Horizon Residential Homes Limited

Middleton Hall Care Home

Inspection report

205-207 Grimshaw Lane
Middleton
Manchester
Lancashire
M24 2BW

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08 December 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Middleton Hall is a care home that provides 24-hour residential care for up to 24 people. At the time of our inspection there were 22 people living at the home. It is a detached building providing accommodation over two floors and is situated in the Middleton area of Rochdale. It is surrounded by a large garden. There is a small car park to the front of the property.

This was an unannounced inspection which took place on 7 and 8 December 2017. We last inspected the service in June 2014. At that inspection we found the service was meeting all the regulations we reviewed. Since then the provider of the service has changed. This was the first inspection for this service under its new provider.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found one breach of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to inaccurate documentation. You can see what action we have told the provider to take at the back of the full version of the report.

Medicines were stored safely. However, we found there was not always sufficient detail to guide staff contained in the 'when required' medicines protocols. We have made a recommendation about this.

There were systems in place to help safeguard people from abuse. Staff understood what action they should take to protect vulnerable people in their care. Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people. At the time of our inspection there were sufficient staff to respond to the needs of people promptly.

The home was clean, well-decorated and well-maintained. Maintenance checks on services and equipment were up-to-date. There were systems in place to protect staff and people who used the service from the risk of fire. Procedures were in place to prevent and control the spread of infection.

All new staff received an induction to the service. Staff had undertaken a variety of training which enabled them to carry out their roles effectively. They received regular supervision which provided them with opportunity to voice any concerns and plan their professional development.

Staff encouraged people to make choices where they were able. The service was working within the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People were happy with the quality of food provided. People who had poor dietary or fluid intakes had these

monitored. However, we found documentation to record this was not always accurate.

People who used the service were complimentary about the staff. We observed kind and caring interactions between staff and people who used the service. Care plans, which were reviewed regularly, were detailed and reflected the needs of each person.

People who used the service and staff spoke positively about the registered manager. There were a range of policies available for staff to refer to for guidance on best practice. Systems were in place to monitor the quality of the service and drive improvement. There was a complaints process in place, although there had not been any complaints during 2017.

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.

Arrangements were in place to safeguard people from harm. Staff had been trained in safeguarding and were aware of their responsibility to report any possible abuse.

Employee recruitment processes were in place and the required pre-employment checks had been carried out. This helped to ensure staff were safe to work with vulnerable adults.

There was a lack of detail in 'when required' medicines guidance.

Is the service effective?

Requires Improvement

The service was not consistently effective.

New staff received a thorough induction. Staff had received training in a variety of subjects which enabled them to carry out their roles effectively. Staff received regular supervision.

People told us they liked the food provided at the home. However, documentation used to record people's food and fluid intake was not always accurate.

Is the service caring?

Good

The service was caring.

People were complimentary about the staff. We observed kind and interactions between staff and people who used the service.

People's dignity and privacy were respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and were reviewed regularly to ensure they were up-to-date. A variety of activities were available for people to participate in.

The service had a system in place for receiving, handling and responding to complaints. No recent complaints had been received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a registered manager who people found to be approachable.

There were systems in place to monitor the quality of care and service provision at this care home. However, concerns we found during our inspection had not been identified.

Middleton Hall Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 07 and 08 December 2017. The first day of the inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using this type of service or caring for someone who uses this type of care service. On the second day one adult social care inspector returned to the service.

Before the inspection we reviewed information we held about the service. We looked at the Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make. We also reviewed the statutory notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay.

Prior to the inspection we contacted the local authority and Rochdale Healthwatch to ask if they had any comments or concerns about the service. Rochdale Healthwatch provided us with some positive feedback which they had received about the service. Healthwatch is the national independent champion for consumers and users of health and social care in England.

During our visit we spoke with the registered manager, three care assistants, the activities coordinator, seven people who lived at the home and two relatives. We looked around the home checking on the condition of the communal areas, toilets and bathrooms, kitchen and laundry. We also looked in several bedrooms after we had received permission to enter them. We spent time observing a lunchtime meal and the administration of medicines.

