Hillbrook Grange Residential Care Home

Hillbrook Grange

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 11 and 12 October 2017 and was unannounced. Hillbrook Grange Residential Care Home was incorporated in 2010 as a private company and is administered by a board of Trustees/Directors. Due to the home being a 'not-for-profit' charitable organisation all surplus funds are reinvested in the business for the benefit of the people who live there.

The service is located in the Bramhall district of Stockport and is close to local shops and other amenities. Accommodation consists of single occupancy bedrooms located on the ground and first floors. There are two lounges, a quiet lounge/library and a dining room on the ground floor and extensive landscaped gardens adjoining the home. The service can accommodate up to 41 people; at the time of the inspection there were 28 people living at Hillbrook Grange.

At a previous inspection conducted on 13 October 2016 the service was given an overall rating of requires improvement and there was one breach of regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 because the registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant people had not always had their capacity assessed when decisions were made in their best interest and applications to lawfully deprive some people who met the criteria for DoLS had not been made. At this inspection we found the service was now meeting the requirements of this regulation; the service was adhering to the requirements of the MCA and staff had a good understanding of how to support people who lacked capacity

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at Hillbrook Grange told us they felt safe and staff were kind and caring. The staff we spoke with told us they had completed training in safeguarding and were able to describe the different types of abuse.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm.

Equipment used by the home was maintained and serviced at regular intervals.

The service used a dependency tool that was updated every week to reflect changes in people's needs.

We saw that there were risk assessments in individuals care plans to identify specific areas of concern. The care plans covered essential elements of people's needs and preferences.

We looked at five staff personnel files and there was evidence of robust recruitment procedures.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences.

The home was clean and there were no malodours. Stockport council had conducted and infection control audit in May 2017 and the service had scored highly in all areas audited.

Staff sought consent from people before providing support

Staff received appropriate induction, training, supervision and appraisal and there was a staff training matrix in place. Staff told us they had sufficient induction and training and this enabled them to feel confident when supporting people.

Following the last inspection the service had identified the need for more person-centred care planning training and we found that this had been undertaken.

People told us the food at the home was good. There was a four week seasonal menu in use and this was displayed on the wall in the dining room. We found people's nutritional needs were monitored and met.

People's health needs were managed effectively and there was evidence of professional involvement.

The environment was suitable for people's physical needs.

People who used the service told us staff treated them well and respected their privacy and dignity. We observed positive interactions between staff and people who used the service.

We found the service aimed to embed equality and human rights though good person-centred care planning.

We saw people were provided with a range of useful information about the home and other supporting organisations.

The service did not provide end of life care directly, which was supported by other relevant professionals.

Care plans contained a good level of detail and had a person centred approach.

The home had been responsive in referring people to other services when there were concerns about their health.

The home employed an activities coordinator and activities on offer were displayed around the premises. When people had undertaken an activity this was recorded in their care file information.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care.

The home had received a high number of compliments since the date of the last inspection.

The service was registered as a charity and had a board of directors/trustees. Board meetings were held approximately every two months in order to ensure the board were kept informed of issues. Our

observations indicated that the directors/trustees worked well with the staff team and were actively involved in supporting them.

Staff had access to a wide range of policies and procedures regarding all aspects of the service.

The service worked in partnership with other professionals and agencies in order to meet people's care needs.

There was a service user guide and statement of purpose in place.

Formal feedback from staff, people who used the service and their relatives was sought through annual quality assurances surveys.

The service had a business continuity plan that was up to date and included details of the actions to be taken in the event of an unexpected event.

Regular audits were carried out in a number of areas, however medicines and care plan audits had not identified the issues we found with the storage of creams, the need to ensure up to date records of their application and other gaps in care plan records.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises and on the provider's website.

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.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service.

Compliance/safety certificates regarding the premises and equipment were all up to date and in place.

The service had appropriate arrangements in place to manage medicines safely but there were some gaps in documentation for topical creams.

Is the service effective?

Good

The service was effective.

Staff received supervision and appraisal and a schedule of meetings was identified for the year.

