

Underwood Hall Limited

# Wentworth Grange

## Inspection report

Nursing Home  
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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	Good ●
Is the service effective?	Requires Improvement ●
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 15 and 20 December 2016 and was unannounced. A previous inspection, undertaken in August 2016, found three breaches of legal requirements. The provider subsequently sent us an action plan of improvements they were intending to make to meet regulations.

Wentworth Grange provides accommodation and support for up to 51 older people with personal or nursing care needs. The accommodation consists of a main house, with accommodation spread over two floors, and an annex building known as Hampton House, within the grounds of the main building. Hampton House is a single storey conversion which predominantly supports people living with dementia or cognitive impairment. At the time of the inspection there were 39 people living in both areas of the home.

The home had a registered manager in place and our records showed she had been formally registered with the Care Quality Commission (CQC) since October 2010. 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.

At a previous inspection we had found some issues with the safety of the premises, in that window restrictors in the Hampton House area did not meet current guidance and a garden area was not secured. At this inspection we found window restrictors had been fitted to vulnerable areas. On the first day of the inspection we noted the garden gate, previously unsecured, could still be potentially opened and the area exited unobserved. By the second day of the inspection this matter had been fully addressed.

We had also previously noted not all potential safeguarding issues had been referred to the local safeguarding adults team. At this inspection we found safeguarding issues and notifications had been logged, although the standard of the records meant it was sometimes difficult to track progress of matters. People told us they were safe living at the home. Staff had a good understanding of safeguarding issues and had received training in relation to protecting vulnerable adults. There was regular maintenance of the premises and fire risk and other safety checks were carried out on a regular basis. Accidents and incidents were monitored and reviewed to identify any issues or concerns.

Suitable recruitment procedures and checks were in place, to ensure staff had the right skills. All staff had been subject to a Disclosure and Barring Service check (DBS). People and staff told us they felt there were sufficient staff to provide care and support.

At the previous inspection we had found some issues with the management of medicines at the home, including the effective administration of topical medicines. At this inspection we found new processes had been introduced to ensure all topical medicines were in date and stored appropriately. There were some minor gaps in MARs and some "as required" medicine care plans required additional detail. We have made a recommendation regarding this.

Staff told us they had access to a range of training and updating. The home had a dedicated training manager who oversaw the provision of internal and external training courses. Staff told us, and records confirmed they received annual appraisals and bimonthly supervision.

People told us, and our observations confirmed that the home was maintained in a clean and tidy manner.

People's health and wellbeing was monitored and there was regular access to general practitioners, dentists, district nurses and other specialist health staff.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw applications for DoLS had been made appropriately and, where granted, the expiry dates were monitored. People were asked their consent on a day to day basis. Some relatives of people living at the home had been legally granted Lasting Power of Attorney (LPA). However, on the first day of the inspection we found formal consent had not always been sought from these relatives, or relatives without this legal approval had signed consent forms. The provider was addressing these issues by the second day of the inspection.

People were happy with the quality and range of meals and drinks provided at the home. The home had employed an executive chef to improve the range and standard of meals at the home. Specialist diets were catered for and we observed people were supported effectively with meals and drinks.

People told us they were happy with the care provided. We observed staff treated people patiently and with due care and consideration. People and relatives said they were always treated with respect and dignity.

The home was in the process of moving to a new electronic care records system and not all current records had been fully transferred or updated. We found the majority of care plans were comprehensive, person centred and related appropriately to the individual needs of the person. Some areas relied on standard phrases. Care plans were reviewed regularly. A range of activities were offered for people to participate in. The registered manager maintained a record of complaints or concerns, although it was not always possible to fully track responses to complaints.

At the previous inspection we had found records were not always readily available and that audits were predominantly tick box in nature. At this inspection we noted the provider employed an audit manager who carried out checks and audits related to people's care and the environment of the home. A new senior management meeting had been instigated to oversee the running of the service and staff said this had improved matters at the home. A range of other meetings also took place to monitor care and the running of the home. Specific checks by the registered manager, and questionnaires offered to people living at the home, remained limited and tick box in style. Records requested as part of the inspection were readily available.

