3A Care (Altrincham) Limited

Oldfield Bank Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 July and 01 August 2018 and was unannounced. This is the first inspection we have carried out of this service under its' current registration with the provider 3A Care (Altrincham). When we last inspected the service in October 2016, the service was being run by a different provider and was rated requires improvement overall. At this inspection we rated the home requires improvement overall, and identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to provision of safe care and treatment.

Oldfield Bank Residential Care Home (Oldfield Bank) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oldfield Bank provides accommodation and personal care for up to 28 older adults, including people living with dementia, in one adapted building. Accommodation is across four floors, with a lift available between floors. The home is located in a residential area of Altrincham, Greater Manchester.

There was a registered manager who had been in post since May 2018, and was registered with the CQC in July 2018. 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.

Some staff had found the change in provider, and changes made to the management team by the new provider difficult to accept. This had resulted in some resistance to change amongst the staff team, although both staff and the registered manager felt this situation was improving.

The home provided accommodation to people staying on a permanent and temporary basis. We found people living at the home on a permanent basis had comprehensive care plans and risk assessments in place. However, we found this was not the case for one person staying on a temporary basis who did not have a complete care plan or risk assessments. We have recommended that the provider reviews how they manage and monitor temporary placements at the home.

There were sufficient numbers of staff to meet the needs of people living at the home. There were times when staff were particularly busy, and when communal areas were unsupervised for short periods of time. However, we did not observe any issues when these instances arose or any significant delays in people receiving the support they needed.

Staff took steps to help ensure risks to people's health, safety and wellbeing were reduced. This included using sensor mats, providing support and supervision and ensuring people had mobility aids to hand. However, in one instance, a person had a bed sensor mat in place and informed us they had not consented

to this. This demonstrated staff did not always balance risk management with people's rights to make informed decisions effectively. This issue was addressed when we raised it with a manager.

We identified some shortfalls in the safe management of medicines. Medicines were not always stored securely or recorded accurately. For example, we found the door to the treatment room open on one occasion and the keys for the medicines trolley and controlled drugs cupboard were inside the treatment room. Night staff did not administer medicines, and had to contact the on-call staff to administer any 'when required' medicines such as pain relief. This could result in potential delays in people receiving their medicines.

The provider was in the process of fitting magnetic locks to stairwell doors at the time of the inspection to help reduce the risk of people injuring themselves who were not able to use the stairs safely without assistance. Required checks and servicing of the premises and equipment had been carried out in most cases. However, we found there was no legionella risk assessment and the passenger lift thorough examination was overdue. Actions were taken during the inspection to address these shortfalls.

We observed that the majority of staff interacted well with people living at the home. Staff acted respectfully and were attentive to people's needs and comfort. There were some long-standing staff members at the home and only limited use of agency staff. We observed one isolated incident where a staff member started to position a person's leg to support them to transfer from their chair whilst they were asleep. However, the remainder of interactions we observed were positive and staff communicated well.

Staff encouraged people to retain their independence, and care plans reflected people's abilities as well as their support needs. Staff told us they would be happy for a friend or family member to live at the home because of the caring nature and commitment of the staff working there.

People told us staff respected their privacy and dignity. However, we also received a comment that there was limited space for people to meet visitors in a quiet or private area other than their bedrooms. The provider was in the process of refurbishing the home and this included plans to create a family/waiting room.

Care plans were person-centred and comprehensive. People told us they had been involved in planning and reviewing their care, and they told us staff acted to meet their preferences.

Staff received regular supervision and a range of relevant training. The registered manager was in the process of reviewing training provision and recognised that improvements could be made in this area. For example, only basic training was provided in relation to dementia care.

Staff worked with other professionals to meet people's healthcare needs. We received feedback from one healthcare professional who told us staff acted upon the advice they gave in relation to people's care. The service considered whether people staying at the home short-term may need to be supported to register with a local GP practice on a temporary basis.

We received positive feedback about the food provided. We saw the cook considered people's dietary requirements and preferences when preparing food.

