Care Quality Commission

Hestia Healthcare Properties Limited

Timperley Care Home

Inspection report

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on 3 February 2015. The previous inspection was on 4 March 2014, when we looked at certain areas as a result of concerns raised. The last full inspection had been on 24 June 2013. On both these previous inspections we found the service was complying with regulations in the areas we looked at.

Timperley Care Home is a care home offering both residential and nursing care for up to 51 people. On the day of our visit there was one vacancy.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The building was a modern purpose-built care home which was well maintained and offered a safe environment. There were sufficient numbers of staff on

Summary of findings

duty and more staff were being recruited to fill vacancies. The recruitment processes were robust. Staff were well trained in safeguarding and the registered manager reported safeguarding incidents. The administration of medicines was safe and monitored effectively.

We found that Timperley Care Home was not always correctly applying the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards which form part of that Act. Mental capacity assessments had in some cases either not been carried out or carried out incorrectly. We found that this meant people were not always being protected. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the full version of the report.

We found that staff attended to people's needs. Family members told us they were pleased with the care being given. The home had earned a Dignity in Care award. Several members of staff had followed a programme in end of life care.

Care plans were held on a computer system which had some advantages but created the risk that they were not personalised. We found there were some activities but that some people would benefit from a greater range of purposeful activity.

The registered manager had not submitted a Provider Information Return which we had requested. There were good systems of audits and oversight by senior managers. Under the registered manager there was strong leadership and staff had a clear sense of the organisation's values.

Summary of findings

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. The building was modern and purpose built with safety needs in mind. The building was well maintained.

Staffing rotas showed there were sufficient staff on each shift. Proper recruitment checks were undertaken.

Staff were trained to identify safeguarding incidents and to report them. Medication was monitored and mistakes reported.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not being correctly applied to protect people who lacked capacity to make certain decisions.

We found the training was generally good and up to date.

People told us they liked the food and people were well nourished.

Is the service caring?

Good

The service was caring.

Staff were attentive to people's needs. Family members were for the most part pleased with the care provided to their relatives.

Staff had received training in end of life care. The home was due to receive a Dignity in Care award.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Timperley Care Home used a computer system to create and store care plans. These were thorough but not very personalised.

There was a programme of activities but more could be done to involve more people.

Meetings were held to involve people and relatives in decisions about the home.

Is the service well-led?

Requires Improvement

The service required improvement under this question, because it had not submitted its Provider Information Return.

Relatives and staff were happy with the management team.

There was a good system of auditing and a clear management structure.

Timperley Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 3 February 2015 and was unannounced. This means that the service did not know we were coming in advance.

The inspection was led by an adult social care inspector who was accompanied by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience was familiar with services supporting older people.

Prior to the inspection we requested the service on 12 November 2014 to send us a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Although we reminded the registered manager about the date this needed to be returned, we did not receive it back. We took the failure to return the PIR into account when we made the judgements in this report.

Prior to the inspection we contacted Trafford Healthwatch, who did not hold any information about the service.

At the inspection we talked with nine people living in the home. We also used the Short Observational Framework for Inspection (SOFI) during our visit. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We talked with seven relatives and six members of staff including both nurses and care workers. We also talked with the registered manager and a director of the provider.

We looked at five care files which were held on a computer database. We looked at staff rotas, recruitment files, records of audits and other documents which we requested.

Good

Is the service safe?

Our findings

We talked with nine people who were living at Timperley Care Home. They told us they felt well looked after. One person said: "I feel safe here, staff are always around." One family member said: "The staff are very good here. They inform me if anything happens. I haven't had any concerns about [my relative's] safety."

The home was nearly fully occupied, but did not feel too crowded. The building was a modern purpose-built care home. The corridors were well-lit and wide, which meant there was plenty of space for people to move around safely. The registered manager explained that the more active, independently mobile people lived downstairs, where staff were especially alert to keep an eye on their movements. People with more limited mobility, and who required nursing care, were on the first floor. The registered manager added that people were assessed individually and placed in the environment best suited to them. There were nurses stationed on each floor, who could call on each other to assist if needed.