People who used the service and their relatives said the food was good and there was a four week seasonal menu in use.

There were appropriate records relating to the people who were currently subject to DoLS.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us they felt the staff were caring.

Staff attitude to people was polite and respectful using their names and people responded well to staff.

Staff respected people's privacy and dignity

Is the service responsive?

Good

The service was responsive.

The home used an electronic care plan system which was up to date and staff had access to all the latest relevant information.

Care plans were well organised and easy to follow.

Residents and relatives meetings were carried out and feedback about the quality of service was sought from them.

Is the service well-led?

Requires Improvement

There was no registered manager in post at the time of the inspection, which means this domain cannot be rated as higher than 'requires improvement.'

People were asked their views about the service and their suggestions were acted upon and the culture of the service was focussed on the needs of people who used the service.

Audits had not identified the issues we found with medicines and care plans.

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Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 October 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and one adult social care assistant inspector from CQC.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also reviewed information received from HM Coroner which indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks. We also contacted the Stockport local authority who regularly monitor the service.

Prior to the inspection we received a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service.

We spoke with five people who used the service, one visitor and eight members of staff including care staff, the office administrator, three trustees/directors and the activity coordinator.

We also looked at records held by the service, including 13 care files and medication administration records (MARs) and five staff personnel files. We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation, in order to establish if people's needs were being met.

We observed care within the home throughout the day including a medicines round and the lunchtime meal.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at Hillbrook Grange and there were sufficient staff to support them. Comments included, "I feel safe from bullying and there are always enough staff; if I felt unsafe I would ask to leave, I would ask any of them," "There are always enough staff; If I didn't feel safe I would speak to any of the carers but especially [staff name] she is always so nice," "There is no bullying and I feel safe. You can never have enough staff; they work hard so everyone is assisted smoothly, politely, courteously. If I didn't feel safe I would speak to the staff or go to the General Medical Council (GMC)." "There is no bullying from the staff."

The staff we spoke with told us they had completed training in safeguarding and were able to describe the different types of abuse. One staff member said, "If I had safeguarding concerns and the manager wasn't there I would tell the senior staff member and report verbally and document in the report; signs of abuse could be bruises, change in behaviour, becoming withdrawn." A second staff member told us, "I report safeguarding concerns to the senior verbally initially, and then I document them. I have had safeguarding training; signs of abuse are bruises, being withdrawn and changes in behaviour." A third staff member said "I report safeguarding verbally to a senior staff member; signs of abuse may be withdrawn, change in behaviour, aggression. I have done annual safe guarding training and I would phone the police if there was no one senior to report my concerns to." A fourth commented, "To keep people safe I walk with them, make sure they wear appropriate footwear, use their mobility aid and clear the corridors." A fifth staff member told us, "The safeguarding policy is to improve practice and protect residents from abuse." They were able to describe the process they would follow if they had concerns including discussions with management, the local authority, police or CQC.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm. We looked at the safeguarding policies and procedures which were clear and up to date and included an outline of Stockport local authority safeguarding framework and multi-agency policy dated 2016. We saw from records that staff had completed training and refresher training in safeguarding.

Equipment used by the home was maintained and serviced at regular intervals, including hoists, stand aids, the passenger lift, profile beds, laundry, call bells, the fire alarm system and fire-fighting items, gas and electrical appliances. The servicing of equipment helped to ensure each item was safe to use when required. A disaster recovery action plan was in place to provide staff with guidance on what to do in cases of emergencies such as fire, flood, gas leaks, power failure or structural damage.

We asked staff if they felt there were sufficient staff on duty to safely meet people's needs. Comments included, "We normally have enough staff but when residents are 2:1 it can be tight, mornings are busier as they all get up at similar times. I don't work nights," "Most of the time the service is fully staffed; holiday time can be challenging," "There are adequate staff but the crisis response beds are sometimes inappropriate for this service; people are admitted as needing a care home but their needs can be more complex and they actually require a nursing home."

We looked at staff rotas and found there were six care staff on duty during the day and three care staff on duty at night. A senior member of staff also completed a sleep in duty. These were supported by ancillary staff such as catering, domestic, laundry, administration, maintenance and an activity coordinator, which meant care staff could focus on care tasks.

