke with confirmed staff knew what they wanted and offered them choice. They felt this was due to the home having a good retention rate, which meant staff had learned to know their preferences and how the wanted to be cared for. One said, "Staff know what I like, I like to sit here quietly watch others doing activities, reading my paper and after diner staff take me for a nap." Another told us, "My keyworker knows how I like my bath, they know what time I like going to bed and what time I like to wake up." A third stated, "Staff know me well, they are very clever people, they always ask 'are you alright, do you need anything'." Whilst a fourth said, "Staff offer you a choice of what to wear in the morning."

Over the course of the inspection we spent time observing the care provided in all areas of the home. People regularly praised the staff for the care and compassion they received. We saw everyone was clean, presentable and well dressed. Staff were observed to be kind, caring and patient in their interaction with people, taking time to engage in conversation and asking people if there was anything the wanted to do, such as go to the quiet room, TV room or join others in activities. Staff were attentive to people's needs for example during an art and craft session, a staff member noticed a person was struggling to hold their paintbrush, so provided the person with brushes of different sizes, so they could see which one was easiest to use. We also observed appropriate physical contact being provided by the staff, such as hand holding or placing their arm around someone whilst speaking discreetly with them, which resulted in smiles from the people they were supporting.

The staff we spoke with displayed an awareness and understanding of how to promote people's

independence. One said, "It's about encouraging them to do tasks by themselves, reassuring and offering them praise when they achieve something." Another said, "I offer [person] a chance to choose every piece of clothing they want to put in the morning and also ask if they prefer to do that with or without my support and help." People living at Hope Manor confirmed their independence was promoted. One told us, "I do as much as I can for myself, but staff take care of me mostly and with compassion." Another stated, "Staff do some things for me but still encourage me to do other things for myself." A third stated, "I like to do things for myself, getting up and about, staff know that."

The home held resident meetings every three months, with a timetable in place for the year. We saw these were also open to relatives. We looked at the minutes from the last meeting in March and noted that 13 people had attended with the agenda covering activities, ideas for outings, meal options, whether people were happy with the environment and any issues people wanted to raise. We asked people about their experiences of meetings within the home. One told us, "Last week there was a meeting, we talked about food and staff asked if we are happy about everything." Another said, "Staff always invite us to meetings, to check if we are okay with everything they do for us." A third added, "We have meetings, staff do listen to us and I mean that sincerely."

At the time of the inspection nobody using the service was in receipt of end of life care, however the staff members we spoke with told us they had all received training in this area, with the home subscribing to the 'six steps to success' end of life training programme. All care files had a section for end of life care and support, and where people had been open to discussing this, their files contained end of life or advanced care plans, which clearly displayed the person's wishes for when they were at this stage of their life.

Good

Is the service responsive?

Our findings

At the previous inspection on 23 and 24 March 2016 we found insufficient evidence to demonstrate how people who used the service, and their relatives or lawful representatives, were involved in reviews and changes to care. During this inspection we saw the home had introduced a 'service user review sheet', specifically to capture involvement of people and their relatives or representatives in care plan discussions and reviews. The document covered each individual care plan and included if any action had been required, who was responsible for actioning and date of completion, as well as a section for any other comments and the signatures of those involved. These documents had been completed in each of the care files we looked at.

Whilst the people we spoke with couldn't remember if they had been involved in discussions about their care, relatives told us they had been included. One said, "Me, my sister and my brother in law are always kept involved in our mum's care plans. Between us we have attended a few care plan reviews and we all agree the standard of care our mum is getting is brilliant." A second told us, "I can access mum's file anytime I want, I am satisfied that all her needs are met."

We saw the service provided care which was personalised and responsive to people's individual needs and preferences. Each person had a detailed pre-admission assessment in their care file, which was in the form of a tick list with additional areas for notes. This covered all areas of care and captured each person's needs, risk areas and what they wanted from the support provided. We saw that baseline observations were completed upon admission, including the person's weight and a body map to identify any existing wounds, bruising or other injuries.