People told us they would be confident to raise any concerns they might have. We saw that staff had effectively identified and recorded complaints whether written or raised verbally. Complaints had been investigated and responded to appropriately, with actions taken to improve the service when necessary.

The registered manager had introduced a range of audits and checks to help them monitor the quality and safety of the service. However, the checks had not identified the issues we found relating to the safety of the service, nor ensured they had been addressed.

The opinion of people using the service and their representatives had been sought, and feedback provided on how staff had acted upon their views. The service acted upon feedback from relevant others such as the local authority and infection control lead.

Staff told us the new provider was investing in the service, and we saw a refurbishment was underway. The new provider and registered manager had started making a number of improvements. This included installing a new call-bell system, enclosing the garden area, improving care plans and introducing a new electronic care planning and records system, which was due to go live shortly after the inspection.

Staff told us the registered manager was approachable and they felt motivated to provide good quality care. The registered manager had clear plans for how they wanted to work with staff to continue to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always stored securely, and administration records had not always been completed accurately.

Staff took steps to reduce risks to people's health, safety and wellbeing. However, risk assessments were not always formally recorded.

People had not always been involved in their risk assessments when they were able. Staff had not considered capacity and consent in all cases when putting in place measures to help manage risks.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and a range of relevant training. However, staff had only received basic training in supporting people living with dementia.

People gave us positive feedback about the food provided. The cook was aware of people's dietary requirements and preferences.

The service worked with other professionals to meet people's healthcare needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring. We observed that staff were concerned for people's wellbeing and they ensured people were comfortable.

Staff promoted people's independence. People's abilities were reflected in their care plans along with the support they needed.

People told us staff respected their privacy and dignity. However,

there was a lack of space in the home to meet with visitors privately.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and person-centred. People told us they were involved in developing their care plans.

People told us they would be comfortable raising any concerns they had. Complaints had been recorded and acted upon.

The provision of activities had improved. However, there were limited opportunities for people to get out of the home.

Is the service well-led?

Requires Improvement

The service was well-led.

There was a registered manager in post who had clear plans for how they intended to continue to support the service to improve.

Despite having struggled initially with changes to the provider and management team, staff were motivated and committed to providing a quality service.

The registered manager had introduced a range of audits to help them monitor the quality and safety of the service. However, these had not identified the shortfalls we found relating to the provision of safe care and treatment.

Oldfield Bank Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 31 July and 01 August 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included the last inspection report from when the service was registered with a different provider, the report produced when we registered the service and a copy of an infection control audit carried out by the infection control lead within the Trafford local authority area. We reviewed statutory notifications the service had submitted to us. Statutory notifications are information the providers are required to send us about certain significant events such as safeguarding, serious injuries and incidents where the police are involved.

We used information the provider sent us in the Provider Information Return to help plan our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection site visit we spoke with four people who were living at Oldfield Bank, and nine staff members. This included the registered manager, three care staff, the deputy manager, the care manager, a housekeeper, a cook and the nominated individual. We spoke with one healthcare professional who was visiting the home at the time of our inspection.

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

We reviewed records relating to the care people were receiving, including five care plans, five people's medication administration records (MARs) and daily records of care. We also looked at records related to the running of a care home. This included three staff personnel files, records of training and supervision, audits and quality assurance checks and records relating to the safety and maintenance of the premises and equipment.

We requested feedback from Trafford local authority quality and contracts monitoring team and Healthwatch Trafford. We received feedback from the local authority in relation to their most recent monitoring visits, and Healthwatch Trafford shared the findings of their 'enter and view' report with us. We used this information to help plan the areas of focus during our inspection site visit. Healthwatch aim to help people get the best out of local health and social care services by listening to people's views and acting as an 'independent national champion' for people who use services.

Requires Improvement

Is the service safe?

Our findings

There were some improvements required to ensure the provider was managing medicines safely. Medicines were not always stored securely. On the first day of our inspection we saw keys to the medicines fridge had been left in the fridge, which was in a communal area of the home. Staff addressed this concern immediately by removing the key when we drew their attention to this issue. On the second day of our inspection we found on one occasion that staff had not shut the door to the treatment room properly, and the keys to the medicines trolley and controlled drugs cabinet were hung up inside this room. Whilst we did not see anyone using the service attempt to access the medicines room or fridge, there would be an increased risk of unauthorised persons accessing people's medicines. The provider told us they would check the lock to the treatment room to ensure it was catching properly and would brief staff in relation to the procedures for keeping the keys to the medicines storage on their person.