Staff felt supported by management, who they said were approachable and responsive. We noted the provider had failed to display their current inspection rating on the home's website and on the first day of the inspection the rating certificate was not displayed conspicuously in a public area.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the requirement to display performance rating. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Window restrictors previously missing at the last inspection had been fitted to windows where there was a risk of falls. People told us they felt safe living at the home. Safeguarding matters were recorded and staff had undertaken training about, and had knowledge of, safeguarding issues.

Medicines were handled securely and there were appropriate systems for administration, safe ordering and storage of items. Some "as required" plans required more detail.

Suitable recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home. People told us they felt there were sufficient staff on duty to support their care needs. The home was clean and tidy.

### Is the service effective?

Requires Improvement ●

Not all aspects of the service were effective.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and formal applications and assessments under the Deprivation of Liberty Safeguards had been made for those people who potentially met the criteria. Where people were unable to make decisions for themselves and lasting power of attorneys were in place, the appointees had not always been involved in decisions or clear best interests decisions recorded.

People told us food and drink at the home was good and special dietary requirements or personal preferences were catered for.

People said staff had the right skills to support them. A range of training had been provided and staff received regular supervision and appraisals. Some improvements had been made to the environment of the Hampton House annex to support people living with dementia. Further environmental improvements would be considered.

### Is the service caring?

Good ●

The service was caring.

People said they were happy with the care they received and were well supported by staff. We observed staff supported people appropriately and recognised their needs. Relatives were kept informed of any changes to people's care or condition.

People had access to a range of health and social care professionals for health assessments and checks. Care was provided whilst maintaining people's dignity and respecting their right to privacy.

### Is the service responsive?

Good ●

The service was responsive.

New electronic records were in the process of being updated and care plans reflected people's individual needs. Plans were reviewed and updated.

A range of activities were provided for people to participate in. People told us they were able to make choices about their care.

People were aware of how to raise complaints or concerns and information on complaints was available throughout the home. Records of complaints received were not always easy to follow.

### Is the service well-led?

Requires Improvement ●

Not all aspects of the service were well led.

The service was not displaying the current service rating conspicuously in the home or on the provider's website, as legally required to do so.

A range of checks were undertaken to ensure people's care and the environment of the home were effectively monitored. Specific checks by the registered manager remained limited. Checks had not always identified the short fall in consent forms being appropriate and up to date.

Staff were positive about the support they received from management and described the registered manager as approachable. New senior management meetings had been instigated to drive improvement at the home.

# Wentworth Grange

## 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 15 and 20 December 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using, or caring for someone who used this type of service.

Before the inspection, the registered provider completed a provider information return (PIR). 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. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local authority contracts team, CCG and safeguarding adults team. The contracts team told us they had no current issues with the home. The safeguarding team said they were currently looking into one matter at the home.

We spoke with nine people who used the service and three relatives to obtain their views on the care and support they received. Additionally, we spoke with the registered manager, lead nurse manager, training officer, audit manager, administrator, events organiser, two care workers and the executive chef.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, twelve medicine administration records (MARs), three records of staff employed at the home, complaints records, accidents and incident records and a range of other quality audits and management records.

# Is the service safe?

## Our findings

At the inspection in August 2015 we had found issues with regard to the safety and security of the premises. Window restrictors in the Hampton House annex of the home did not meet Health and Safety Executive guidance and a gate leading from an enclosed garden area had not been secure, meaning people were at risk of leaving the building unobserved.

At this inspection we found window restrictors had been fitted to vulnerable areas to prevent any falls from height. On the first day of the inspection we found that, whilst the provider had fitted some additional bolts to the garden gate, these were both undone and only the original bolt was shut. This could be easily reached and undone, meaning the area was unsecure. We spoke to the provider about this and by the second day of the inspection a tumbler style padlock had been fitted to the gate. This allowed staff to open the gate with a code, as required, but made the area otherwise secure.

