

Bowlacre Home

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was carried out on 28 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be attending. Three Adult Social Care (ASC) inspectors carried out the inspection. The service was last inspected on 27 May 2014 and was found to be meeting all the regulations inspected.

Bowlacre Home is a large detached building set back from the main road in its own well maintained grounds. The building has been adapted and extended over the years to provide accommodation for 37 people. The home is owned and managed by a voluntary housing association. There were 33 people living at the service on the day of the inspection.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their medicines safely and in line with their prescriptions. Medicines at the service were not well managed. Concerns were raised in relation to storage, recording, administration and auditing of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have effective systems in place to monitor and manage the prevention and control of infection and areas of the premises were not properly maintained. Pressure cushions, mattresses and some items of furniture were dirty and stained and some areas of the service including the bathrooms and shower areas had deteriorated and were impossible to effectively clean. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found that the premises were unsuitable for people living with a dementia related condition. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The registered manager was able to demonstrate they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found that Mental Capacity Act (2005) guidelines were not always followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered provider had some audits in place to check that the systems and processes at the service were being followed, however they had failed to identify concerns in relation to expired maintenance

certificates, medicines, infection control, care planning, the environment and activities. This was a breach of a Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People were offered some activities that included arts and crafts and monthly entertainers. However, the frequency of activities had decreased in recent months and the choice on offer was limited. We made a recommendation about this in the report.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's assessed needs. Staff had been employed following appropriate recruitment and selection processes.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the service deemed essential, such as, safeguarding, moving and handling and infection control.

People's nutritional needs were met. People told us they enjoyed the food and that they had enough to eat and drink. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day.

People told us they were well cared for and we saw people were supported to maintain good health and had access to services from healthcare professionals. We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the service. People were able to make choices and decisions regarding their care.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes, dislikes, and contained detailed information about how each person should be supported. However, some aspects of care lacked detail.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were recorded; however, actions were not always taken in response to suggestions.

Full information about the CQC's regulatory response to any concerns found during this inspection will be added to the report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

Infection control practices were not followed and this increased the risk of infection or cross infection.

Staff displayed a good understanding of the different types of abuse and had received training on how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The premises were not always adequately maintained and had not been suitably adapted for people living with a dementia related condition.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found the Mental Capacity Act (2005) guidelines had not been followed.

People's health needs were met. People who used the service had access to additional treatment from healthcare professionals, when needed.

People had access to adequate food and drinks and information was available to meet any specific dietary needs.

Is the service caring?

Good ●

The service was caring.

We observed good interactions between people who used the

service and the care staff throughout the inspection.

People were treated with respect and dignity, had their independence promoted and were provided with a choice about how their care was delivered.

Is the service responsive?

The service was not always responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. However, these plans did not always contain enough detail for some aspects of people's care.

People had access to a limited range of activities and the number of activities offered had decreased in recent months.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

The service had a quality monitoring system in place; however, it was not effective and failed to identify areas of concern.

The CQC had been notified of most significant events that occurred at the service. However, a deprivation of liberty safeguards notification had not been submitted.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

Requires Improvement ●

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

This inspection took place on 28 September 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was not asked to submit a Provider Information Return (PIR) prior to the inspection, as the date of this inspection was changed. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four members of staff, the registered manager, four people who used the service and three people's relatives. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, people's medication records, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Is the service safe?

Our findings

We looked at the systems in place for medicines management. We reviewed medication administration records (MARs) for everyone in the service and looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not always in place.

Medicines were not always stored securely. The medicine trolley was left in the sun lounge and was not secured to the wall. The team leader showing us around said they did not know where the lock and chain was to secure it. The staff responded to our request for this to be made secure and a new lock and chain was obtained. The trolley was secured to the corridor wall near to the registered manager's office for the remainder of our inspection. We saw that the controlled drugs cabinet was not secured to a solid brick wall. When we asked the registered manager if the cabinet was secured in-line with the requirements of The Misuse of Drugs Act (Safe Custody) Regulations 1973 they could not confirm this, but said they would ask the maintenance person to check and make sure.

Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge was checked daily and recorded to monitor that medicine was stored at the correct temperature. We found that staff were not recording the temperature of the medicine cupboard and on the day of our inspection the thermometer showed that it was at 23.5 degrees centigrade, (the maximum recommended temperature for room storage of medicines is 25 degrees centigrade). As it was not a particularly hot day, this meant there was a risk that the temperature may exceed 25 degrees centigrade on warmer days and staff would be unaware. This meant medicines may not have been fit for use and increased the potential risk of harm to people who used the service.

We found that the Controlled drugs (CDs) held in the service were regularly assessed and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Checks of the CD record book showed that these were all accounted for and the records were accurate.

The recording of medicines was not safe. We found two MAR sheets without a photograph to identify the person using the service, and important information about the people's GP, start date of the medicines and allergy information was missing. The team leader with us said they would ensure that that these issues were addressed.

There was no protocol written for two people who were prescribed sedatives on an 'as and when needed' basis (PRN). This would have instructed staff when to give the medicines. There was nothing recorded in the two people's care plans for medicines about the use of the sedatives, but the team leader on duty could describe for us the behaviours that would lead to the medicine being given. This meant there was an increased risk that these medicines could be administered inappropriately.

One person had sedative tablets in the medicine trolley but these were not on their current MAR sheet. We checked with the previous MAR that showed these were given PRN. This indicated staff were not checking

the new MAR to make sure all medicines in current use were transferred onto the new sheets. Staff told us that this person had not required this PRN in recent weeks.

The administration of medicines was not always safe. We saw that one member of staff left two inhalers and two tablets on a table with the person using the service. We did not see them come back to make sure these had been taken appropriately.

Medicines that were known to be more effective when administered early in the morning before meals were not being given at the right times. This included ulcer healing medicine and thyroid medicine. Instead, we found that staff were administering these at the same time as other medicines at breakfast time.

We noted that one person using the service had an over the counter cough remedy in their possession. The staff were not aware of this when we asked them about it. They said they would speak to the person and ensure it was stored safely until it could be checked with their GP about them taking it with their other medicines.

Medication audits were carried out by the service's pharmacist. The most recent audit had been carried out in July 2016 and the pharmacist had recorded that improvements needed to be made in respect of the recording of pain relief patches and supplementary feeds. The previous pharmacy audit had been carried out in April 2015. Action had been required in respect of staff being aware of the storage arrangements for internal and external preparations. There was no record of whether the recommendations of either report had been actioned. In house medications audits were being carried out. These covered checks on records, storage, policies, staff training, disposal and controlled drugs. The audits of February and May 2016 recorded that no corrective action was required.

During our inspection on 28 September 2016, we found that the registered provider did not have effective systems in place to monitor and manage the prevention and control of infection.

We were shown the cleaning schedules for the service, which gave basic details of the daily, weekly and monthly cleaning tasks carried out by the domestic and care staff. We saw a number of pressure cushions that were dirty and in need of cleaning. We were told that these were not part of the daily cleaning schedules.

We found that there was no bed or mattress audit in place and some of the beds/mattresses were not washable and had visible stains on them. Throughout the service, we saw armchairs that were not washable, were stained and dirty and could not be cleaned effectively. This meant there was a high risk of contamination and cross infection between people.

We saw that staff had left un-named items in the bathrooms around the service, these included bars of soap, sponges, deodorant and shampoo. This could indicate that people shared toiletries, which was not hygienic. This was discussed with the registered manager who arranged for them to be removed.

The bath seats to the fixed hoists used for assisted bathing were dirty and the upstairs bathroom hoist seat was not safe for use. There was a hole in the flooring in two bathing areas and the tiling in toilets, bathrooms and shower areas was either missing, cracked or unsafe which meant these areas could not be cleaned effectively. The upstairs shower room had a manual sluice for cleaning buckets next to the shower, which was unhygienic practice. The shower curtain was coming off its track and there was no evidence of when the shower curtain was last washed; staff could not give us an answer to this question when asked.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, fire extinguishers, emergency lighting and gas safety. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

People told us they felt safe. A relative told us, "My [family member] was very stressed when they lived at home. They are much more relaxed since moving to Bowlacre and have improved in health; they feel safe." One person who used the service told us, "I like it here, I feel very safe."

The registered provider had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the registered manager used the local authority's safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local authority's safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents. We saw the last concern was submitted in July 2016.