Staff recorded the administration of people's medicines on medication administration records (MARs). We saw these records had been completed without omissions. However, we identified two instances when the MARs had not been competed accurately by staff who had signed to indicate medicines had been administered when they had not. In one instance, this was an error in recording and had been identified in a medicines audit. However, in the other case we saw two paracetamol tablets had not been administered, but had been signed as administered. Staff were unable to work out how this error had occurred.

We saw that some people were prescribed medicines there were applied on patches, and other people were prescribed cream medicines. Body maps were used to help ensure staff understood what area of the body to apply creams to. However, in the case of patch based medicines, body maps were not used to track what area of the body staff had previously applied the patch to. This is important as certain patch-based medicines may cause skin irritation if they are applied to the same site too often.

Staff told us that night-staff did not administer medicines. They said that should any 'when required' (PRN) medicines need to be administered, that they could contact the on-call staff member to attend and administer medicines. No-one living at the home was prescribed any when required medicines that might need to be administered in an emergency. However, this arrangement could prevent the timely administration of medicines such as pain relief and could result in prolonged discomfort.

The provider took reasonable steps to ensure the premises and equipment were safe for people using the service. However, we identified some shortfalls that the provider was either in the process of addressing, or addressed because of our feedback.

The home was based over four floors and contained sets of relatively steep and narrow stairs. The provider had requested the installation of keypad controlled access to these doors to help reduce the risk of people using the stairs when they were not able to do so safely. The keypads and locks were in the process of being installed during our site visit, but were not operational at that time.

We saw there were regular inspections and checks of equipment such as hoists, slings, bedrails, the fire

alarm and wheelchairs. The routine thorough inspection of the passenger lift was overdue. However, the nominated individual showed us evidence that they had booked a re-inspection. Checks of gas and electrical appliances and the electrical system had been carried out by a competent person, and the provider had acted upon recommendations made following a fire risk assessment they had commissioned from a third party.

The provider did not have a legionella risk assessment in place. However, staff took steps to reduce the risk of legionella developing in the water system, such as regularly flushing infrequently used outlets. The provider also obtained an annual bacterial analysis to help identify the presence of legionella. This confirmed there was not legionella present at the last test, and the provider contacted a specialist company to obtain a risk assessment when we made them aware of this shortfall. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults.

Records of water temperatures showed that the temperature of some outlets was above the recommended 44 degrees centigrade, which may prevent a scalding risk. However, we saw staff tested and recorded the temperature of the water before supporting people with bathing, which would help control and reduce this risk. The registered manager told us the boiler had been replaced shortly after the inspection and had been adjusted to ensure water was dispensed at a safe temperature.

The provider had contingency plans in place to help ensure they could respond effectively to emergency situations including equipment failure, fire and loss of utilities for example. There were plans in place relating to how the premises would be evacuated in case of emergency, and people had personal emergency evacuations plans (PEEPs) in place. However, we found one person's PEEP had not been updated following a change in their support needs relating to their mobility, and one person did not have a PEEP in place, which staff told us was because they had been admitted on a temporary basis. It is important that information in PEEPs is accurate and in place for all people staying at the home so that staff and emergency services are aware of the support people require to leave the building in the event of an emergency.

Staff recognised risks and took actions to help ensure people received safe care. However, risk assessments were not recorded in every instance, and staff did not always effectively balance risk reduction measures against people's right to make informed decisions. We saw staff ensured people's mobility aids such as walking frames were placed close by, and when required, equipment such as pressure relieving cushions and mattresses were used to help reduce the likelihood of people developing pressure ulcers.