At the previous inspection we had found the management of medicines was not robust or effective. In particular, we found topical medicines were not well managed. Topical medicines are items such as creams and lotions that are used on the skin. We had found some items had been out of date. We had also found there were some gaps in the medicine administration records (MARs). Recommendations on the use of care plans to define when "as required" medicines should be used was not being taken into account. "As required" medicines are those given only when needed, such as for pain relief.

At this inspection we found the management of medicines had improved. We noted a new system had been instigated to monitor the use of topical medicines and ensure they were in date. A weekly check was undertaken of all topical medicines to ensure they had not been opened for longer than three months or beyond the manufacturer's recommended expiry date. This task was allocated to a senior care worker and the process was checked by the manager. Items we looked at were within recommended dates.

There were some minor gaps in MARs recording relating to the day of inspection and these were immediately addressed when brought to the attention of staff. We found the remaining MARs well maintained and up to date. The manager showed us a copy of a medicines audit carried out by the local pharmacy for both Wentworth Grange and Hampton House, in October 2016. The review was comprehensive and covered a range of issues related to the ordering, storing and administration of medicines. We saw there were limited items listed for action and, where matters had been highlighted, the home was following the pharmacy advice. For example, we saw the reviewing pharmacist had advised that for "as required" medicines, when they were not given, then the code "O" should be added to the record. We saw staff were following this practice.

Staff had received training with regard to the safe handling of medicines and staff competencies had been checked through the use of an observed practice session. Staff who did not directly administer medicines had also received training. We observed medicine administration in both homes and found it to be carried out appropriately. People we spoke with told us they received their medicines on time and they were appropriately supported to take them.

"As required" medicines were listed on people's care records, although the detail of how these items should be administered fluctuated. The Lead Nurse Manager told us the home was in the middle of changing to a different electronic recording system and not all records were fully up to date. We recommend the provider follows national guidance on the use of "as required" medicines and develops detailed care plans for their effective administration.

At the last inspection we had noted not all potential safeguarding matters had been referred to the local authority safeguarding adults team. At this inspection we found the provider maintained a log of all safeguarding notifications to both the CQC and the local safeguarding team. Whilst we were able to track these referrals the records were sometimes not well ordered. There was one ongoing safeguarding investigation at the time of the inspection. The Lead Nurse Manager talked us through the events leading up to the safeguarding referral and the subsequent action taken. She also made us aware of another recent minor event that was being recorded as a safeguarding matter, to ensure transparency and openness. We will monitor the progress and outcome of the ongoing investigations.

People we spoke with told us they felt safe living at the home and that the staff were kind to them. One person told us, "The staff are very good here; they look after me well." At the last inspection staff had confirmed they had received training in relation to safeguarding vulnerable adults and were able to confirm the action they would take if they were concerned about any incidents or events. At this inspection we found staff continued to be aware of their safeguarding responsibilities. Information on making a referral to the local safeguarding team or raising a concern was displayed on various notice boards throughout the home.

Premises safety and risks were monitored and addressed. Checks were in place to ensure fire equipment was working effectively and fire detection systems were fully operational. Lifting equipment had been subject to regular Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) testing. Water systems were monitored and where systems were not in regular use these had been flushed to prevent possible Legionella infections. We saw copies of gas safety certificates, fixed electrical safety certificates and evidence that small electrical items had been subject to portable appliance testing (PAT).

Risk assessments related to people's direct care were recorded and updated within the home's electronic care records. We saw the system prompted staff to utilise the Malnutrition Universal Screening Tool (MUST) to check their nutritional intake. MUST is a nationally recognised system for monitoring and reviewing people's nutrition intake and any risks associated with nutrition. There were also checks using the Waterlow assessment tool to monitor any skin integrity issues and assessments of people in relation to the risk of falls. People had individual emergency evacuation plans (PEEPs) in place to support their movement from the home in the event of a fire or other emergency. This meant there were processes in place to monitor and mitigate risks associated with the environment of the home and direct care activities.