We spoke with staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. Staff told us, "I have had training on safeguarding of adults" and they demonstrated a good understanding of what to do if they had any concerns. Staff were confident about whistle blowing and said the registered manager was quick to act on anything raised with them.

We viewed the services accidents and incident file and found that all events were accurately recorded and logged. However, we found that they were not regularly audited. The manager was able to describe the circumstances that could increase the risk of a person falling such as a change in medication, decrease in mobility or infection; however, they were unable to tell us at what stage they would refer people to either the local falls team or the GP. It is important that accidents and incidents are regularly monitored to ensure that the risk of reoccurring incidents was minimised. This concern was dealt with in the well-led section of this report.

We observed that there were sufficient numbers of staff on duty to enable people's needs to be met. There was always a staff presence in communal areas of the service and we found that people did not have to wait for attention. The registered manager told us that the standard staffing levels on day shifts were five care assistants plus one or two care team leaders. Overnight, there was one care team leader and two care assistants on duty. The registered manager was on shift in addition to care staff. We checked the staff rotas and saw that these staffing levels had been consistently maintained. A small number of agency staff were used; the registered manager told us that this was to cover for annual leave and sickness. The staff rota evidenced that regular agency staff were used so that they knew the people who lived at the service. This provided consistency in care. In addition to care staff, there was a cook and a kitchen assistant on duty each day, three domestic / laundry assistants on duty each day and a maintenance person Monday to Friday. This meant that care staff were able to concentrate on supporting people who lived at the service.

We asked people who used the service and visitors if they felt there was enough staff on duty. We received very positive responses and one person told us, "I looked at a number of services before coming here. I have

fallen a number of times in the past and felt unsafe at home. I love it here as the staff answer the call bell quickly and there is always someone around. I feel safe, comfortable and very happy here."

We checked the recruitment records for three members of staff, including two new employees. These records evidenced that an application form had been completed, references had been obtained and telephone calls had been made to referees to verify the information supplied in written references. Checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. These checks meant that only people who were considered suitable to work with vulnerable adults had been employed at Bowlacre Care Home.

Is the service effective?

Our findings

On the day of our inspection there were 33 people using the service and the registered manager said the majority of them were living with dementia, but only 12 had been diagnosed. However, we found little evidence to indicate that dementia friendly design had been used when decorating or furnishing the service. We saw that bedroom doors had a photograph of the person using the room and their name, but that was all. The service lacked signage to orientate people to where the communal toilets and bathrooms could be found and décor within the service could have been better. For example, we saw that both lounges had 'busy' patterned carpets, which were not the most appropriate for people with visual and other sensory impairments as the patterns could represent other things (such as holes) to people living with dementia causing them to trip or stumble.

The interior decoration of the service was not satisfactory as we saw areas where the ceilings were stained from water leaks and paint was peeling away in strips. The main lounge carpet was worn and stained. We were told by the team leader that this had been recognised by the management team and quotes for a new floor covering were being obtained. The registered manager confirmed this and said no date for replacement had been decided on yet. We discussed that the busy pattern of the carpet was not the best for people living with dementia and the registered manager said that a more dementia friendly choice was being made. The upstairs corridor carpet was of a plain design but was dirty and stained. We were told by the registered manager that they planned to change this to a hard floor covering, but no timescale for this was available.

There was a large external garden with flowerbeds and raised beds. The registered provider employed an external company to maintain the gardens, which were well kept. We saw that people were provided with a range of benches around the garden and there were areas of lawn and patio where they could walk and sit in comfort. We noted that the slopes down to the garden had handrails to steady people wishing to mobilise on foot down to the flat walkways around the gardens. We also saw that the external down pipes attached to the building were made of cast iron and these were rusting away and broken in places which would add to the problems of damp within the building. These needed repairing or replacing.

The above concerns were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care services.

DoLS are part of the MCA legislation, which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us they had submitted DoLS applications for eight people who were currently using the service. We saw the local authority had granted one of these. It is a requirement of the conditions of registration that the registered provider notifies the CQC of all DoLS authorisations. Prior to the inspection, we had checked and found that no notifications had been received from the service. This was addressed in the 'Well led' section of this report.