Risk assessments were in place in relation to potential hazards such as equipment, moving and handling, falls, malnutrition and pressure ulcers. However, we found one person did not have any completed risk assessments in their care file or that could be located elsewhere. Staff had identified risks this person may face to their health, safety and wellbeing, and had taken actions to reduce these. However, their assessments were not formally recorded, which would pose an increased risk that control measures would not be implemented consistently. We spoke with this person who told us staff had put a sensor on their bed that would alert staff if they got up so staff could provide assistance. However, they told us they had not been consulted in relation to its' use and did not want it there. Staff had told them they would ask a manager whether the sensor could be removed, but had not done so. We raised this issue with a member of management staff who spoke with the person and removed the sensor mat. They told us they would speak with staff to help improve their understanding in relation to managing risks when people had mental capacity to make their own decisions.

As detailed in the preceding paragraphs, we identified multiple areas where improvements were required to ensure that reasonably practicable steps were taken to ensure people received safe care. The shortfalls in safe practice relating to the management of medicines, risk assessment, balancing risks and restrictions and maintenance of safe premises were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff on duty to meet people's needs. However, reports from people living at the home and our own observations indicated there were periods when the staff team were 'stretched' and less able to provide support promptly.

We received mixed feedback about staffing levels. Whilst one person, told us they thought there were sufficient numbers of staff, two people told us they thought more staff would be beneficial as they sometimes heard people shouting out for assistance. We observed that there were short periods of less than five minutes when communal areas were unsupervised whilst staff provided one to one support to people, or were serving meals. During the times that the communal areas were unsupervised we noted there were people who needed or were requesting assistance from staff. However, staff were frequently passing through these areas and there were no significant delays in people receiving the support they needed.

Staff told us that staffing levels had increased since our last inspection of the service, and they felt they had sufficient time to be able to meet people's needs and provide them with effective support. The provider had recently installed a monitored call-bell system. This recorded the length of time it took staff to respond to call-bells, and would help the registered manager identify any issues at specific times of the day in relation to staffing levels or staff deployment. The registered manager also intended to introduce a dependency tool, that would help guide them in their assessment of how many staff were required to meet people's needs.

The service had procedures in place to help ensure any staff employed were of suitable character. We saw staff member had completed application, which provided a full work history. The service held copies of proof of identity, a recent photograph and health questionnaire. References had been obtained and criminal records/barred list checks (Disclosure and Barring Service/DBS checks) had been carried out before a staff member started working at the service.

Everyone we spoke with told us they felt safe living at Oldfield Bank. One person said, "It's very good. It's warm and comfortable." Staff we spoke with could tell us how they would identify any potential safeguarding concerns and they were aware of how to report and escalate their concerns if required. Safeguarding records, and notifications sent to CQC in relation to safeguarding matters demonstrated that the registered manager had reported safeguarding concerns to the local authority as required, and had put in place measures to help ensure people were protected from harm. After the inspection, the registered manager assured us that there was an organisational safeguarding policy in place. However, staff were unable to find this during our site visit. However, we did not identify any concerns with how the provider was managing safeguarding incidents, and they were able to show us they had a copy of the local authority's safeguarding policy.

Some people living at the home had behaviours that could challenge the staff. The training matrix showed only two staff members had received training in behaviours that challenge. However, staff told us they felt able to respond effectively and manage any situations when people may become agitated or anxious. We reviewed one person's care plan that provided only basic guidance, such as 'use distraction' to inform staff how they should support a person who had behaviours that challenged. However, when speaking with staff, we found they had a much more in-depth understanding of how to support each person effectively than what was recorded in the care plans. This included how to recognise potential triggers and ways to

effectively de-escalate if people showed signs of agitation. Another person was prescribed 'when required' (PRN) medicine to help manage their behaviour. Staff spoke with us in detail about techniques they used to effectively support this person without the need for using this medicine. This was good practice and demonstrated that staff adopted the least restrictive approach when supporting this person. During the inspection we observed that staff responded effectively to provide reassurance and support to people to minimise the likelihood of behaviours that challenged.

Good

Is the service effective?

Our findings

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had recognised where potentially restrictive practices may amount to a deprivation of liberty. Where this was the case, we saw appropriate applications for DoLS had been made to the supervisory body (local authority).