The Lead Nurse Manager told us there were thirty nine people living in both buildings of the home. She said there were two qualified nursing staff on duty in the Wentworth Grange building. Additionally, there were three care workers on the lower floor and three on the upper floor, although one of these workers was also the activities worker, who spent some hours on care and some on activities. She said there were three care staff working in the Hampton House annex, which supported people living with dementia. Hampton House staffing usually included a senior care worker on each shift. We spent time observing all areas of the home and found staff members were frequently around and available to support people. People and staff told us there were enough staff on duty to support their care needs. People told us they did not have to wait for care and we observed that when call bells were activated they did not have to wait long periods to receive support. Some people commented that they would welcome staff to have more time to sit and speak with them, particularly those people who spent significant time in their rooms. One person told us, "The carers



don't talk much; they don't spend much time in here." The Lead Nurse Manager told us staffing was an ongoing process. She said the current dependency tool was going to be updated in January to better reflect the full care needs of people.

At the previous inspection we found staff recruitment procedures were thorough and robust. At this inspection we found recruitment processes remained fully appropriate, with evidence of interviews, identity checks and Disclosure and Barring Service checks. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people.

## 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 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 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. We saw that, where necessary, applications had been made to the local authority for authorisation of DoLS for some individuals or DoLS had been granted following an assessment.

We saw that where people had capacity to agree to care being delivered then their consent was sought. Some people, particularly those people living with dementia, did not always have the capacity to agree to aspects of their care delivery. On the first day of the inspection we saw some people's care records contained copies of Lasting Power of Attorney (LPA) documents. LPA is a legal application authorised by the Office of the Public Guardian which gives permission to certain authorised individuals to make decisions where people do not have the capacity to do so themselves. We saw some people's records indicated LPAs were in place but did not contain a copy of the LPA documents to ensure all aspects of the LPA were being followed. One person had an LPA in place which listed several relatives as nominees. However, a consent form had been signed by a relative who did not have authorisation under the LPA. One person had a pressure sensor mat in place to alert staff if they got up during the night. This is a restriction of their freedom and either a best interest decision or authorisation from a person with LPA is required to meet the requirements of the MCA. This person was also receiving covert medicines. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse them. There was no best interest decision or authorisation from a person with LPA for this approach. A relative with LPA authorisation visited the home in the afternoon and care staff then asked them to formally agree to the care and support being offered. This meant these actions may not always have been in line with MCA requirements.

We spoke with the registered manager about best interest decisions and the need to ensure valid LPAs were in place. On the second day of the inspection we saw action was in progress to ensure that full copies of LPA documents were available in people's care records, any consent forms were only signed by nominees with valid LPA or that best interests decisions were undertaken and recorded.

At the previous inspection we had made a recommendation to the provider to consider national guidance on developing environments to best support people living with dementia. The provider told us they had attended a presentation by staff from Stirling University about supportive environments and had noted the recommendation to keep environments simply decorated. We saw this advice had been followed with no use of bold patterns on walls and carpets. The Lead Nurse Manager told us work was on going to change the colour of handrails in the home to make them more visible. However, there continued to be little use of visual signage for areas such as toilets or bathrooms, to help people identify these facilities, or the use of

alternative colours, such as differently coloured doors for bathrooms and toilet areas. We spoke to the registered manager about the environment on Hampton House. He told us they would continue to develop the environment over time and would look at additional advice on improving the presentation of the home. We noted redecoration of parts of the home was being undertaken at the time of the inspection.

People and relatives told us they felt staff had the right skills to support them or their relatives care. At the previous inspection in August 2015 we found staff had received an appropriate range of training and updating of skills. At this inspection staff told us they continued to have access to ongoing training and development opportunities. A number of staff had been supported to undertake National Vocational Qualifications training in various subject areas. We spoke with the provider's Training Officer. They told us all staff coming into the service were subject to a detailed induction process which followed the Care Certificate guidance. The Care Certificate is a national set of standards that care workers are expected to meet before fully providing support and care. They told us the Care Certificate was also going to be rolled out to existing staff to ensure consistency across the staff team. They said the home used the local Learning and Development Unit (LDU) for all mandatory training, but also contracted with outside agencies for practical training, such as moving and handling. They said a number of staff had also been trained as trainers to deliver support and updating in-house. There was also access to specialist training from district nurses or community matrons. A number of staff told us they had received training on supporting people with behaviour that could be challenging from the local behaviour support team. We saw posters advertising first aid training for the new year and asking staff to sign up to one of two sessions.