We viewed care plans and saw that capacity assessments had not taken place prior to people making decisions about their care. We saw when there was confusion over whether people were able to consent to their plan of care; the care plan agreement document had been left blank. For example, we looked at the care file for one person who had been assessed as lacking capacity to consent to their care plan by their GP. We found that the consent form was blank and there was no evidence that a meeting had been held with the person's representative to discuss and agree to the plan of care in place. We were told that one person's family had lasting power of attorney (LPA) in relation to the person's affairs for health and welfare and finance. However, there was no record of this in the person's file and the registered manager was unable to evidence they had seen a copy of this document. We received a copy of this LPA document following the inspection and found it only related to the person's finances. This meant that decisions could be made on their behalf without legal authority. We asked the registered manager to address this and ensure they held copies of these documents within the person's care plan.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our discussions with staff, we found that most had the appropriate levels of knowledge regarding MCA for their roles. However, one member of staff said they had not completed dementia awareness or training on the Mental Capacity Act 2005 (MCA). They were unsure about what the word capacity meant but once we spoke more about it they were able to say how they enabled people to make choices in their everyday lives. Staff explained how they requested consent before carrying out any care tasks by asking people and talking them through each step of the care intervention.

Staff told us that the majority of people using the service were easy to look after. However, there was the odd person who had some agitated behaviours. They told us, "Some people can be rude and stubborn, but this is a part of their dementia condition. They can refuse care on occasions, but you just leave them for a few minutes and try again later. This often works or we try a change of face so another member of staff will approach them." The registered manager told us that restraint was not used at the service and this was confirmed by the staff we spoke with.

Staff carried out induction training when they were new in post. Staff records showed the topics covered included hand hygiene, infection control, health and safety, fire safety, basic adult life support, consent, continence promotion, dementia care, diversity and equality, first aid, nutrition, the Mental Capacity Act 2005 (MCA) and food hygiene. The training certificates included a record of which elements of the Care Certificate each topic related to. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

We checked the service's training record and this showed that the organisation considered essential training to be fire safety, moving and handling, basic first aid, food hygiene, infection control, health and safety, dementia and safeguarding adults from abuse. This training had been completed by most staff. Optional

training was also available for staff; this included medication, palliative care and dementia (with an overview of MCA / DoLS).

In addition to this, 13 care staff had achieved a National Vocational Qualification (NVQ) at Level 2 and 12 staff had achieved this award at Level 3. Four staff had achieved this award at Level 4, including the registered manager. One domestic assistant had completed NVQ Level 2 in housekeeping. This meant that staff had the relevant skills and knowledge to undertake their role and provide care and support to meet people's individual needs.

The registered manager told us that they had decided to hold supervision meetings with all staff who worked at the service every six to eight weeks. They acknowledged that this was ambitious and had resulted in people not having supervision or appraisal meetings as regularly as planned. However, we saw that staff had attended between one and three supervision meetings during 2016. A member of staff told us they felt well supported. They said they were working towards a Level 3 award and were receiving support from the registered manager and team leaders.

One person told us, "The food is lovely and always nice and hot. We are always given a choice of meals and I am having chicken curry today. We get plenty of drinks as well. I am diabetic but I am not on any active treatment so just have to watch what I eat. My GP does a regular blood test to check out my blood sugars and makes sure my diabetes is under control."

We observed the serving of lunch in the dining room. Meals were served to people on a tray and plates had a plastic cover to keep the meal clean and warm. Tables were set with cutlery, tablemats and napkins. Most people chose to eat their meal in the dining room; one person had their meal in the sun lounge and two or three people had their lunch in their bedroom. We noted that staff created a pleasant atmosphere and encouraged people to chat to each other.

People were given a choice of orange or cranberry juice and were given a choice of main course. We saw that the cook spoke with people after breakfast to explain the meal choices for that day. Meals were described to people rather than being shown to them. We discussed with the registered manager how it might have been easier for people to understand the choices if a picture of the meal or sample meals had been shown to them, and this was acknowledged.

There was nobody living at the service who required assistance to eat their meal although some people had their meal served in a bowl and ate their meal with a spoon. We saw that people were able to eat at their own pace and that staff gently encouraged people who were reluctant to eat. After the meal, people were offered a choice of tea or coffee.