The service used a dependency tool that was updated every week to reflect changes in people's needs and ensure they were getting enough support. The dependency tool also indicated individuals' preferences in relation to getting up and going to bed each day and any specific dietary needs such as a soft diet. This meant that staff could see easily essential information which was particularly useful for new staff or bank staff if/when used.

We saw that there were risk assessments in individuals care plans to identify specific areas of concern and how these were managed such as; falls, skin integrity, nutrition, choking, moving and handling, and personal emergency evacuation plans (PEEPs). The risk assessments were reviewed and updated when changes occurred. This demonstrated the home responded appropriately to risks and provided guidance to staff on how to minimise these risks.

We looked at the care plans for 13 people who used the service. These were stored on an electronic system called CMS which was accessed by staff from computers around the home. There were two iPad and six desktop PC's available for staff to use.

We saw all care plans included an initial choking screening tool and 'keeping me safe eating and drinking' section. The care plans covered essential elements of people's needs and preferences. There was a section entitled 'This is me' which provided an oversight of the person which was not filled in for 12 out of 13 care plans looked at and at the time of the inspection the home was in the process of continuing to update these. Senior care staff told us this information would be in individuals' bedrooms so that agency or bank staff would have enough information, however on checking three bedrooms they were not found. A staff member said "They used to be there." This meant that on some occasions information on individuals' needs may not be easily accessible to the staff supporting them. However we saw that information that would be identified in 'This is me' was actually recorded in other sections of the CMS.

We looked at how the service managed people's medicines and noted the home used a pre-dispensed blister pack system. We saw that medicines were stored appropriately in a dedicated medication room. We saw that all liquid medications had been dated when opened to ensure they were still usable and controlled drugs (CD's) were stored in accordance with the appropriate guidelines. There were clear protocols for the use of 'as required' (PRN) medications and homely remedies. We saw that the home returned unused or unwanted medications to the pharmacy on a regular basis. The home had a clear policy regarding giving medications covertly but at the time of our inspection there was no one needing this type of support.

We saw that medication administration records (MARs) had been consistently signed when medicines had been administered and had photographs of each person on them to enable positive identification and ensure the medicine was given to the right person.

We found all topical creams which were applied by the care staff had dates on them to identify when they were opened, which would help to ensure they were fit for use. However we saw there were gaps in the signing of these records which were kept in the staff room. Records for the previous month also had significant gaps in the signing which indicated that these records were not being audited effectively. We looked at creams held in three bedrooms and found they had all got a recent date on to identify when they had been opened and we could see they had been used which indicated that creams were being applied

but not always accurately recorded. This had been identified on the previous inspection as a concern.

We saw that in one person's bedroom there were two open tubes of anti-inflammatory cream on the side of the sink. We asked a staff member about this who identified that these should have been stored out of sight as the person was living with dementia and had tried to use the creams as cleaning products in the past. This indicated there was a risk of harm to the individual although no harm had actually occurred. We saw in the other two bedrooms the creams were stored safely out of sight under the sink.

We spoke with three staff about their understanding of the medication policy and all felt that they had enough knowledge and training. One staff member said, "Management has been fantastic, I feel I am up to date and have the skills to do my job." Another told us, "I have been watched by a senior when giving medication." A third commented, "I have had training to administer medication but not yet had observations so I am still under supervision. I have never seen a medication error but I would report it to the senior."

We looked at five staff personnel files and there was evidence of robust recruitment procedures. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences. Where appropriate these contained an associated body map to identify the specific site of the injury and identified the action to be taken to reduce the potential for further re-occurrence in the future. Records also included information on if the ambulance/paramedic or GP had been called, if the incident had resulted in a safeguarding referral, if a new care plan had been made or amended following any incident and if relatives had been informed.