People's care files were split into five sections; general information, assessments, care plans, daily records / communication and miscellaneous. Each file began with an introduction page which contained the person's name, date of birth, room number, admission date, GP details and any allergies, along with a current photograph of the person. The files also contained a personal information page which included how the person likes to be referred to, if they had any representatives in place such as a Lasting Power of Attorney (LPA), their medical history and medicines taken upon admission. These two documents ensured staff had easy access to key information about each person.

Each file also contained a social history section, which included personalised information such as where the person had been born, childhood memories, education, relationships, employment history, activities they enjoyed and any other interests. This ensured staff knew what was important to each person and helped inform the care planning process.

Each care file contained a range of care plans covering areas such as eating and drinking, mobility, personal care and social needs. Each care plan listed the person's needs, any identified problems in that area, their strengths and any specific risks. This was followed by a detailed 'aim of care', which explained what the care plan was trying to achieve. We saw that some sections of the care plan, such as the personal care section, had been written in the first person capturing the views and wishes of each person. The person had

explained what tasks they were able to complete themselves, what areas they needed help with and how often they wished to bathe along with their preference. We also saw evidence of specific risks assessments and care plans being drawn up to address individualised problems or areas, such as for people living with a sensory impairment. Each care plan was reviewed on a monthly basis with any updates or changes clearly documented.

During the inspection we noted other examples of person centred practice, for example the home arranged for a clothing company to visit the home periodically in order to provide people who may experience difficulties accessing the community, with the opportunity of purchasing their own clothes and footwear. The visits were advertised in advance to allow people to organise finances and see what they may need to purchase.

We looked to see how people spent their day and what activities were carried out at the home. People told us they liked to be busy and that there was always something going on. One said, "There are loads of activities, I like going on trips in a minibus." Another stated, "I don't do much, as I can't be bothered, but there is always something going on, I like to sit and watch the others." A third told us, "There is a bit of everything, I get to take a walk with staff, go shopping, buy a cake for myself or I get some visitors." Relatives were also complimentary, one said to us, "[Activity coordinator] does a good job; she makes sure that the residents are all doing different things."

We saw the home had one designated member of staff who coordinated activities on weekdays between 9.00am and 2.00pm as well as at the weekend. Staff members helped to facilitate activities in the absence of the coordinator. We noted the coordinator had completed arts and craft courses to assist in supporting all people using the service, including those experiencing symptoms of dementia. When speaking with the coordinator they were very passionate about their role, telling us this was because "it means something to residents. They also stated, "You have got to be one step ahead, so you can respond to their preferences and varying abilities and for this to happen I have to continuously work with staff to monitor who took part in what activity, what they like, what they can do and what they no longer manage to do", they added, "We try to keep the residents busy without tiring them out, we have two activity sessions per day and two entertainers every month. Even though there is not much 1-1, I know some residents prefer not to join groups and would rather watch telly or stay in the quiet room, like [person's name] who likes to browse a magazine or a daily newspaper or [person's name] who enjoys pampering and crosswords."

On the first day of inspection, a reminiscence activity was starting as we arrived. People had the opportunity to take part, or could choose to go into one of the other two lounges to relax, watch television or read. The coordinator lead the session, taking time to ask each person about their memories of the local area using photographs and images to support or start the conversation. We also observed people listening to music and singing along and completing an art and craft session. The activity coordinator was seen to be enthusiastic, supportive and encouraged people to take part, whilst respecting the wishes of those who preferred their own company, or some peace and quiet.

The home had two notice boards which both advertised the activity schedule for the week and also displayed photographs of past outings or activities, which acted as a remembrance aid for people. Some of the activities on offer included, reminiscence and sing-along, healthy hips and heart exercise, arts and crafts along with cupcake days and coffee mornings. We noted outings had recently taken place to the circus and a fish and chip restaurant.