The Lead Nurse Manager also spoke to us about "micro learning sessions" that she undertook on an ad hoc basis. She said these sessions were impromptu events that were used to update staff or cover relevant information. We saw a log of these events had been kept and demonstrated a range of areas had been covered in these brief updates. The Lead Nurse Manager and the Training manager told us about a competency package they had developed for senior care staff at the home. They told us senior care staff were supported in gaining a range of experience and were assessed to ensure they had the correct understanding and competencies. They said staff were supported about assessing people's needs using an SBAR model of review. SBAR (Situation, Background, Assessment, Recommendation) is an effective and efficient way to communicate important information. It offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured. We saw copies of the competencies package. The Lead Nurse Manager told us a similar package would be developed for nursing staff. This meant the provider continued to provide a range of training and development opportunities for staff working at the home and ensured staff competencies were updated and reviewed.

Staff told us they received regular supervision and annual appraisals and records supported this. The audits manager demonstrated the supervision system in place at the home. They explained supervisions were set to take place bi-monthly and these were recorded on forms linked to secure storage boxes, to ensure these personal records were kept confidential. They said they monitored the supervision tracking records to ensure they were taking place and prompted supervisors, if necessary. This meant staff had access to regular support and appraisals to monitor their work and consider their development needs.

People's health and wellbeing was supported. There was evidence in people's care records that general practitioners or other specialist health staff had visited people at the home, or people had been supported to attend hospital appointments. Relatives we spoke with confirmed the home contacted the general practitioner, or took action, if their relations were unwell or needed assessing. This meant people were supported to maintain appropriate wellbeing whilst at the home.

At the previous inspection we had determined people's nutritional needs were being met at the home. At this inspection we saw this continued to be the case. The registered manager told us the home had engaged an executive chef to help improve the quality of food at the home. We spoke to the executive chef, who was visiting the home on the first day of the inspection. He was very enthusiastic about improving the quality of food and the dining experience for people in care and at the home in particular. He told us he did not work directly for the provider but oversaw the provision of meals at the home. He told us he was keen to make food a positive sensory experience for all people living at the home. Both he and the registered manager talked about how meals and snacks were available throughout the day and that people could request items at any time and these would be freshly prepared for them. We did not directly witness anyone availing themselves of this facility, but spent time speaking with people over the meal time period and observing how people were supported with their nutritional intake. People told us they were happy with the meals provided at the home. Comments included, "The food has improved greatly since the new chef started"; "The food is very good; but there is too much for me" and "The chef drops in to ask my opinion on the food."

We observed staff supporting people with their meals in the Hampton House annex. One person was provided with a cup of soup. They took a drink from the cup and then said spontaneously, "Oh, that's lovely; very nice." Although food had been brought to the annex in a hot trolley it still looked fresh and appetising when served. Some people were supported with pureed diets. These were well presented with pureed potato and vegetables piped to make the meal look attractive. Staff supported people appropriately, encouraging them to eat and drink, asking them if they had enough but also engaging in conversation and supporting the social side of the mealtime experience.

## Is the service caring?

### Our findings

At the previous inspection in August 2015 we had found staff at the home to be kind and caring and had rated this domain as 'Good.' At this inspection people and relatives continued to tell us they were happy with the care they received and they felt well supported by staff. People told us, "I am very happy here. I am more spoilt here than I was at home. I can have as much tea and coffee as I like" and "The staff call to see me regularly; I know most of them by name." A relative told us, "I find it all very pleasant here."