We discussed staffing levels with the registered manager. She stated that her preference was to have three nurses on duty, and though this was not always achieved there were never fewer than two. There were one or sometimes two nurses at night. There were also nine or ten care workers on the morning shift (finishing at 2pm), eight or nine on the afternoon shift (2pm to 8pm) and four or five at night. We looked at staffing rotas for the week preceding and the week of our inspection, which confirmed the numbers of staff present.

Agency cover was used as a last resort, and one agency nurse had been used the night before our visit. One of the day nurses had stayed late to ensure the agency nurse was fully briefed. The registered manager explained there were some vacancies for both nurses and care workers. Agency nurses were used, but the vacant hours for care workers were filled by existing staff working extra shifts. One of the senior staff told us they were about to interview 11 potential new care workers. The provider had brought in three nurses from abroad, who were awaiting validation and meanwhile working as care workers. This showed that the service was being proactive in addressing the availability of staff in order to ensure there were enough staff to fill the rotas.

During the inspection we observed that staff were on hand and people were not kept waiting when they needed assistance. The building was designed with the nurses' station just outside the main lounge on each floor. This meant that staff could keep a discreet eye on people in the main lounge while not being obtrusive.

We talked with six staff and asked them about their understanding of safeguarding. One person told us they had not had any cause to report abuse while working at Timperley Care Home, but they would not hesitate to report it if necessary. They said their motto was "If you see it, report it." They added that they would not be scared to whistleblow if they had to, and explained how they would go about doing so. Other staff members stated similar views. We saw from the training matrix that the majority of staff had undertaken refresher training in safeguarding adults during 2014.

The registered manager had reported 16 safeguarding incidents during 2014, ten of them involving allegations of abuse or suspected abuse. This did not indicate a high level of abuse within the home, rather that the registered manager and senior staff were conscientious in reporting events both to the CQC and to the local authority. We discussed a number of these incidents with the manager, including one which had led to the resignation of a nurse. We were satisfied that the registered manager was alert to her responsibilities to report all instances of potential abuse and thereby keep people safe. There was evidence that robust action was taken where necessary to ensure that staff conducted themselves in a safe manner and people were adequately safeguarded from the risks of abuse.

We asked about recruitment practices and saw that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. We saw the record of an audit which checked that the necessary documents were on each staff member's file. Each personnel file had a checklist of documents that needed to be seen at the time of appointment, including proof of identity, a DBS check (a Disclosure and Barring Service check for any convictions or cautions) and references. There was an interview checklist used to record job candidates' experience, qualifications and suitability for the job. These processes were designed to ensure that only suitable staff were appointed.

We spoke with the two clinical leads who were both nurses. We asked them about the administration of medicines. One

Good

Is the service safe?

nurse explained how they were responsible for the complete cycle of medication from ordering it each month, through checking it in along with a colleague, and then to administering it. The nurses checked that the medication received matched that on the MAR (Medication Administration Record). When it was time to administer, they checked the photograph on the MAR matched the person. This was especially important for agency nurses who would not know the residents individually.

The stock of medicines was checked daily by a clinical lead which provided an additional check to ensure that people had received the correct medication. There was also a monthly audit of medicines conducted by the registered manager. We checked the stock in the Controlled Drugs cabinet (controlled drugs require to be securely stored and carefully monitored). We found that the stock of one medicine we selected to look at matched the record. We saw a record showing it was checked at every handover between shifts.

We knew from notifications received over the previous year that occasional errors were made. In one instance a nurse gave medicine to the wrong person, and informed the clinical lead immediately they realised. The nurse contacted the GP of the person who had taken the medication, and followed advice to observe them. This meant that the home had responded appropriately to a medication error. In another case medication had been omitted in error, and the clinical lead reported the error to the registered manager. Appropriate disciplinary measures were taken against the nurse in question. This showed there was a zero tolerance approach towards medication errors.

We saw records of maintenance and checks of the building, including fire safety certificates, records of fire drills and maintenance of the fire alarm system. The provider had commissioned a detailed fire risk assessment in July 2014. In May 2014 the Greater Manchester fire and rescue service wrote to the registered manager stating: "The current standard of fire precautionary checks...is excellent and a credit to your organisation."

Each person had a personal evacuation plan stored on the computerised system. In the event of a real emergency it would be important to have that information readily accessible. The fire procedures gave instructions for evacuation. There was a 'resident fire evacuation register' which stated the equipment needed to evacuate each person and the number of staff required to assist.