The cook showed us the list of people's special dietary needs that was displayed on the kitchen wall. They told us several people required a diabetic diet, three people were on a soft / blended diet, one person had a vegetarian diet and two people were on an enriched diet. These people had extra milk and butter added to their meals as well as being provided with food supplements due to the risk of weight loss.

People were weighed monthly or weekly depending on the plan they were currently on. When weight loss was identified, we saw that referrals were made to the GP or dietician and a plan was implemented to ensure a person's nutritional requirements were met.

People's care plans recorded their current health care needs, including details of their prescribed medication. Records we saw evidenced that health care professionals such as GP's, dieticians, community

nurses and chiropodists were involved appropriately in people's care. We saw that any contact with health care professionals was recorded; this included the reason for the contact and the outcome

One person told us that they were going for a chest X-ray due to breathing difficulties. They said that one of the care staff was accompanying them to the hospital, as they needed a wheelchair for mobilising over a long distance. They stated they had good access to their GP and that the staff were very good at making an appointment for a visit if they felt unwell. Another said, "I am diabetic and so the district nurse comes to give me insulin every morning and tea-time. My blood sugars are usually stable and they also check my feet and toes as a safety check due to my diabetes." This meant that people's health needs were monitored and advice sought where necessary.

Is the service caring?

Our findings

All of the people we spoke with told us the staff were kind, caring and knowledgeable about their needs. One person said, "The staff are excellent." Another person told us, "I love it here. The staff are great and I get on well with them all." Relatives told us they felt staff genuinely cared about their family member. Comments included, "Staff genuinely care. I visit on different days of the week and I have always found staff helpful and friendly. They are the 'right' people to do the job" and "[My family member] receives really good care. They have 'never looked back' since they moved here."

One visitor told us they had been visiting their friend for the last six years and usually came twice a week. They said, "This service is excellent." They told us they had meals with their friend and found the food to be very good. They said, "[Name] has their meals in the living room with their friends when they want to." The visitor told us that their friend felt safe in the service and their room was always nice and clean. They said that the lounge was cosy and a nice environment for visitors and people using the service.

A relative told us their family member had a hospital appointment one lunchtime. Without asking, the cook prepared them some sandwiches to take to the hospital so they did not miss their lunch. The relative felt this demonstrated that the staff were considerate and caring.

People told us they were given a choice about how their care was provided. They told us they were able to choose what time they got up in the morning and what time they went to bed. They told us they were given a choice of meals, where they sat and whom they spent their time with. They also said they were able to decide what activities they wanted to join in with. One relative told us, "The staff do listen to what [Name] says, they let [Name] stay in bed if they are not feeling so well and they can have what they want to eat. For example some days [Name] likes to have cornflakes for dinner and they can have this." One person who used the service told us, "I make my own decisions on a daily basis and the staff respect this."

People who used the service were encouraged to express their views about the care they received. People we spoke with told us they would not hesitate in talking to someone if they felt unhappy about anything. One person told us, "You can be open and honest about what you think of the place and there are no repercussions for voicing your opinion. The staff will listen to you if you have any concerns and they sort them out straight away."

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified situation. A relative told us, "Care staff have been here for years and are all very good. They always respect [Name's] privacy and dignity. We can go to a private room when we wish to talk confidentially and at one point [Name] was disrobing in the lounge and staff were quick to cover them up and protect their dignity."

Staff told us they promoted the independence of people using the service. One member of staff said, "Very few people use a hoist. They try to remain independent as much as possible and we promote this within the

service. One person said, "The staff are fantastic. I am fairly independent and they respect my need to do as much as possible for myself, but they give me support when I am feeling unwell."

Staff understood the needs and wishes of people using the service. For example, staff could tell us which people did not like to be cared for by male members of staff and told us that their wishes were documented in their care file and respected by the staff. The care files we checked confirmed this. People who used the service told us that staff were patient with people and were able to diffuse situations when people became anxious by using humour and other diversion techniques.

Relatives who we spoke with told us they were free to visit people living at the service as often as they liked and they were kept informed of any issues regarding their family member. They said they normally spoke with the registered manager or staff when they visited, but would receive a telephone call if anything unusual or urgent occurred.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles.

Is the service responsive?