One person we spoke with talked about how staff had taken extra care to support them to attend a social event at the home. They told us, "The carers took a lot of trouble to get me into a wheelchair and into the lounge, so I could listen to the singing. It was really good and I enjoyed it immensely."

We spent time observing the relationships between people and staff at the home. We saw staff were extremely attentive and respectful to people in their day to day contact. We witnessed staff routinely enquired how people were and would regularly ask people if they could do anything else for them, after fulfilling an initial request. One person sneezed and a member of staff immediately asked them if they needed a tissue and asked them how they were feeling and whether they felt they were getting a cold. We also witnessed staff chatted with people during the delivery of routine care, enquiring about how people were, whether their family was due to visit or commenting on the fact they had been out or were due to go out. We observed staff support one person who had become distressed and required help to maintain their personal care. We saw staff dealt with the issue sensitively and constantly reassured the person. We saw the home had received several compliment cards or letters, all of which expressed sincerely thanks for the care offered to relatives or friends, although not all the items were dated to indicate how recent the comments were.

People told us they were involved in their care and relatives told us they were always kept informed about any changes to people's conditions or care needs. Relatives said communication from the home was generally good and any requests were responded to. We saw there were 'residents' meetings which took place approximately every two months. Notes from these meetings indicated people had been asked if they were happy with the care, whether there were any issue they wished to raise and also asked their views on activities at the home, or suggestions for future events or activities.

We saw there were sections in people's care records to record if people had an identified advocate or who was the key relative who normally advocated for the person. We saw that sometimes this was not always a person who had lasting power of attorney, or was sometimes identified as a solicitor. We spoke with the registered manager about the use of the term advocate and he told us he would ensure people identified as advocates had the correct permissions to make any formal decisions.

At the last inspection we saw people's privacy and dignity was promoted and supported. At this inspection we saw staff continued to ensure people were cared for in a dignified manner and their privacy was respected. We saw staff knocked on people's doors and sought permission to enter, even if the doors to the rooms were left open. Where people were being supported with personal care we saw doors were kept

closed and staff slipped in and out of rooms discretely. People's independence was also promoted. In Wentworth Grange corridors were wide and easy to negotiate. There was a lift between floors. People were encouraged to walk around the home or were escorted to social events taking place. In the Hampton House annex area there was a large open plan dining and lounge area, which people could use freely. People were also able to walk around the corridors and staff observed them discretely to ensure they were safe.

## Is the service responsive?

### Our findings

At our inspection in August 2015 we noted the service was responsive to people's needs and had rated this domain as 'Good.'

At this inspection we saw the home and staff remained responsive to people's care needs and people and relatives confirmed this. During our inspection we encountered a person who told us they were feeling unwell and looked uncomfortable, having slipped down their bed slightly. We drew this person to the attention of the staff on duty and they immediately responded and attended to the person and made them comfortable.

The registered manager and the Lead Nurse Manager told us the home was in the process of changing care records from one electronic recording system to another. The Lead Nurse Manager told us the home was moving to the Care Docs system, as they felt this was a more responsive system. She told us care staff would be able to record daily care activities directly onto the system, utilising tablet (hand held computer) technology. She said not all current records had been transferred onto the new system, but paper records from the old system were available and a back-up copy of all previous electronic records had been made. A member of the care staff demonstrated how the new style system would work fully when operationally for all people at the home.

Care records were individualised and person centred. There was evidence of an assessment of people's needs which covered a range of areas related to their health, personal care, mobility and psychological needs.

Following on from this assessment, care plans had been developed to address people needs. We saw care plans related to people's nutritional support, mobility and minimising falls risks, overall health needs and, where appropriate, support for people living with dementia. Some care plans were highly individualised and provided staff with detailed actions to follow to support the person. For example, one person was noted to occasionally have issues with panic attacks. The care plans detail the action staff should take during these episodes including reassurance, using short simple phrases and staying with the person. The plan also indicated staff should not automatically use touch as a method of reassurance, as the person did not find this helpful. Other care plans, especially those related to people's mental capacity were less personalised and tended to rely more of set phrases such as, "Ensure decisions are made in the person's best interests." We spoke to the Lead Nurse Manager about this. She said the detail in the plans would increase as plans were slowly transferred across to the new system.