We saw maintenance records for the lifts, and monthly monitoring checks of the water system designed to prevent legionella. The building was well maintained in order to provide a safe environment for people living there.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, people's rights are protected if they are unable to make decisions for themselves.

The record of training showed that most staff had received training on the MCA via e-learning (i.e. study on a computer). This included training on DoLS.

We examined the application of the MCA and DoLS in the home. In one instance we learned that one person was receiving medication covertly, in other words it was mixed with their drink so they would not realise they were receiving it. In that person's medication care plan, it stated: "...is given their medication covertly in their drinks due to non-compliance, this has been decided as being in their best interests." It was also stated that the person "lacks capacity to make decisions."

There was, however, no mental capacity assessment relating to this person, and specifically no mental capacity assessment relating to their capacity to consent to receiving medication in this way. There is a specific method, set out in the MCA, to assess people's capacity to make a specific decision. This process is often carried out by a doctor, although it need not be. In line with the MCA a mental capacity assessment should have been completed relating to the covert administration of medication. Only if the person was deemed to lack capacity could a decision be taken in their best interests.

Consideration should also have been given to applying for an authorisation under DoLS, as administering medication covertly might be construed as a restriction on the person's rights.

We raised this issue with the registered manager. They told us that the covert administration had commenced while the person was in hospital. Nevertheless, the provider is responsible for ensuring the principles of the MCA are followed while the person resides in the home. We saw another example of covert medication where the care plan stated "Covert medication placed by GP", but there was no record of a mental capacity assessment having been undertaken.

On another person's file it was recorded that they were "unable to make decisions that affect [their] life and well-being." However, the mental capacity assessment answered N/A ("not applicable") to the questions intended to determine whether or not the person has or does not have capacity. We pointed this out to the registered manager who agreed that the form was incorrectly completed.

In another instance an application for a DoLS authorisation had recently been submitted, and refused. The care plan stated, correctly, that: "The principles of the Mental Capacity Act need to be adhered to when this assistance is required" (namely assistance with decision making). A mental capacity assessment had been done. To the question "Is [the person] able to make informed decisions about key aspects of their life?" the answer given was "sometimes". Elsewhere on the care plan it was recorded that "[the person] has no mental capacity." These two statements were contradictory.

It was also recorded that a DoLS authorisation was required for this person: "Owing to [the person's] current lack of mental capacity to make decisions for themselves and [their] current circumstances, both an urgent and a standard authorisation for a deprivation of liberty safeguard order has been requested in order to ensure [the person] can receive the care they need." It was not stated on the care plan what restriction or restraint was being imposed.

The care file continued: "An urgent authorisation request for a denial of liberty was submitted, however the required standard authorisation hasn't been submitted yet." This sentence betrayed a misunderstanding of DoLS. Under the legislation a care home (or 'managing authority') grants itself an urgent authorisation. It must at the same time submit an application for a standard authorisation to the local authority.

We learnt that in this instance the local authority had subsequently refused the application on the basis of information in the application which was in fact incorrect.

Requires Improvement

Is the service effective?

The registered manager explained that the application had been submitted by the temporary manager in January who had only been at the home for a short while. The service had not notified the CQC of the refusal of the application, which it is required to do under regulations.

These instances together demonstrated a failure to apply the principles of the MCA and DoLS, and constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When new staff joined Timperley Care Home there was a process of induction and on-the-job training. We looked at the training record and saw that all care staff participated in training in core subjects and in a variety of additional courses. Each member of staff had their own training file which included copies of certificates. One member of staff described to us their training as a mixture of e-learning and face to face tuition. This person had also achieved an NVQ (National Vocational Qualification) level 5 in social care within 12 months, which was a significant qualification.

A new training manager was due to start the week after our inspection. We saw the provider's recent draft learning and development strategy which set out the goals and objectives of its training programme. The strategy was based on the five questions now asked by CQC inspectors. We also saw a schedule of clinical training dates due to take place either in Timperley Care Home or a sister care home. The five courses were mandatory for all clinical staff and managers. The registered manager told us it was her intention to develop Timperley Care Home into the training hub for new homes which the provider was intending to open in the North West. This illustrated the importance attached to staff training.