Where people were able, they had signed consent forms relating to their planned care. If people were not able to consent to their care, we saw evidence that staff had consulted others involved in the person's lives such as family members. Staff demonstrated a reasonable understanding of the principles of the MCA, such as that any decisions made on behalf of a person who lacked capacity should be in their best interests and the least restrictive option necessary.

We found evidence of both good and poor practice in relation to how staff followed the principles of the MCA. For example, people told us staff asked for their consent before providing any care or support, and we also observed this happening. As discussed in the safe section of this report, staff had not sought consent from a person in relation to the use of a sensor mat on their bed. However, in other cases, we saw staff had documented capacity assessments and best-interest decisions in relation to decisions about people's care. Capacity assessments were time and decision specific and considered whether the proposed approach was the least restrictive option, or whether the person could be supported to make the decision themselves at another time.

The registered manager was in the process of reviewing the training and induction provided to staff, and recognised that this was a priority area for them to address. Staff told us they felt they received sufficient training and induction to enable them to meet people's needs effectively. However, only basic training was provided in areas such as dementia care, and the registered manager felt the training provided could be improved. Training certificates in staff files indicated that staff had undertaken training in a range of relevant topics including safeguarding, first aid, infection control and moving and handling.

Staff told us they received regular supervision where they were able to discuss any concerns they might have, and receive feedback on their performance from the registered manager. Records showed that

supervisions included discussions in relation to training and development, and actions were identified for follow-up at the staff member's next supervision. Most staff had received two supervisions in the previous eight months, with the aim being to provide six supervisions within the year.

Staff had assessed people's abilities and care requirements in relation to a range of areas, including their physical, psychological and social support needs. We saw people who were residing at the home on a long-term basis had full, comprehensive assessments in place. However, full care plans had not been completed for all people who had moved to the home on a temporary basis. For example, we saw care plans and assessments covered people's needs in relation to mobility, medicines, pressure area care and prevention, personal care, oral hygiene, eating and drinking, psychological/emotional needs and interests/hobbies. However, the care plan for someone who was admitted for a temporary stay was much less detailed, despite there not being any definite date that they would be moving on from the home. We discussed this with staff who told us they would put in place full care plans for this person.

People's health care needs were recorded in their care plans, along with details about how staff would support people to maintain good health. This included working alongside other health professionals including GP's, district nurses and speech and language therapists (SaLTs). Records showed that staff made referrals to appropriate health professionals if they identified input from other professionals might be required. For example, we saw staff had referred people to the dietetics service if they had concerns about unplanned weight loss, and to SaLT where staff had noticed issues relating to the safe swallowing of food and drinks. We spoke with a visiting health professional who told us staff were always on hand to facilitate any assessments they carried out. They told us staff acted upon any advice they gave in relation to the care and support people needed.

Staff had access to contact details for people's GPs and the out of hours service if needed. We also saw that staff had considered whether people might need to be supported to register as a temporary patient at a local GP practice if they were staying at the home on a short-term basis away from their regular practice.

We were given positive feedback about the food provided. People told us they could choose alternative dishes if they did not like what was on the menu. We observed that there were regular drinks rounds, and people told us they had access to food and drinks when they wanted them, including outside of the regular meal times. Comments included, "I quite like the food and you do get a choice. It is sausages today, but they will give me something else if I ask. I can walk to the kitchen and get a drink if I want", "The food is generally nice. It's always your choice" and "What is cooked is okay. I've not had reason to ask for anything else, but I could ask."

We observed the mid-day meals and saw staff were attentive and provided people with the support or encouragement they needed to eat and drink. Where people needed support to eat, we saw that staff interacted well with them and supported them to eat at a pace that was comfortable to them. The cook showed us they kept records of people's dietary requirements and preferences. They described how they ensured food prepared was suitable for people with particular dietary requirements, such as diabetics, people with allergies or requiring modified texture diets. The cook told us they always used fresh ingredients and prepared meals 'from scratch'.