As part of the inspection we reviewed the care records of two people living at the home. The records included their care plans and risk assessments. We reviewed other information about the service, including training and supervision records, three staff personnel files, medicine administration records, audits,

meeting minutes and maintenance and servicing records.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living at Middleton Hall. Comments we received included, "I've not seen anybody bullied here. Never ever. I feel perfectly safe here. This is my home. The staff here I consider my family" and "We are happy with the staff.'' One member of staff said, "I would definitely recommend it (the home).''

All new staff received training in safeguarding adults and children as part of their induction programme and then subsequently as annual refresher training. The service had a safeguarding policy to guide staff on best practice. All safeguarding incidents were recorded and reported to the local authority safeguarding team so that investigations could be carried out when needed. Staff we spoke with were able to tell us how they might recognise signs of abuse and were aware of their obligation to report any bad practice they witnessed. No one we spoke with had any safeguarding concerns about the home or staff. One staff member told us, "I can't fault this place. I've never seen any bad practice.'' We saw that there were notices displayed throughout the home encouraging people to speak up if they witnessed poor practices. The notices said 'If you see something, say something.'

Staff employed by the service had been through a thorough recruitment process. We reviewed three staff personnel files and found that they contained all the relevant documentation, including an application form, interview record, reference checks, health questionnaire and photographic confirmation of identification. All staff had Disclosure and Barring Service (DBS) criminal record checks in place. These help the provider to make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

We looked round all areas of the home to check on the maintenance and cleanliness of the building. We found the environment was clean and free from unpleasant odours and the communal rooms were well-maintained and decorated to a high standard. However, the downstairs corridor carpet was stained. We were informed this was due for replacement within the next few months. There was an on-going programme to replace all the carpets and old flooring with modern laminate flooring. Steps had been taken to minimise risks to people from the environment. For example, radiators were covered, which minimised the risk people could burn themselves if they touched or fell against them. We saw that where there was an uneven surface in the corridor flooring, this had been highlighted by the use of hazard tape and notices to inform people to take care. Windows were secured with window restrictors to minimise the risk from people falling or climbing out of them.

We looked at what systems were in place to prevent and control the spread of infection. Toilets and bathrooms had adequate supplies of liquid soap and paper towels. Pedal bins were in all toilets and bath/shower rooms which meant soiled items could be disposed of correctly. We found that two toilets and a shower room did not have posters showing the correct handwashing procedure. We asked the registered manager for these to be provided. There was an adequate supply of personal protective equipment such as disposable aprons and gloves and we observed staff using these when necessary. For example, while serving food. Cleaning equipment such as mops and buckets were colour-coded to minimise the risk of germs being

spread across different areas during routine cleaning.

The home had a small laundry and disposable aprons and gloves were readily available for staff to use while handling soiled items. The registered manager told us there were plans to extend the laundry to make it a more suitable size. There were also plans to create a sluice room, as this was missing from the current layout of the home. A shower room (closed to people who used the service) was temporarily being used as a sluice room.

The kitchen had achieved a rating of five stars at the last food standards agency inspection in September 2017. This meant food ordering, storage and preparation were classed as 'very good'. We inspected the kitchen and found it to be clean and tidy and the cleaning schedules and records of fridge and freezer temperatures were up-to-date.

The home was secure. The entrance was kept locked and people could not enter the building without being let in by a member of staff. There was a 'signing in' book for visitors. This ensured staff were aware of who was in the building at any one time. There were no restrictions on people's movements within the building apart from in areas where it may not be safe, such as the laundry and kitchen.

All servicing of equipment, such as of the gas boiler, passenger lift, portable appliance testing (PAT) and hoists were up-to-date. Monthly checks on the call system, wheelchairs, window restrictors and peoples' rooms ensured equipment was well maintained and safe to use. Although a monthly check on the hot water temperature was carried out, there was no system for staff to check and record the hot water temperature prior to people bathing. We brought this to the attention of the registered manager. They arranged for this to be put in place so that risks to people from scalding while bathing could be minimized.