We looked at how complaints were handled. The notice board contained a copy of the complaints procedure, which was accessible to all people living at the home. The home had a complaints file in place,

which included the policy and procedure for dealing with any concerns received. The file included a monitoring log, which detailed the date, who made the complaint, nature of complaint, action taken, outcome and date closed. We saw that three complaints had been received within the last 12 months; each had been handled as per guidance with written letters sent out explaining the outcomes.

We asked people living at the home if they knew what to do, should they have a complaint. All stated that they would speak to a staff member or the manager, but stated they had nothing to complain about. One person said, "Never complained, not even once, but if I wasn't happy I would tell someone." Another stated, "You can't miss the manager, if she is available she comes to you and if I said I have any concerns, I would be making it up." We asked relatives for their experiences, one told us, "Yes we had a concern before and it was sorted." Another said, "If I am not happy I will speak to one of the staff or manager, I don't have any pressing concerns."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The home had a clear management structure in place. The registered manager had been supported by an experienced deputy manager, who had recently transferred to another of the provider's homes to become the registered manager there. A new deputy manager had been identified and had been trained up over the last 12 months to take on this role, however at the time of inspection had not yet commenced the post. The owner also regularly visited the home, providing support to the registered manager and supporting the deputy in the registered manager's absence.

The staff we spoke with felt the home was well-led and managed and they felt supported. One told us, "Managers are very supportive and approachable, they are always there even when they are off, someone is on call." Another said, ""Everyone is very nice and caring, we support each other." A third stated, "I can talk to managers about any concern I have."

People living at the home also spoke positively about the management, stating they were approachable and friendly. One told us, "The manager is fun, always listening and giving lots of hugs and sometimes kisses." Another said, "The manager is really nice, you tell her about her your concerns, she gets it right." A relative told us, "The managers and the owner are very approachable and always visible."

Staff and relatives told us there was a positive culture within the home. Comments included, "It's nice as soon as you walk in, everyone gets along", "the atmosphere is good" and "this is the right place for our [relative], I would recommend it to anyone, honestly."

We saw that team meetings were completed on at least a bi-monthly basis. Minutes were taken and action plans generated. We looked at the minutes from the last three meetings and saw staff were able to add to the agenda and discuss issues or concerns pertinent to them, as well as go through agenda items generated by the registered manager. Updates or issues about people living at the home were also covered, to ensure staff were up to date with the latest information. Staff we spoke with confirmed meetings were held regularly and told us they found them "effective".

The home had a policies and procedures file in place which included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were up to date and contained the date of the next review, to ensure the most up to date copy was always available.

The home used a range of systems to assess the quality of the service. This included the annual circulation of a 'customer survey', which was given to people living at the home and their relatives. The survey consisted of 15 questions covering five areas; care, food, housekeeping, activities and general, with people asked to

rate each question on a scale from poor to excellent. We saw the last survey had been sent out in May 2016, with this years scheduled to be sent. We looked at a sample of the responses and noted all were positive, with the majority of ratings being either good or excellent, with no poor noted in any area. Comments recorded on the forms included, 'Noticed an overall improvement in all aspects with the running of the home' and 'as a family we cannot thank the team at Hope Manor enough for the care given and shown to [relative].

The home had an audit file in place and carried out a range of audits on either a monthly, quarterly or annual basis, depending on the area being audited. The file contained an index which clearly documented what audits had been completed and their frequency. On a monthly basis the registered manager completed audits of people's weights, Waterlow charts and pressure relieving equipment in place, medication, random drug audits, nutrition, dependency levels, mattresses, the kitchen as well as completing observations of staff's competency and provision of care. For all audits we saw action points had been generated, the person responsible for completing recorded the action that had been taken detailed along with the date of completion.

Alongside the individual audits, each quarter the registered manager completed a full audit of service provision, which concluded all aspects of the environment, staffing and staff training, support provided to people living at the home and care plans. Again detailed action plans and what had been done to address any issues had been clearly recorded.