Because the new electronic had only been operational a few weeks there were no fully detailed reviews of care recorded. We looked at the paper copies of people's previous care plans and saw risks and care plans had been regularly reviewed and updated, as required.

Care plans also contained details of people's choices. For example, records detailed how people liked to be supported with their medicines, whether they preferred male or female carers and activities they particularly

liked. For example, one person was noted to particularly enjoy watching black and white films. People we spoke with told us that in general their choices were supported and respected. One person did tell us they did not always get a female care worker, as they had requested, but told us about the support they got from the male worker, "I've got used to him now. He is okay."

People told us there were a range of activities taking place at the home, although some said they did not always know what was going on and did not get a leaflet advising them of events. A list of activities was on display in dining rooms and the lift. As it was leading up to Christmas there were a number of festive activities booked to take place at the home, including a pantomime and a carol service. On the first day of the inspection a singer was visiting the home. We spent time observing the event and saw people enjoyed the activity and joined in with the songs. We spent time speaking with the home's events organiser. They told us she had worked at the home for around five years but had only taken over the events organiser role within the last 12 months. They told us there were regular singing groups that came to the home and performed both in the main building and the Hampton House annex. We asked the organiser whether they had spoken to people and relatives about the sort of activities people particularly enjoyed and what activities she used to support people living with dementia. They said they had spent time sitting speaking with relatives when people first came to the home. They said they tried to involve people living at Hampton House in all the general events, if at all possible, but had also supported them through the use of painting, craft and other activities. They described how they had supported people from the Hampton House annex to participate in pumpkin carving for Halloween. They said they were well supported by the managers at the home and wider staff. They said they tried to organise events for quieter times so staff could support people to attend the events. They confirmed they had a monthly budget for activities, but this could be spent flexibly.

Information on how to raise a complaint or concern was on display throughout the home. The information encouraged complaints as a way of improving quality at the home. The registered manager maintained a log of formal complaints about the home and care delivery. We saw the log book recorded the nature of the complaint and detailed an investigation had taken place. Records also indicated that there was often a meeting between the registered manager and the person or family member. In one instance we saw a copy of a written response to an issue raised by a relative, which included a brief explanation and an apology. We asked the Lead Nurse Manager whether all complaints were responded to in writing. She told us they preferred to meet with people to discuss the issues rather than simply write back. This meant that whilst there was evidence complaints were logged and dealt with, it was not always possible to see the full details of the investigation or the response to families or people.



## Is the service well-led?

### Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since October 2010. The registered manager was also the nominated individual for the provider. A nominated individual is the Commission's first point of contact when dealing with the provider. The registered manager was present and assisted us on both days of the inspection.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulations require a provider to display the current rating of performance for the home conspicuously at the home. The regulation also requires the provider to display the current rating awarded to the service on any website in a place that is easily accessible to service users. As this was the second rating inspection for the home we checked the provider's website prior to carrying out the inspection. We found the correct rating was not displayed on the website. On arrival at the home for the inspection we checked to see if the current rating was displayed in a public place. We could not immediately see the rating displayed. We asked the administrator whether the rating was displayed. They took us to the rear of the building, to an area mainly limited to staff access, where the rating was pinned on a board. They told us the rating must have been moved due to current redecoration of the entrance. They then placed the rating certificate on display in the entrance hall. We later spoke with the registered manager about the rating display. He told us the rating was displayed permanently on the notice board at the rear of the home and that when people came to look around the home he regularly took them into this area, so they would be able to view the rating when in this area. He told us the website was due to be renewed in February 2017 and the rating could be updated then. We advised the registered manager this timescale was not appropriate. We further checked the website on 28 December 2016 and found the rating displayed remained incorrect. This meant the provider was not complying with regulations about displaying the current rating publically and prominently both at the home and on the provider's current website.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 20A. Requirement to display performance rating.