Both staff and people living at the home commented that they felt areas of the home needed re-decoration. The provider told us a refurbishment plan was underway, which had started with the fitting of new bathrooms and wet-rooms. They showed us plans that had been drawn up for further refurbishment and re-arrangement of the layout of some of the communal areas. The home was surrounded by well-maintained gardens, and a fence had recently been installed to make the area more secure. People told us staff

sometimes supported them to access the gardens when the weather was good.

The home provided support to some people who were living with dementia. We saw there were some limited adaptations to make the environment more accessible and 'dementia friendly'. For example, there were pictorial signs on the doors of the different communal areas and on bathrooms/toilets, and people's names and photos were displayed on their bedroom doors. This would help people orientate themselves and identify which room was theirs. We discussed the plans the provider had in place for the refurbishment of the premises, and how the environment could be made more accessible to people living with dementia. The provider told us the refurbishment plans were being developed in conjunction with a company that specialised in care home design and that consideration would be given to how the environment could be made more 'dementia friendly'.

Good

Is the service caring?

Our findings

During the inspection we observed that staff interacted with people showing kindness, respect and compassion. When staff were able, we saw they took time to speak with people socially about shared interests, and there was use of appropriate touch to offer reassurance to people. Staff were attentive and showed concern for people's comfort and wellbeing. For example, we saw a member of staff approach a person with a cushion and say, "[Person], I've brought you your cushion" to which they responded, "Oh you are kind." At another point in the inspection, staff noticed that a person was struggling to hear and they checked that their hearing aid was working correctly.

At one point in the inspection we observed a member of staff start to position a person's legs to support them to transfer from their chair whilst they were asleep. A second member of staff came to assist them and gently woke this person and checked they were ready to be supported. We raised this with the provider who told us they would address this with the staff team.

Other than this isolated occurrence, we saw that staff communicated with people well. For example, we observed staff ask people if they had any pain and whether they needed their prescribed pain relief medicines. Staff communicated clearly what they were doing when supporting people with moving and handling equipment such as hoists, and provided reassurance as needed.

People told us they got to know staff working at the service well. Staff told us there was only limited use of agency staff when required to cover any staffing shortfalls, which we confirmed by looking at the staff rotas. There were also several long-standing members of staff at the home, which would help people build relationships with a consistent staff team. All staff we spoke with told us they would be happy for a friend or family member to use the service. When asked why, comments included, "Because it's dead homely and friendly, a dead good atmosphere" and "Because all the girls who work here are very caring."

People told us staff respected their privacy and treated them with dignity. One person told us, "I like to go to my room in the afternoon where I have my own phone and TV. The staff bring tea up to us which is what I want." A second person said, "Yes the staff do respect my privacy. They are very pleasant and always treat us with respect. They knock on your door before coming in. I can't fault the staff." However, some people also commented on a lack of private spaces in communal areas where they could meet family, friends or visiting professionals. They told us they had previously been able to use a conservatory on the ground floor for such purposes, but this room was now being used more regularly as the main dining area. The provider showed us plans for the refurbishment of the home, which included the provision of a waiting/family room. This would help ensure people had an area where they could meet guests in a quieter area.

Staff understood the importance of protecting confidential information about people using the service, and ensuring it was only shared when there was a legitimate need to do so. However, records were not always kept securely. We saw care records such as weights records, daily reports and bathing records were kept on a shelf in one of the communal lounges. Whilst this ensured they were easily accessible to staff, there was also an increased likelihood that this information could go missing or be accessed by unauthorised

person's.

People felt that staff supported them to retain as much independence as possible. Staff we spoke with also demonstrated an understanding of the importance of helping people maintain their independence. For example, staff talked about people who were staying on a temporary basis who intended to return to independent living in the near future. They spoke about the importance of not taking away their independence so that they retained the skills they would need to live outside a 24 hour support setting. During the inspection we observed staff encouraging people to eat and drink independently or mobilise without support when they were able to do so safely. Care plans demonstrated that people's abilities had been considered alongside the support they needed, which would help reduce the likelihood of staff providing support that was not required.