We looked at how the home managed infection control. The home was clean and there were no malodours. Domestic staff were able to describe the cleaning routine for the home, and showed us how cleaning products were stored safely and how they were carried around the home using a trolley to ensure that they were always within sight and did not pose a risk to others. We observed there was easy access to infection control equipment for staff such as gloves, aprons, and hand gel. There were charts on the back of the communal bathroom areas that were signed four times a day to indicate they had been checked and were clean and well stocked. The domestic supervisor explained that they were hoping to introduce a similar system in people's bedrooms.

We found Stockport council had conducted and infection control audit in May 2017 and the service had scored highly in all areas audited, with most areas achieving 100 percent. One person told us, "The staff always wear a uniform, I wash myself and go to the toilet myself but I have seen them wear gloves." A second person commented, "They [staff] always wear a uniform and gloves, they change their gloves after helping me on the toilet or helping me wash."

Good

Is the service effective?

Our findings

At the previous inspection on 13 October 2016 the home was rated as 'requires improvement' in this domain and this was because of the lack of capacity assessments, recorded best interest meetings and the need to check out additional DoLS criteria which amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required documentation was in place and the service was now meeting the requirements of this regulation.

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).

There were appropriate records relating to the people who were currently subject to DoLS and the home maintained a DoLS tracker/register which was up to date and identified the name of the person, the date of approval and expiry, the date the relevant paperwork had been received, the date CQC were notified, the date the DoL was discharged. There were appropriate mental capacity assessments in place, which were linked to screening tools and restrictive practice tools which outlined the issues and concerns. There were applications for DoLS where the indication was that this was required and these were up to date and reviewed regularly.

The provider kept a record of attendance at the home by any relative of a person who lacked capacity and was subject to a DoLs, which was required as a condition by Stockport council. These were placed in the care records of each person concerned and identified who had visited and what had happened during the visit.

Staff had a good understanding of how to support people who lacked capacity. One staff member said, "If a resident asked to leave, I would talk to them first, try to find out why, then report this to a senior staff member." A second told us, "If someone told me they wanted to leave I would talk to them and speak to their family; but if they don't have a DoLS I can't actually stop them."

Throughout the inspection we heard staff seeking verbal consent from people prior to providing support and this ensured that people gave their consent to the care being offered before it was provided. One staff member told us, "I seek verbal consent when providing care to residents; some female residents prefer a female member of staff." A second said, "I introduce myself and gain verbal consent with all residents before doing anything." A person who used the service commented, "I like them all so I don't feel it necessary to ask who cares for me." We saw most people who used the service were able to provide consent to day to day

care and confirmed they could make their own decisions. One person said, "The staff do respect my choices, I prefer to sit quietly in the library, they worry about me not having enough company but I am very happy sitting here, I don't like a lot of company." A second person told us, "They [staff] do respect my choices, I like to sit in my room and they are okay with that."

We looked at staff induction, training, supervision and appraisal information and saw there was a staff training matrix in place. We saw staff had access to a range of training including MCA/DoLS, end of life care, food safety, falls prevention, fire safety and evacuation, first aid, food safety, safeguarding, infection prevention and control, health and safety, moving and handling, dementia, understanding behaviour and communication. Staff who administered medicines had completed training in this area and other staff had completed training in the use of the nutritional screening tool, pressure area care, understanding delirium, care planning, stoma and catheter care.

Following the last inspection the service had identified the need for more person-centred care planning training and we observed that this had been undertaken. Where applicable training was aligned with the requirements of the Care Certificate for staff who had not previously worked in adult social care and there was a dedicated and suitably qualified 'in-house' assessor in post regarding this. We found that the service had identified staff 'champions' in a number of areas including pressure ulcers, dignity in care, MCA/DoLS, the electronic care planning system (CMS). One staff member was also a health and safety /infection control coordinator and most staff had achieved NVQ level 1, 2, 3 4 or 5 in health and social care.

Staff told us they had sufficient induction and training and this enabled them to feel confident when supporting people. They confirmed they received one to one supervision meetings. Comments included, "I do administer medication and I have annual training. I have been here nearly three years and have had training twice so far in this. I have also had safeguarding training, twice in three years so far," "I have done safeguarding, first aid, moving & handling, food safety, medication and fire safety training," "I do regular training to keep up to date with best practice though I haven't had training yet for people with particular needs," "For my induction, I shadowed other staff for three days, then I was supervised for another three days. I have done six training courses in the last seven months," "I had a three month probation/induction where I received supervision. I have had training on how to use all lifts and annual training on MCA/ DoLS," "I haven't needed to discuss any training after it has happened; I have always felt ok about it."