At the previous inspection in August 2016 we had found records about the service were not always immediately available. We had also found quality monitoring systems employed at the home were not robust and predominantly tick box in nature.

At this inspection all the records that were requested were made available to us in a timely manner. We found daily records of a good standard. We were told care records were in the process of transitioning from one electronic system to a new system. Those new care records we looked at were well completed and contained good detail overall. Records relating to safeguarding matters and to complaints, whilst available, were not always easy to follow and sometimes lacked full details of the process followed. Electronic records were all password protected, to each individual member of staff, to ensure personal details relating to people at the home were kept securely.

The provider had an audits manager in post. They explained they checked and reviewed a number of aspects of care at the home including reviewing accidents on a monthly basis, ensuring supervisions was kept up to date, audits of medicines and medicines records, food hygiene audits and infection control audits. They also told us they supported the domestic team at the home by helping with checks on rooms. We saw copies of various checks and audits carried out by the audit manager. However, these checks had failed to identify that some aspects of consent for people living in Hampton House were not fully meeting legal requirements. The registered manager told us he continued to carry out monthly checks on the home. We saw these remained simple tick box in nature and provided little in the way of information about the quality of the service or any action taken. We spoke to the registered manager who agreed the checks were not appropriate and would look at reviewing the checks to make them more meaningful.

We were shown a folder containing a range of quality questionnaires that people or relatives had completed. The questionnaires followed a rolling programme covering such items as domestic care, food, entertainment. The questionnaires were a series of simple yes/no questions and there was no detail or analysis of the responses. Some of the forms had been completed by care staff on behalf of people at the home. We spoke with the audit manager about these questionnaires. They agreed they were not appropriate and said they were looking to improve the process in the new year. This meant that whilst there had been some improvement in the auditing and checking of the service there were still further enhancements and changes to be made to ensure full and proper checks were in place.

The Lead Nurse Manager told us one of the most positive developments in recent months had been the establishment of the management meetings. She said this meeting involved senior staff in the organisation along with the registered manager and the provider. She said opportunity was also offered to other staff, such as care staff, to attend on a rolling basis. She said the meeting allowed issues to be discussed in an open forum and for actions to be planned and followed up. Other staff we spoke with confirmed the quality of care and staff morale had both improved since the management meetings had been instigated. Staff said they felt able to raise issues at the meeting and that they would be listened to and action taken, where possible. One staff member told us, "I have no problems speaking up in meetings and sharing problems; they will listen." Staff said one of the recent issues had been that the registered manager had not always been available in the past, but that he had changed his hours and was now available more.

We saw a number of other staff meetings took place at the home. These included quality circle meetings, which looked at a range of quality issues and how they should be tackled. These included cleanliness issues and matters related to staff sickness. There were also nursing staff meetings and senior staff meetings.

People we spoke with told us they knew who the manager was and could approach him about any concerns. They told us they could speak to him in person or were able to contact him by telephone. They said all the senior staff at the home were approachable and responsive. Staff we spoke with were also positive about the management of the home. They said staff morale had been low a few months previously but had improved considerably over recent weeks. Comments from staff included, "It's a good staff team. Staff morale is good. (Registered manager) has been really good to me. He is a good manager" and "(Registered manager) is really good. Authoritative and knows his stuff. He knows where he wants to go and is trying to take everyone with him."

The registered manager told us the home was coming to the end of a five year plan, which had involved a range of refurbishments and changes. He said he wanted the home to be more like a hotel and this included the quality of care and service. He explained further about the changes in meals at the home and the introduction of chiller displays, as a way of both advertising the sorts of items available to people but also encouraging them to eat and make choices. He said he believed this was the first home in the country to do

this. He said he wanted the home to be high quality and several senior staff had invested considerable amounts of time in the project, but that the home was always learning.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments
Diagnostic and screening procedures	The most recent rating for the provider was not displayed conspicuously on the provider's website or within the location. Regulation 20A (1)(2)(3)(7)
Treatment of disease, disorder or injury	