There were systems in place to protect staff and people who used the service from the risk of fire. A fire risk assessment had been carried out by an external company in March 2017. Firefighting equipment, such as extinguishers and the alarm system were regularly checked and the fire exits were all clear at the time of our inspection. Everyone living at the home had a personal evacuation escape plan (PEEP). PEEPs explain how each person would be evacuated from the building in the event of an emergency, and contain information about their mobility. These were kept in people's care records and also in a file in the reception area where they were easily available for the emergency services.

No one living at the home at the time of our inspection required assistance with moving through the use of a hoist. We were therefore unable to observe staff carrying out this procedure. However, we did observe two members of staff moving people in wheelchairs without resting their feet on the wheelchair footplates. People who are moved using a wheelchair should have their feet supported by foot rests to ensure good posture and to minimise the risk that their feet or legs might become trapped or damaged. We reported this to the registered manager who told us he would immediately raise the matter with staff to ensure this practice did not happen again.

We inspected the systems in place for the storage and management of medicines. Medicines were stored in a trolley which was secured to the wall in the locked treatment room. This ensured medicines were stored securely. The medicine's fridge temperature was recorded daily to ensure medicines were stored at the correct temperature to maintain their efficacy. Records we checked showed the temperature was consistently within the appropriate range. Some prescription medicines are controlled under the Misuse of Drugs legislation e.g. morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. We found controlled drugs were securely stored.

We observed a lunchtime medicines round and saw that this was carried out safely by a senior care assistant who had been trained and deemed competent in medicines administration. We reviewed the Medicines Administration Records (MARs) which contained information necessary for the safe administration of medicines, such as photographs of people living at the home and information about allergies. Those we reviewed had been completed correctly which indicated that people had received their medicines as prescribed. No one was receiving their medicine covertly, that is hidden in food or drink. However, the registered manager was aware of the process and documentation needed to ensure any decision made to give medicines covertly was agreed as being in the person's best interest.

Some people were prescribed one or more medicines to be given "when required", such as pain-relieving medicines. When medicines are prescribed in this way specific documentation is required which describes how staff can recognise if this medicine is needed and if it is effective. We found that although this documentation was in place, it was not detailed enough. For example, one person was prescribed a medicine to take when they experienced an angina attack. Angina is chest pain that occurs when the blood supply to the muscles of the heart is restricted. The documentation said that staff should give the medicine when the person experienced angina. However, there was no information about the symptoms of an angina attack, such as pain, breathlessness or feeling sick, to guide staff. Another person was prescribed two different medicines to treat pain. However, there was no information in their records to show which medicine staff should choose to treat any pain they experienced.

We recommend that the service review its 'when required' medicines protocols to ensure they provide sufficient information to guide staff.

The care records we reviewed showed that risks to people's health, such as falls and risk of pressure sores had been assessed. These were reviewed regularly to ensure they remained relevant. Accidents and incidents were recorded and reviewed to make sure risks to people were minimised.

We looked at staffing throughout the home. As well as the registered manager, there was an administrator, senior care assistants and care assistants. There were also staff to cover maintenance, the kitchen, the laundry, activities and cleaning duties.

Opinion was divided about whether there were enough staff. One person who used the service said, "They work so hard; more staff would be beneficial. They give up their lunch breaks to look after residents." Another told us, "Staffing is adequate but they could do with some help. They look after us very well; they think of the residents." A third person said, "For me, yes, there are enough." Two members of staff told us they felt there were normally enough staff working to respond to peoples' needs. However, one care assistant told us that occasionally there were only two care assistants working the day shift, instead of three, which they felt was not sufficient. They told us "We feel the pressure when there's only two.'' We looked at the staff rota for three weeks. Normal staffing was one senior care assistant and two care assistants working from 08.00 until 20.00 and an additional care assistant working from 08.00 until 14.00. We could only see one day where there was not the additional care assistant working from 08.00 until 14.00. The registered manager told us that very occasionally agency staff were used. However, most shifts that needed covering due to staff sickness were worked up by the regular care team. From our observations at the time of our inspection we found there to be sufficient staff to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

We looked at the training and supervision of staff. All new staff had an induction which covered a range of topics. It included principles of care (privacy, dignity, independence, choice and respect), safety at work, communication and recording of information, safeguarding, fire safety, infection control and moving and handling. A period of shadowing more experienced staff ensured new starters were competent before they were allowed to work unsupervised. We looked at the induction record for a member of staff who had recently joined the team. We saw that they had completed their induction and the record had been authorised by their mentor.