People told us their family and friends were able to visit them freely. One person said, "My Son comes to visit me regularly, and my sister comes too. There are no restrictions on visitors." Information on advocacy services was displayed on a notice board in the home. This would help ensure people were supported to access these services if they were not able to self-advocate or did not have friends or family who could advocate on their behalf.

We saw assessments carried out prior to people moving to the home prompted the assessor to consider whether people had any support needs arising from protected characteristics such as disability, race or religion. There was no record of any specific staff training in relation to equality and diversity, although the nominated individual told us they were confident such training had taken place in the past. We were also told there were plans to roll out new equality and diversity training to staff.

Good

Is the service responsive?

Our findings

Care plans were detailed and person-centred. We found they contained information about people's routines, social histories, interests and hobbies. They also gave staff information on people's preferences in relation to a range of areas including food, activities and how they received their care. For example, one person's care plan detailed that they liked to get up early in the morning and to have a glass of water. Such details would help staff provide personalised care to people living at the home. Staff told us they had the opportunity to review care plans and said the information contained was up-to-date.

Care plans contained details about any communication support needs people had arising from disability, impairment or sensory loss. Needs were identified during the initial assessments staff carried out, and we saw steps were taken to help ensure people could receive and understand relevant information. For example, we saw staff checked people had working hearing aids if required, and information such as the activities timetable was displayed pictorially, which would assist some people to understand it.

People we spoke with told us they were given the opportunity to be involved in developing and reviewing their care plans. One person said, "Oh yes, staff involve me in decisions about my care and planning my care" and another person confirmed, "Yes they [staff] involve me and they ask about my preferences." Staff had reviewed care plans monthly. Where possible, people or their representative had signed to indicate their involvement in developing care plans.

No-one using the service was receiving end of life care at the time of our inspection. We saw any wishes people had in relation to end of life care were recorded in their care plans. This included any wishes arising from any religious beliefs that person held.

People told us staff gave them choices, and we observed this during the inspection. For example, people were asked where they wanted to eat their meals and whether they wanted to join in with activities. One person said, "Oh yes, they [staff] do co-operate and give choices." We looked at minutes of a residents' meeting that took place in February 2018 that showed staff encouraged feedback about the service, and plans such as those relating to the refurbishment of the home were discussed.

There was a range of activities provided, although not everyone was interested in taking part in organised activities. For example, one person told us, "I don't go [to activities]. [Person] does, but I'm not interested. There is nothing very exciting, but they do try hard to keep us amused." During the inspection a seated exercise group took place, and we observed staff engaging people in conversation and activities such as colouring and jigsaws on a one to one basis. The TV was also on, and the service had a smart speaker that responds to voice commands and was used to play music. However, one person commented that the TV was sometimes on too quietly to hear, or there was music on at the same time as the TV. This would make it more difficult to pay attention to either, and could also make communication between people more difficult due to the increased noise.

There were few activities taking place outside the home or that supported people to be involved in their

local community. However, no-one we spoke with expressed a wish for such activities at that time. Care plans contained good detail about people's interests and hobbies and how their current care needs could affect their participation in activities. This information would be valuable in further developing the provision of activities and occupation for people living at the home.

People's care plans had considered whether people were at risk of becoming socially isolated, and what staff could do to help prevent this. We saw staff were mindful to spend time with people, including those who did not spend their time in the communal areas. People also told us they had visitors, and we observed that some people living at the home had formed friendships and enjoyed socialising with other people living at the home.

The service had an effective system in place for identifying and responding to complaints. People we spoke with told us they had not made any complaints, but would feel comfortable doing so if they had any concerns. We looked at records of complaints and saw the registered manager had investigated and responded to complaints appropriately. This included taking actions to address concerns that people had raised to improve the quality of the service when necessary. The complaints procedure was displayed at the entrance to the home along with forms people could use to help them submit a written complaint. However, we also saw that complaints made verbally had been acknowledged and recorded. The registered manager carried out a monthly complaints audit, which included an overview of complaints received, and a check of staff knowledge in relation to the complaints procedure. This would help ensure staff responded effectively to any complaints they received.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who had started work at the home in May 2018 and was registered to manage the service with CQC in July 2018. The former registered manager had stepped down from the role and was working as a care manager at the home. In addition to the care manager, the registered manager was supported by a deputy manager and a team of senior care assistants.