We looked at staff supervision records and saw that each staff member had a meeting planner in place for the year which was in accordance with the provider's supervision policy and procedure. One staff member said, "I receive supervision every three months, it helps as I can ask questions." A second told us, "I can now put forward suggestions; I couldn't with the previous manager."

People told us the food at the home was good. We saw that diet and hydration records were maintained and people who were nutritionally at risk had been referred to the relevant professionals such as a dietician or speech and language therapist (SaLT) as required and supplementary drinks were being provided and recorded.

One person told us, "I like the food so far and if I didn't I would ask for an alternative." A second person said, "The food is lovely and I always get a choice." A third person commented, "I like the food, there is a good variation, they always have a choice; I don't eat meat on a Friday and they always respect that."

Some people needed thickeners in their drinks. Thickeners are prescribed for some people with swallowing difficulties. We saw that details of this, including information about the consistency required was available in the kitchen. This provided staff with the necessary information to ensure people received their drinks

appropriately so that they were protected from the potential of choking.

There was a four week seasonal menu in use and this was displayed on the wall in the dining room. The dining tables were neatly laid with place mats and cutlery and the dining experience was calm and relaxed. The chef told us that people were asked each day what they wanted to eat and the list was sent to the kitchen; if people changed their mind they were able to order an alternative each day. We verified this by looking at daily meal choice sheets; each person had an individual diet sheet and there was guidance for staff on different diet types and fluid/diet consistencies. There was a small photograph of each person on each table where they normally sat and on the back of this it was identified if the person was on a special diet type; this would assist staff, particularly if they were new to the home, to ensure people received the correct diet type. The chef told us this could change if someone preferred to sit elsewhere.

Food temperatures were checked and recorded at each serving. A new pictorial menu was being developed with pictures of the foods identified on the menu; this would assist some people to better understand what they were choosing to eat. We checked the food stocks in the kitchen and found that there was an adequate supply of fresh and dry goods and the freezers were well stocked. Fridge temperatures were recorded daily and a daily and weekly cleaning schedule was in place. The environmental health officer food hygiene rating score (FHRS) was five; food preparation facilities are given an FHRS rating from zero to five, zero being the worst and five being the best. There was a food hygiene policy and we saw that staff had completed training in food hygiene.

We found people's nutritional needs were monitored and met. People's nutritional status was assessed as part of the admission process and risk screening was carried out using a nationally recognised tool. We saw that any risks identified were recorded in care plans and people were weighed as required.

People's health needs were managed effectively and there was evidence of professional involvement, for example GPs, podiatrists, district nurses, SaLT, community psychiatric nurses (CPNs), dietetic advice, chiropodists or opticians where appropriate. This demonstrated people had access to health care professionals when required. Staff recorded in each person's care file when they had been visited and treated by health care professionals.

The environment was suitable for people's physical needs. There were wide corridors, hand rails, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was some signage for bathrooms and toilets which would assist some people living with a dementia to better orientate around the building. People were able to personalise their bedrooms with individual items such as family photographs, bedding and personal objects and there was adequate space and seating in each bedroom for visitors to use and spend private time with their relative.

There was an open reception area in the entrance to the building and a seating area near the reception with a room which could be used by visiting relatives to see people in private. The room could also be used to hold reviews of people's care with health and social care professionals. There was a separate treatment room where health professionals could examine people and consult with them in private.

Good

Is the service caring?

Our findings

People who used the service told us staff treated them well and respected their privacy and dignity. Comments included, "I think they respect my privacy; they don't walk in when I'm on the toilet," "They always treat me with respect," "They are always respectful," "They always knock before coming into my room, they pop their head in at night to check on me, they don't say anything and if I'm not asleep I pretend to be asleep so I don't bother them. They shout 'are you okay' when I'm in the bathroom and they don't walk in," "They respect me and treat me as an individual," "They do listen to me, they never force me to do anything and they will act on what I say," "They always explain what they are going to do; they always knock before coming in; they shout through to the bathroom to ask if I need help."