Staff undertook yearly mandatory training in fire safety, nutrition, moving and handling, health and safety, safeguarding vulnerable adults and children, infection control and basic life support. Other training, such as equality and diversity, pressure ulcer prevention and dementia was completed every three years. Training was provided either face-to-face, or through e-learning courses. The registered manager kept a training matrix which identified when staff needed to refresh their training. A recent training matrix showed that the majority of staff were up-to-date with training. We saw evidence that further training sessions had been booked for those people who needed to complete their refresher training in infection control, safeguarding, mental capacity and DoLs.

Records we checked showed that staff received supervision two or three times a year and an annual appraisal. Supervision meetings provide staff with an opportunity to discuss their progress and any learning and development needs they may have.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). All staff received training in the MCA, Deprivation of Liberty Safeguards and restrictive practice. The 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. During our inspection we saw that staff sought peoples' consent before undertaking any care or support task and always explained to people who used the service what they were about to do. People we spoke with told us that staff always asked for consent before giving care. One person said, "Oh, yes, they always ask first.''

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). At the time of our inspection there were seven people living at the home with an authorised DoLS in place. The registered manager kept a record of the expiry dates for all authorised DoLS to ensure new applications were submitted in time.

From reviewing the care files we saw that people who used the service had access to healthcare professionals, for example speech and language therapists and district nurses. During our inspection we spoke with one visiting healthcare professional who commented very positively about the home. They told

us that where people needed their outside support, such as for wound care, the registered manager always referred them promptly and that the service was quick to seek advice when it was needed. This meant that the service was effective in promoting the health and well-being of people who used the service.

People's nutritional requirements were assessed on admission to the home and were reviewed regularly. People were weighed monthly, or weekly if needed. A malnutrition universal screening tool (MUST) score was also recorded. The MUST score helps staff identify if a person is malnourished, at risk of malnutrition or obese. Where people were identified as having a poor diet or fluid intake they were commenced on a fluid and/or nutrition chart to record how much they ate and drank.

We looked at the diet and fluid charts for five people. We found that staff recorded the type of food eaten, but not the amount. Therefore nutritional charts did not give an accurate picture of each person's food intake. We discussed this matter with the registered manager during our inspection. He told us that this was an area for improvement that he had already identified and was in the process of devising a new and more detailed food monitoring form, which would also record the amount of food eaten. The use of this form has been implemented since our inspection.

Some people had their fluid intake monitored through the use of a fluid balance chart. We reviewed the fluid balance chart of one person who was prescribed two food supplement drinks per day. The fluid balance chart for two days showed no record that these supplement drinks had been given. Fluid balance charts for three people showed no record of drinks being offered or consumed after 16.30 on several occasions. One person's chart showed that they had received drinks totalling 760mls between 09.30 and 16.30. There was no record to show they had been offered a drink after 16.30 on this occasion. Therefore we could not be sure this person had received any fluids after this time. We could not be sure that fluid balance charts were an accurate reflection of people's fluid intake.

On one chart it had been recorded that a person had drunk 180mls at 15.00 and 180 mls at 16.30. However, we saw a member of staff completing this chart at 14.20. This was an inaccurate record of this person's fluid intake.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

All but one of the people we spoke with said that the food was good or better. The main meal of the day was in the evening, with a lighter meal, such as soup and sandwiches at lunchtime. People could have a cooked breakfast or cereals and toast if they preferred. People could have hot drinks and a biscuit between meals. One person said, "The food is excellent. It's all home-made stuff. And we have elevenses.'' Another person told us "I enjoy the food. Sandwiches like mum used to make. I have cereal every morning." However, one person told us they did not like the food, commenting, "It's not what I like. But I eat it don't I? Sandwiches – don't mention that to me, I hope I never see another one. I don't like fancy food, like tea cakes."

We observed lunch on the second day of our inspection. There were sufficient staff to serve the food and to assist those people who needed support with their meal. Most people sat at the dining tables. We noticed that the tables were not covered with clothes and no condiments or sauces were easily available. However, the food looked hot and people seemed to enjoy their lunch.