Our findings

Care was based on people's assessed needs and preferences. People had their needs assessed before they moved into the service. Information was gathered from a variety of sources including, for example, any information the person could provide, their families and friends, and any health and social care professional involved in their life. This helped to ensure the assessments were individual to each person and the service was able to meet the needs of people before they moved in. The information was then used to complete a more detailed support plan which provided staff with the information to deliver appropriate care.

We saw that care plans addressed any identified need including, moving and handling, nutrition, falls, medication and personal care. We saw that some people's care plans contained good detail and were reviewed regularly. They included good detail regarding what tasks people were able to carry out themselves and information on their likes, dislikes and personal preferences. However, we found that in some people's care plans, areas of need had not been fully assessed and relevant plans were not present in their file. For example, one person experienced periods of distress, which caused them to display both verbal and physical behaviour that could challenge the service. However, we found that there was no clear description of what the person's distressed behaviours looked like nor was there a plan in place that advised staff on how to effectively support the person during these periods of distress. Despite this, staff were able to provide a good account of how they managed this behaviour.

We found that there was a lack of accurate care records in place and have reported on this further in the well-led section of this report.

We saw evidence in the care files that care reviews took place once a year with the funding authority, person using the service and families (as wished). However, one person who used the service told us, "I have never seen my care plans and have not discussed these with the staff. I could talk with the staff if I had any issues about my care but this has not taken place on a formal basis." A relative also said, "I have never seen [Name's] care file or been asked to contribute to this. I have also not taken part in any reviews. However, if I had any concerns then I can always talk with the staff or the manager about anything. We asked the registered manager about this and they told us that some families read and had input to the care files, although there were no formal reviews for self-funding people, which meant they did not always have a formal opportunity to discuss their care and treatment.

A member of staff told us that the activities coordinator worked at the service each Tuesday and Thursday. They organised activities such as arts and crafts, reading and games. They said that staff were responsible for organising activities on other days of the week, and that these activities included quizzes, bingo and a giant game of noughts and crosses. We did not see any of these activities take place on the day of the inspection and the staff member acknowledged that these activities did not always take place. Staff told us, "Some staff do activities when they have time. There are no organised trips out, but there is regular entertainment twice a month."

Some of the people who used the service told us they enjoyed the arts and crafts. One person told us, "I

enjoy doing craftwork with the lady on a Tuesday; we make different things which keeps me occupied." Another said, "I enjoyed the handicraft and have done some crochet; we sat outside and did it on the lawn. I come and sit outside most days and have a walk around the garden." Other people told us they were able to occupy themselves, saying, "I have a television in my room and the service provide me with a newspaper every day so I have something to read. I enjoy keeping up with the news and events going on in the outside world. Someone comes into the service to do a sing-a-long every so often." A relative told us, "[Name] is very deaf and has poor vision so finds it difficult to do activities. These take place on Tuesday and Thursday afternoons. On a Tuesday, people do craft work and on a Thursday, there is music. I have never known there to be any outings."

We viewed the monthly 'diary of events' for August and found that seven activity sessions were scheduled. This included manicures, flower arranging, indoor netball, wool craft, indoor golf and two of the regular entertainers. However, we saw that there were no activities scheduled for any of the Thursdays across the month. We found this pattern was repeated for the month of July and June. This meant that people were currently only provided with one activity per week.

We recommend that the registered manager seek advice and guidance on the provision of a stimulating activity programme.

The registered provider had a complaints policy and procedure in place and this was on display, however as it was positioned high up on the wall and not in plain sight of people using the service it could have easily been missed. We saw that all complaints received had been investigated, action taken and recorded in the service's complaint file. We saw that the last formal complaint was received in March 2016. Although the complaint had been addressed and action had been taken by the registered manager to resolve the issue the complaint had not been signed off by the complainant to indicate they were satisfied with the outcome. We also saw that a minor complaint log had been started but there had been no entries made since September 2013. We discussed the need to record minor complaints to enable the registered manager to develop a clear picture of any ongoing issues so they were able to appropriately address these.

All of the relatives we spoke with told us they had not had any reason to complain. Relatives mentioned staff by name who they felt they could speak to if they had any concerns, and told us they were confident their concerns would be listened to. One relative said, "I would speak to [Name of manager] or [Name of team leader] if I had any concerns, but I have never had any issues." One person who used the service told us, "I would speak to the manager or one of the girls if I needed to complain."