People who used the service also told us staff were kind caring. One person said, "They get full marks from me and I've decided to stay. I can do anything I want here and my room is beautiful."
A second person told us, "They always introduce themselves as I don't know them all yet." A third commented, "Staff are always kind and they listen to me and what I say." A fourth told us, "Staff are definitely kind to me." A relative told us, "There are a lot of really good things about Hillbrook Grange, the gardens are great, and the staff are kind and caring."

One person who used the service particularly requested to speak with us, they said, "I want to congratulate staff here on their splendid work, staff are extremely hard working, very caring, self-giving, not looking for rewards. They get satisfaction from doing good work. I won't say who but there is only one person who doesn't pull their weight, the rest have a great camaraderie. I used to go into a few homes when I was working, this is much better and far nicer than any home I have been in before. I know I am here for the rest of my life and I am happy about that."

We observed positive interactions between staff and people who used the service. Staff were patient and spoke to people in a kind way. For example, we observed one staff member engaging in general conversation with a person whilst they cleaned their bedroom, explaining what they were doing throughout and chatting about the benefits of keeping the room clean. On another occasion we saw a person had enquired about our visit and the staff member sat down next to the person and explained the reasons why we were visiting which reassured the person concerned.

Throughout the inspection we overheard lots of laughter and conversation between staff and people and staff took their time to speak to people individually, for example when asking what they wanted to eat or if they wanted to take part in activities. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service.

We looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. For example when one person had been referred to the home who required a

halal diet the service had responded by ensuring there was a separate food preparation area and utensils for this, as required.

We found there were appropriate policies in place which covered areas such as equality and diversity, confidentiality, privacy and dignity.

We saw bedrooms were all single occupancy which afforded privacy and some had en-suite facilities. Each bedroom could be locked if the person chose to do so and locks were in place on bathroom and toilet doors, ensuring privacy.

We saw people were provided with information about the service. There were notice boards to indicate which activities were to be carried out each day. There were leaflets in reception about the service, how to complain and advocacy arrangements. There was a service user feedback policy in place along with a charter of rights.

The food hygiene certificate and previous inspection reports were on display in the home and a copy of the last report was also displayed on the provider's website, along with a wide range of other useful information for people who may be considering a placement in the home. Each person was provided with a 'resident guide and information' pack which included information about the service and staff, how to make a complaint, along with a copy of the statement of purpose. A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

There was information about likes, dislikes and preferences in care files for how care should be carried out which demonstrated people and their relatives had been involved in decisions about planning their care and support.

We found people's care files were held in the staff office where they were accessible but secure and staff records were also held securely in lockable cupboards in the main office. Medication administration records were stored in the lockable treatment room. Any computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held. We observed throughout the inspection that staff held telephone conversations with people's relatives or health professionals in the privacy of an office.

The service did not provide end of life care directly, which was supported by other relevant professionals but people's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Some people we spoke with living at the home confirmed this was the case. At the time of the inspection no person was in receipt of end of life care.

Good

Is the service responsive?

Our findings

We asked people and their relatives if staff were responsive to their needs. One person said, "Staff are very professional and I always trust them, I can't speak highly enough of the staff here." Another person told us, "I get lots of support from all the lovely staff; they all know what they are doing." A third commented, "The staff always have time for a chat, especially [staff name], they always notice if I'm a bit down and they have a chat with me and then I feel better."

Care plans contained a good level of detail and had a person centred approach. We saw prior to admission the provider completed their own initial assessment to determine that the home was able to meet the person's support needs. Some people also had additional assessment information received prior to admission from the referring local authority. This enabled staff to establish what people's care needs were and the type of individual care people required and the involvement of people and their relatives was recorded in their care file information.

Each care plan contained a variety of risk assessments and included areas such as nutrition, mobility, pressure sores, physical health, mental health and pain management. The plans contained a profile of the person concerned including basic personal information such as height, nationality and previous occupation and this was completed for every person.