During our inspection we looked around the home to see how it was decorated and furnished and to check if it had been suitably adapted for the people living there. Some measures had been taken to make the environment 'dementia-friendly'. These included, pictures and words on signs for the bathrooms, showers,

toilets and communal rooms; menus with pictures and words; memorabilia on high shelves around the main lounge and carpets, floorcoverings, curtains and other soft-furnishings without 'busy' patterns. Stripes or strong patterns can be confusing and disorientating to people with dementia. There were also extra notices pointing in the direction of the toilets. There was some personalisation of bedroom doors, although the signs indicating the names of the occupants was small and could be difficult to read for those with visual impairments. There was a large clock in the communal lounge, which showed the correct time. However, there was nothing to show the date, day and season, which can be an effective way of helping to orientate those people living with dementia.

Bedrooms we viewed had been personalised with photographs, furniture and other personal effects. The home had two nicely decorated communal areas and a conservatory which led out onto the large secure garden. The garden, which was accessible to anyone using a wheelchair, contained raised beds, flower pots, garden furniture and a lawn.

Good

Is the service caring?

Our findings

We received positive comments from people living at the home about the caring nature of staff. One person said, "They're very kind; they go beyond with their generosity, way beyond what you expect'' and another said, "They're very kind, very considerate." A relative said, "The care these (staff) have given is fantastic.''

As part of their induction programme staff received training about dignity, respect, individuality and independence. All of the people who used the service who we spoke with told us that staff were kind, treated them with respect and listened to them. Comments included, "Yes, they respect me and do what I say – perhaps I frighten them off. I've no complaints yet.''; "Privacy and dignity are very high on their list. They always knock'' and "Yes, they always knock and wait at the bedroom door."

From our observations during the inspection we saw that staff supported and cared for people in a patient, kind and respectful manner and we saw caring interactions between staff and people living at the home. For example, we overheard a care assistant asking someone if they were warm enough. On another occasion we heard a care assistant asking a person where they would like to sit, and if they would like to join the staff sitting at a table. We overheard the maintenance person telling someone that he had planted some daffodil bulbs in the garden where they would be able to see them flowering in the Spring. We observed staff being attentive to peoples' needs.

People were able to choose what they wanted to do, such as the times they got up or went to bed. One person told us, "You can get up and go to bed when you like, but, if you're not at breakfast by 8.30 am, they'll come and check on you." Another said, "Of course I can, I get up, go to bed and so on when I want." We observed staff offering people choice, for example in what they would like to eat or drink.

All the people who used the service who we spoke with felt staff helped them retain their independence as far as possible. One person told us, "They let me walk, and wash and dress myself."

People living at the home were helped to maintain contact with family and friends. Visiting was allowed at any time and people were free to use the telephone to speak to friends and relatives. One person told us, "We can use the phone any time. We can have visitors at any reasonable time, preferably not at mealtimes; they encourage visitors to take us out." Friends and family were invited to residents' meetings, outings, parties and other events. From the notice board we saw that residents' meetings were held monthly and the minutes for the last meeting were posted there.

People were able to attend a religious service and take communion if they wished, as a priest from a local church visited the home every Sunday. Other people went out to a church service accompanied by their family.

From reviewing the care records we saw that staff monitored peoples' health by carrying out clinical observations of blood pressure, oxygen saturation levels, respiration rate and temperature every month. While this showed that staff had concern for peoples' health it was done as a matter of routine and there

was no evidence that people needed it or had requested it. We discussed this with the registered manager who told us they would review this practice.

Good

Is the service responsive?

Our findings

People we spoke with made positive comments about the home. One relative told us, "I'm very happy with the way things are.'' A visiting healthcare professional said, "I love coming in here. They are really friendly and helpful.'' Healthwatch Rochdale had received the following comment as feedback, "I've been at Middleton Hall Care Home now for around 4 - 5 years. It's a nice place to be - there are activities on a regular basis that you can take part in if you want to. The staff are friendly and welcoming - I feel well cared for here.''