We saw comments made in a staff team meeting that indicated there had been issues within the staff team affecting the culture of the service. The registered manager told us staff had initially been resistant to the change in management and changes they wanted to introduce. However, they talked about wanting to work with staff to help introduce improvements and build on good practices already in place at the home. They told us they felt they had a good team in place and valued the support of the deputy manager and care manager in driving improvements within the service. Staff we spoke with acknowledged they had initially found the change in both the provider who ran the home and management difficult. However, both the registered manager and staff felt the situation was improving.

Despite some staff having been unsettled by recent changes at the service, staff we spoke with told us they were happy and took pride in the work they did. One staff member told us, "The staff are good and committed. The care is fantastic and I feel we look after residents very well." A second staff member said, "I love it [their job]". Staff were clear about their roles and responsibilities, and we observed that staff were well organised during their shifts. Senior carers were responsible for 'running shifts' and allocating duties throughout the day, which we saw was done effectively. The registered manager talked about wanting to further develop the role of the senior carers, which they planned to consult with them about.

Staff told us the registered manager and other members of the management team were approachable, and they felt the home was well-led. The nominated individual was also a director of the company that owned the service and was present on both days of our inspection. From our observations, it was apparent that staff were comfortable approaching and discussing any issues or ideas with the nominated individual.

Staff also told us they could see that the new provider (3A Care (Altrincham)) was investing in the service to make improvements. This included a new call bell system and refurbishment of the bathrooms, and replacement of furniture and flooring. They were also introducing new systems such as an electronic care planning and records system. We saw the equipment for this new system was in the process of being set up at the time of our site visit. The nominated individual told us they had used this system in another home they owned with success. They believed it would help improve the accuracy of care records and monitoring, whilst reducing time to complete care records. This would enable staff to have more time to provide direct support to people.

The service had systems in place to help monitor and improve the quality and safety of the service. The registered manager analysed information relating to accidents and incidents to help ensure actions had been taken to help reduce future potential risks and to identify any trends or specific improvements that

could be made to help make the service safer. Since starting in post, the registered manager had introduced a range of audits to help them monitor the service effectively. We saw there was a schedule of audits, which included checks of medicines, training, care plans, infection control, complaints and the mealtime experience. We saw that where the registered manager had identified any short-falls, actions had been identified to help bring about improvements. However, we noted that the person admitted on a temporary basis whom did not have risk assessments or a full care plan in place was not included on the care plan audit. Systems had also not ensured the short-falls we identified relating to medicines management had been recognised and addressed.

We recommend the service reviews their systems for monitoring and reviewing the quality of care received by people admitted on a short-term or temporary basis.

People were asked for their views in relation to the service. We saw there had been a meeting for people using the service in February 2018, and the registered manager told us the next meeting was due in August 2018. Surveys had been sent out to people using the service in March 2018 to ask for their views on what the service did well and where improvements could be made. The provider had displayed feedback on the actions they had taken as a result of comments made in the surveys people had returned. This included actions such as employing a new activities co-ordinator, addressing issues with the laundry service and moving the main dining area to the ground floor conservatory.

The service acted on the advice of relevant others. For example, the service talked about actions they had taken as a result of feedback and recommendations from the local authority quality and contracts monitoring team. This included for example, revisions to the care plan format. We also saw evidence that the registered manager was acting to address any shortfalls highlighted following an infection control audit carried out by the local authority area infection control lead.
Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and safeguarding related issues. Records we looked at confirmed that CQC had received all the required notifications from the service.
This was the homes first inspection since registration under the new provider. This meant there was no requirement for the inspection rating awarded to the home when run by the previous provider to be displayed. However, we noted that the provider was acting in an open and transparent way by displaying the requires improvement rating that had been awarded at the last inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in relation to the provision of safe care. Risks were not always adequately assessed and managed. Medicines were not always managed safely. Some checks and assessments required to ensure premises and equipment were safe had not been completed. Regulation 12(1) (2) (a) (d) (e) (g)