Each section of the care plans we looked at had been reviewed each month, or if/when there was a change to people's care needs. Each care plan that we looked at contained a document called 'This is me' with a photo of the person using the service. 'This is me' was developed by the Alzheimer's Society as a simple and practical tool that people living with a dementia can use to tell staff about their needs, preferences, likes, dislikes and interests

We saw the home had been responsive in referring people to other services when there were concerns about their health. For example, people with swallowing difficulties had been referred to Speech and Language Therapy team (SALT) and provided with an appropriate diet type following their assessment. Daily records were kept of any staff observations and interactions with people, for example one person had 107 observations recorded within a 10 day period.

The home employed an activities coordinator and activities on offer were displayed around the premises. Activities included a weekly hairdresser, beauty treatments, library service, arts and crafts, board games, card games and quizzes, puzzles and jigsaws, bingo, keep-fit, indoor seed planting and flower arranging, coffee mornings, visiting entertainers, fund-raising events and subsidised group excursions (seaside outings, theatre trips & afternoon teas.)

The activities coordinator told us, "The residents complete a questionnaire; this is stored in the activity file. We know most residents enjoy quizzes, sing songs, reminiscing (looking at images of things from their younger years and talking about them), eye-spy, memory games, keep fit, bean bag games, skittles and hoopla. The activities vary from week to week, keep fit is fortnightly. Activities are decided by the

coordinators but they listen to recommendations from all staff. One of the directors recently suggested inviting in a local nursery so the children and residents could interact, this was a big success so we will do this again."

We asked people about activities and one person told us, "They do sing songs but I don't like that, they do fortnightly exercise classes and I enjoy those, [staff name] does the activities and she is lovely. We do walks around the grounds and I like that. They try to encourage me to join in more but I am happy sitting in the library." A second person said, "I don't join in activities, they do ask me but I prefer to be on my own in my room." A third commented, "They do things like sing songs and they always ask me to join in but I don't fancy it."

We found when people had undertaken an activity this was recorded in their care file information, for example one person's file recorded they had taken part in a sing-along, reminiscing, board games, big ball games, maths and spelling quiz on different days within the same week. During the inspection we observed bingo, sing-along and keep fit exercise group activities were undertaken, and many people were engaged in personal activities such as reading, listening to music, watching TV or completing crosswords. An activities questionnaire was also completed by people who used the service in order to determine their preferences.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care and set out how complaints were recorded, investigated and responded to. Details of how to make a complaint were posted around the home and also given to people at the start of residence. The people we spoke were aware of the complaints process and how they would report concerns. One person said, "If I wanted to make a complaint I would speak to the senior." A second person told us, "If I had to make a complaint I would go to a senior; I made a complaint about bullying in the lounge by another resident and it was sorted quickly." A third commented, "If I needed to make a complaint I would speak to the senior carer; I haven't made a complaint."

We looked at any complaints the service had received and saw they had been responded to appropriately, with details from the investigation, the outcome, changes made and any lessons to be learned. The complaints process ensured people who used the service and their relatives had a system in place to state if they were unhappy with any aspect of the care they received.

We noted that the home had received a high number of compliments since the date of the last inspection which indicated the service was consistently responsive to people's needs. Comments received included: 'Thanks you so much for caring for [person name] so well during his stay with you; your warm friendliness and calm treatment of the residents is first class as was your understanding shown to me,' 'Thank you for looking after me and getting me back on the right road to recovery,' 'Thank you for the wonderful care you took of my mum; we couldn't have managed without you and we know she was happy and well cared for."

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the registered manager had left the service unexpectedly very shortly before the date of the inspection to pursue new opportunities. In response the trustees/directors, who all lived locally, had maintained a daily presence at the home to support the staff group and the home administrator who was very knowledgeable about systems and processes. An advert for the manager role had been immediately placed and at the time of the inspection applications had already started to be received, and there was also interest in applying for the role from existing staff members. This showed us the provider had done all that was reasonably practicably possible to recruit another registered manager in a timely manner, when faced with this unexpected situation. Shortly after the date of the inspection the provider contacted us to confirm a new registered manager had been appointed and was due to commence in post on 20 November 2017.