We saw the supervision matrix which showed that staff were receiving regular supervision. Staff confirmed to us they were receiving regular supervision. This meant they were being supported and given the opportunity to raise any issues with their line manager.

The dining rooms on each floor were relatively small, with space for 12 people each. There were two sittings. We saw that people also ate their meals at dining tables in the lounges. We asked people whether they liked the food at mealtimes. Comments included: "The food is fine. I like the meat", "It's okay here, the food is great" and "The food is very nice." People told us that if they didn't want the food that was offered at meals there was always another choice available. This was confirmed by staff who said there was always a minimum of two choices. At lunch there was plenty of food available. One family member said "My relative came into the home very underweight, but has now regained their weight." This indicated that good nutrition, combined with good health care, had benefited this individual.

Good

Is the service caring?

Our findings

On the day of our inspection the registered manager and other staff were due to attend a ceremony and receive a Dignity in Care award from Trafford Council. This meant that Timperley Care Home had been recognised as a place where there was emphasis on improving the quality of care and maintaining people's dignity.

Care plans recorded whether a person's relatives had power of attorney which meant that they should be consulted about important decisions relating to the person's care and welfare. On some care plans it was recorded that the person had an advocate.

One of the clinical leads had completed in September 2014 the 'Six Steps' training which relates to the provision of end of life care. The training was then shared with other staff. We discussed with the clinical lead whether this had brought about any changes in the way the home cared for and supported people approaching the end of their lives. They explained that the staff were now more fully involved in the process and for example wrote letters which had previously been written by GPs. The training also gave staff more confidence when dealing with families around this issue. The clinical lead was an active participant in a local palliative care forum, and also in a care home forum run by the Clinical Commissioning Group. These initiatives showed that the service was actively seeking to improve the quality of end of life care.

We saw one statement of intent. This is a document completed normally by the person's GP when it is anticipated that the end of life is soon approaching. We noticed that the GP had not entered the illness or condition which was likely to be the cause of death. This is a necessary part of the form. We mentioned this to the registered manager who said she would ask the GP to revisit the form. We also noticed that two different versions of a DNAR (do not attempt to resuscitate) form were in use which could potentially cause confusion as they were worded differently. This was also brought to the attention of the registered manager.

There was a system of keyworkers, so that everyone living in the home had a named member of staff who took a special interest in their care and welfare. We asked residents how well they were looked after. Their comments included: "The care is pretty good here", "The staff look after you", and "The staff listen to you." One person, however, complained that staff frequently entered their room without knocking. This meant that staff were not respecting this person's privacy.

During our observation in the lounge we saw that staff were attentive to people and checked they were comfortable. One lady for example walked in wearing a nightdress and using a zimmer frame, and sat in an armchair. After a few minutes a member of staff noticed her and went to fetch a dressing gown. This was done in a gentle way, without any criticism. Staff fetched a blanket for someone else to ensure they were warm enough.

We asked visiting family members how well they felt their relatives were looked after. Some were very positive. One visitor said that their parent had been admitted to the home with a leg wound they had had for two years, which had now completely healed. Another person said "They have encouraged [my relative] to walk again." However, there were also some negative comments. One person said "He's always well looked after, but sometimes not shaven." The registered manager explained that the individual in question often chose not to shave or be shaved. Another visitor said that their relative's keyworker only worked night shifts, and expressed concern that there was a lack of communication between night and day staff. This meant that a notice describing the person's care had to be fixed to the wall of their room. We saw this notice, which while it meant that the correct care was more likely to be given, was potentially disrespectful to the person's privacy.

One member of staff told us they felt the home was not institutional: "People's needs are definitely met. It has a home-like atmosphere. I would put my aunt or uncle here." We also observed the atmosphere was informal and relaxed. Staff did not wear uniforms, although on occasion it was difficult to distinguish staff from visitors and it might be advantageous for staff to wear a badge to enable both residents and relatives to recognise them.

We saw that residents were well dressed and well groomed. One relative commented that their relative was "always colour co-ordinated". We observed that staff interacted with people in a caring and polite manner. We witnessed staff intervening kindly but firmly to prevent a possible altercation between two people who had exchanged angry words. The intervention avoided the situation getting worse.

Good

Is the service caring?