We saw that the service made efforts to capture the views of people who used the service and their families. The minutes of a residents and family meeting in September 2015 recorded people had been reminded, 'Survey forms are available in the basket if you would like to complete one. Thanks to families who have already filled one in. We are taking on board your ideas and suggestions'. The registered manager explained to us that survey forms were always on display in the entrance hall. Returned surveys were collated prior to each residents and family meeting and discussed at the meeting. One suggestion received in surveys was that staff should wear name badges. At the meeting in September 2015, people were told that this was being actioned. At the meeting in September 2016 people were informed 'Staff badges will be done soon.' However, we noted that staff were not wearing name badges on the day of the inspection. The registered manager told us they were still in the process of sourcing name badges. This meant that, over one year later, this suggestion had not been actioned.

Is the service well-led?

Our findings

A quality monitoring system was in place, however, we found it was ineffective and had failed to identify concerns in relation to expired maintenance certificates, medicines, infection control, care planning, the environment and activities.

Stakeholder surveys were carried out for people using the service and their relatives, health care professionals, and staff. We saw that the results were largely positive; however, suggestions raised were not always followed up.

The quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed the CQC of all significant events. This meant we could check that appropriate action had been taken. However, we noted that the registered manager had not notified the CQC of the deprivation of liberty safeguards authorisation that was granted for one person using the service in January 2016. We reminded the registered manager of their duty to notify the CQC of these authorisations.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection, there was a manager in place who had registered with the Care Quality Commission (CQC) in 2007, meaning the registered provider was complying with the conditions of their registration.

People spoke positively of the registered manager, one staff member told us, "The registered manager is brilliant. You can sit and talk with them, they do their best to support you, and everything discussed is kept confidential. The registered manager has the well-being of people using the service at the heart of everything they do." A relative said, "The registered manager is good at getting in touch when they need to. They give me good information about [Name] on the telephone and keep me up to date with their health and well-being."

Residents and family meetings were held twice a year. We saw the minutes of the meeting held in September 2015. The registered manager had informed people that a new convactor fan was due to be fitted in the sun lounge that would keep the room warm in winter and cool in summer. On the day of the inspection, we saw that this convactor fan had just been fitted. Other meetings were held in April 2016 and September 2016. The minutes of the meeting in September 2016 showed the topics discussed included agency workers, availability of dentists and one person asked if an ex member of staff would be returning to the service 'as they liked them and missed them'. All of the relatives who we spoke with told us they had not attended residents and family meetings as they had no concerns or issues to raise, but were aware they did take place. One relative said they gave informal feedback to the registered manager on a regular basis.

Staff meetings were held; we saw minutes of the meetings held in October 2015 and April 2016. Topics discussed included the appearance of people who used the service, team work, dress code, laundry, use of behaviour management forms, recording in care plans, the use of mobile phones and staff smoke breaks.

We saw that the service had a mission statement in place that outlined the registered providers aims and objectives. We saw the aim of the service was 'to be the best residential home in the greater Manchester area, where everyone feels at home.' We saw a service user guide was made available for people when they started using the service and the statement of purpose was readily available on the registered provider's website. This included information regarding fee's and resident's rights.

The registered manager was required to complete an audit for the local authority every three months. We saw the audit recorded the number of service users accommodated, the number of admissions and deaths, safeguarding referrals, hospital admissions, infectious diseases and staff turnover. Another audit was completed by the Clinical Commissioning Group (CCG). They sent the registered provider a questionnaire to complete, and followed this up with a visit to the service. The CCG audit included the appearance of people who used the service, activities, staff interaction with people who used the service, visitor feedback, food provision and the environment. The CCG concluded they had 'high confidence' that the needs of the people who used the service and the terms of people's contracts were being met. The service had received a quality assurance award from Investors in People in July 2016 and the certificate was on display.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were not protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with not assessing the risk of and preventing, detecting and controlling the spread of infections. Regulation 12 (1)(2)(h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use the service were not protected against the risks associated with premises that were not clean and properly maintained. Regulation 15 (1)(a)(e)(2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place effective systems to assess, monitor and improve the

quality and safety of the services provided in the carrying out of the regulated activity.
Regulation 17 (1)(2)(a)(b)(c)