The service was registered as a charity and had a board of directors/trustees. Board meetings were held approximately every two months in order to ensure the board were kept informed of issues. We looked at minutes from the previous five meetings and saw discussions included staff performance issues, service development, financial statements and audits, the appointment of committee members, safeguarding, food, staffing levels, CQC submissions, local authority contracts, resident's health and welfare, health and safety, infection control, premises and facilities.

It was clear from our observations that the directors/trustees worked well with the staff team and were actively involved in supporting them and the senior staff members who were 'managing' the home until a new registered manager was recruited. One trustee had previously supported the home for many years in another professional capacity and therefore had a detailed knowledge of the home.

Although there was no registered manager in post at the time of the inspection we found staff and the trustees understood their role in sending notifications to CQC and had sent us notifications as required by the regulations. People's care records were also kept securely and confidentially, and in accordance with legislative requirements

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, whistleblowing, health and safety and infection control which were available to staff if they needed to seek advice or guidance in a particular area.

At the last inspection we recommended the registered provider and registered manager follow through with quality monitoring plans and the use of new templates and questionnaires in order to provide a more systematic approach to quality monitoring. We looked at the systems in place to monitor the quality of service provided at the home and found audits included accidents and incidents, safeguarding,

dependency, medication including staff competency checks, care plans, weights, CMS, infection control, complaints, appliances fixtures and fittings, equipment. However audits of medicines and care plans had not identified the issues we found regarding the storage of creams and the lack of updated 'This is me' documentation.

Because audits had not been effective in identifying and rectifying some of the issues we found during the inspection this meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance. You can see what action we told the provider to take at the back of the full version of this report.

Audits were also carried out by the local authority and these covered a number of areas including safeguarding, governance arrangements and quality assurance, medication management, information sharing/data protection, inter agency working, recruitment, staff supervision and support, record keeping and activities. We found the home had been assessed as being 'fully compliant' in all of these areas.

The service worked in partnership other professionals and agencies in order to meet people's care needs as required and involvement with these services was recorded in people's care files. The provider had also met with local councillors and the Mayor regarding a proposal to develop a dementia unit in existing grounds adjacent to the home.

There was a service user guide and statement of purpose in place. A statement of purpose is a document which includes a standard required set of information about a service. When people were given a copy of the service user guide at the commencement of their residence they were also given a copy of the complaints policy, a satisfaction questionnaire and terms of residence.

Formal feedback from staff, people who used the service and their relatives was sought through annual quality assurances surveys. We looked at the most recent surveys and comments from residents included, 'Very well looked after by caring people,' 'The carers and all the staff are very kind and helpful and much appreciated,' 'Myself and family wish to thank you for your care and kindness during my stay.'

Comments from relatives included, '[Staff name] does a brilliant job but a variety of more activities would be appreciated,' '[Relative name] is looked after by very caring people; the staff phone me to keep me informed of any developments, however minor,' '[Person name] has a fixed mind-set on how he wants to integrate and can sometimes be a challenge which the staff handle very well,' 'I am very happy with the care [person name] receives but rather unhappy with the amount of laundry not returned to him on a regular basis, but overall thank you very much to everyone- you all have a difficult job to do,' ' Nothing is too much trouble in helping the residents.'

Comments from visiting professionals including GP's and nurses included, 'I have no concerns and would be happy to recommend,' 'I think that you are doing a great job; your dedicate staff make all the difference to your residents,' 'The staff operate a high quality service; they enhance the residents day with their excellent care. They always show dignity and respect to the residents and prioritises them at all times.'

The service had a business continuity plan that was up to date and included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and co-ordinated way.

There was an up to date certificate of registration with CQC and insurance certificates on display as

required. We saw the last CQC report was also displayed in the premises and on the provider's website. This website also provided a wide range of information that would be useful to people considering residence at the home and/or their relatives.

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 17 HSCA RA Regulations 2014 Good governance The service had failed to effectively assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)