Each room had the person's name and a current photograph of the occupier on the door. This could assist a person living with dementia to recognise their own room. Experts in dementia care suggest that often it is better to have an old photograph on the door, for example a wedding photograph, as this may be more easily recognised than a recent photograph. Around the walls were some items such as teddy bears and cushions attached by velcro, which people could remove and carry around with them. This was designed to engage the interest of people living with dementia, and we saw that the items were moved around, showing that they attracted people's attention.

There was also a chicken house outside one of the ground floor lounges, with three chickens. People pointed the chickens and rabbits out to us and evidently enjoyed their presence. This increased people's wellbeing. The garden was secure and a place where people could enjoy the warmer weather.

Requires Improvement

Is the service responsive?

Our findings

Timperley Care Home used an electronic system for creating and using care files. Staff had access to two computer terminals and a laptop where they could read and write care plans and add to daily notes. Staff told us that there was sufficient access to the machines to enable them to use them whenever they needed.

On the front screen of the residents' register (i.e. the list of residents) there was a button enabling staff to print off easily an urgent admission pack, including a summary of care needs, in case someone needed to be transferred to hospital quickly. This meant that all vital information would go with the person to hospital.

There were multiple sections of the care plan which could be accessed on the system. The plans were thorough but were not written in a particularly personalised way. That means that they were not always made individual or specific to the person concerned. The same or similar phrases recurred in different people's care plans. For example, under the section of the care plan relating to mental capacity, one person's plan stated: "The Mental Capacity Assessment and associated care plan needs to be considered when delivering care." On another person's plan it stated: "The Mental Capacity Assessment and associated care plan needs to be used to assess needs." We saw other examples where the same sentences were used in different care plans. This tended to indicate a lack of personalised care planning and was perhaps the drawback of using an electronic system.

The advantage of such a system was that plans could be reviewed and updated easily. The electronic system flagged up five days before care plans were due for review, ensuring they were reviewed on time. We saw reviews, called evaluations, recorded with dates on the care plans. The latest date that each plan had been updated was also recorded.

We asked visiting family members whether they had seen their relative's care plan and whether they had been asked to contribute to it. Two family members told us they had been consulted about the care plans and were satisfied that they knew what was in them. One family member told us that they knew what medicines their relative was taking and what their purpose was. Residents who spoke with us said that staff were always approachable and available to answer any questions they had. One person said "The staff are very helpful."

We asked staff and the registered manager about what activities were available for people living in Timperley Care Home. The manager sent us after the inspection, as we had requested, a four week programme of activities. These commenced on Monday 13 May 2013, and did not necessarily represent the activities in February 2015. This was however presented to us as the current activity schedule. We saw that in that four week period there were a variety of activities laid on. They included Christian religious services which meant the spiritual needs of some people were being met. However, some of the activities might have had limited appeal, especially for men. For example in week 3 hairdressing was the activity on the Wednesday morning, and beauty care on the Thursday morning. On three afternoons in that week no activity was listed.

Some residents and relatives told us that there was little in the way of activities or stimulation. While we were observing in the main lounge the television provided the only activity, except for one person who was reading a book. Although we observed that staff were available to attend to people's personal care needs, they were generally busy and we did not observe them engaging in activities with people. We learnt that in the summer many people enjoyed the garden and watching the chickens. However, there was scope for increasing the range and scope of activities throughout the year.

On the Timperley Care Home website under "Latest updates" there was an account of zoo therapy, when small animals were brought into the home. However, this account was dated 8 January 2013.

We asked to see the complaints policy and records of recent complaints. One family member confirmed they had received the complaints policy when their relative moved in. We discussed with the registered manager one recent complaint and by way of example the process for dealing with it. We were satisfied that Timperley Care Home had a robust policy and procedure for dealing with complaints.

A prominent notice was advertising the next "relatives and friends" meeting which was taking place the week following our inspection. The previous meeting in December 2014 led

Requires Improvement

Is the service responsive?

to Timperley Care Home producing a handbook for all prospective new residents and their relatives, and a short questionnaire was sent to all of the current residents' families requesting their input and opinions as to what they would have liked to know about when visiting prospective care homes for their family members. One family member told us they were unable to attend these meetings because of the timing, but would appreciate receiving minutes of the meeting. The registered manager told us that meetings took place at different times and on different days, to accommodate as many relatives as could come. Another person said they had not attended any meetings, but had completed a questionnaire about their relative's care.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection, on 12 November 2014, we requested the provider to complete and send us a Provider Information Return (PIR). This is a set of details about the service which helps us prepare for the inspection. Providers should have this information readily available to them through the internal systems they are required to have to monitor and improve the quality of their service.

We sent the registered manager reminders by email on 17 December 2014 and 8 January 2015. The provider did not return the PIR or supply the requested information in another reasonable format. At this inspection the registered manager explained to us that she had delegated the task of completing the PIR to a manager who started in January 2015 and who was expected to become registered manager, but in fact left on 30 January 2015. We did not consider this a valid reason for failure to submit the PIR, especially as it was requested in November.

The provider had plans to build several new care homes in the North West and already owned one in Cheshire. The current registered manager had become Operations Manager for the North, upon the appointment of a person intended to be the new manager for Timperley Care Home in January 2015. One member of staff told us that during January the registered manager had been dividing her time between Timperley Care Home and the care home in Cheshire. The registered manager also told us that a lot of tasks in Timperley Care Home had not been completed in January. However, she stated that her focus had returned to managing Timperley Care Home. This followed the departure of the short term manager who had worked for the month of January. The plan was to appoint a new manager so that the current registered manager could resume her role as Operations Manager. Clearly a home of this size requires a full time registered manager.

The staff we spoke with were very positive about the quality of leadership and stated that the recent changes in the management had not affected them. One person said that the registered manager was very supportive. Recently appointed staff told us they felt well supported and valued. Staff told us that the registered manager was approachable and always willing to help with any issues.

The provider's draft learning and development strategy dated January 2015 stressed that "It is important that each employee understand the ...brand." We asked one member of staff whether they knew what the values of the home were. They replied "Dignity, respect and giving residents as much independence as possible." These values did not quite match the values promoted on the provider's website (namely: understanding, individualisation, improvement, dignity and independence). The staff member continued with the example of the home's dog, which belonged technically to the maintenance man, and was wandering around throughout the day and we saw that the dog brought pleasure to most (but not all) of the residents.

Relatives told us they were happy with the quality of the management team. One person told us that if ever they found a problem they could mention it to one of the clinical leads and it would be dealt with.

The registered manager told us she had taken up her post in October 2011 immediately prior to the provider acquiring Timperley Care Home from its preceding owners. She said she and the provider had worked hard to improve the home and to rebuild its reputation. She stated: "I am passionate about this home." We witnessed the registered manager herself cleaning one of the chairs in a lounge, thereby leading by example. The level of occupancy, which is one measure of how well a home is regarded, was high and had increased significantly compared with earlier years.

Responsibility for certain aspects of running the home was shared with two clinical leads, one on each floor, and with senior support workers, who supervised the support workers. In this way there was a well-defined management structure. Hence although there had been some issues regarding the management of the home in January 2015 and paperwork, the staff told us they had not noticed any adverse effect on people living in the home.

The registered manager stated that she or one of the clinical leads was always on call in the event of an emergency, and she could arrive within 15 minutes. She added that she came in from time to time during the night to do spot checks and ensure that everything was in order. Records of these checks were kept on the electronic system.

We saw there was a system of audits, including checking medication, care plans, health and safety, wound care and the working of the kitchen. There was a check that call bells in rooms were in working order. These audits were

Requires Improvement

Is the service well-led?

themselves checked each month by the development director who completed a monthly check record. We asked to see one of these forms. It included checks on progress with training, safety certificates, the environment, medication, care plan reviews and staffing levels. At the end was space for an action plan for any identified improvements. We spoke with the development director who confirmed that he conducted these audits and saw them as a valuable management tool. The most recent quality monitoring visit by Trafford Council had taken place in August 2014 and we saw the report of that visit, which was favourable.

Timperley Care Home had submitted notifications to the Care Quality Commission over the last year in a timely fashion. The one exception was the failure to notify the CQC of the rejection of a DoLS application in January 2015. In some instances we contacted the registered manager to request an update on developments, and this had not always been provided. We obtained a verbal update on these matters during the inspection. In one serious matter the registered manager had reacted appropriately by starting a disciplinary process.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements in place to meet the requirements of the Mental Capacity Act 2005 in relation to people who lack or might lack the capacity to make their own decisions.**