We looked at the care records of two people living at Middleton Hall. A pre-admission assessment was carried out either at the person's home or in hospital and information gathered used to develop care plans and risk assessments. Care records we viewed contained detailed information to show how people were to be supported and cared for. Those we viewed were 'person- centred' as they contained personal information such as details about people's likes and dislikes, their life story, a social/leisure assessment and other information that was particular to each individual. Gender preference for carers was checked during the assessment process. Care plans and risk assessments were regularly reviewed with people and their families. Where people were able, they had signed their care plans to say they agreed with the content. For those people who were unable to sign their care plan, a relative had given their consent to the plan. Other information recorded in the care files included a record of any communication staff had with relatives and details of visits from outside healthcare professionals.

From our review of care files we saw that, where appropriate, consideration had been given to planning people's end of life care, such as the wishes for their preferred place of care. Where needed, a Do Not Attempt Resuscitation (DNAR) request was on file. Where people were receiving 'end of life' care, the home care team were supported by the district nursing service.

Visitors told us they were kept informed if there were any changes to their relative's health. One person said, "The slightest thing that happens to (name) they are on the 'phone.'' We were told that communication between staff and families was good and that staff showed a genuine concern for the welfare of relatives as well as for people living at the home. One person said, "They are very supportive of families'' and "I can talk to any of the staff.''

The home employed an activities coordinator who supported people to take part in a varied programme of activities. There was an activities board which displayed information about the week's activities, which included armchair exercise, bingo, card games, dominoes, quizzes, a film afternoon and a pamper session. One person told us "I don't take part in a lot of the activities. There's bingo, armchair exercises, days out, children's choirs are coming to sing carols, a pantomime. Everyone's involved. Or you can organise your own. I paint a bit.'' Another person said, "I crochet, read, go on outings – I'm looking forward to the pub trip today; my favourite tipple is whisky and dry ginger. I don't think there's anything else I'd like to do.'' On the first day of our inspection staff were escorting fourteen people out to a local pub for lunch and games. One relative told us that their family member was not keen on taking part in activities and liked to stay in her own room. She commented, "She chooses to stay in her room, but they go in and check on her.''

All staff attended a handover meeting at the start of their shift. Information discussed was recorded in the 'daily report book'. For example, we saw entries which showed that staff had contacted the district nurse, as a person was having problems with their catheter, and another entry showed that a request for a doctor's visit had been made when a person had a bad cough. Handover meetings are important as they ensure any alterations in a person's health or care needs are properly communicated. In addition to the handover meeting, the registered manager held an '11 o'clock meeting' several times a week. As well as discussing issues relating to people who used the service and the general day-to-day running of the home, the registered manager used this forum to consider topics about care practice, such as infection control or oral hygiene and to discuss recent accidents or incidents to see if there were any lessons to be learned.

The service had a complaints procedure which explained how to make a complaint and the timescale for receiving a reply. There was a written record of all complaints. This described the nature of the complaint, findings of any investigation, action taken and feedback to the complainant. The service had not received any complaints during 2017. All of the people who used the service who we spoke with knew how to make a complaint, but none had had cause to.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was present throughout our inspection. They had been in their current role for three months, having previously been the home's deputy manager. Prior to that they had worked at Middleton Hall for a number of years as a senior carer and had many years of experience working in adult social care. They are currently enrolled on a National Vocational Qualification level 5 course in management and leadership.

People spoke positively about the registered manager and told us they were approachable. One relative said, "He's spot on with everything''. One care assistant said "(Name) takes on board what you say – he will sort out any concerns about residents.'' The registered manager told us they had good support from the home's owner and received supervision every few months. They had daily contact with the owner in order to discuss any concerns or problems. The registered manager told us this was particularly helpful as they were new to a managerial role. This helped ensure there was oversight of the day-to-day management of the home.

The registered manager took time during each morning to walk around the home. This enabled them to check on the cleanliness and safety of the environment, staffing levels and to observe care being carried out by staff. It also gave them the opportunity to speak to people who used the service and staff about any concerns they had.

The registered manager carried out a number of audits to monitor the quality of the service. These included monthly environmental checks on the standard of cleanliness and safety of the building, furnishings and equipment and monthly checks on medicines administration systems and care files. We reviewed recent audits and found they had all been completed.

There were a range of policies and procedures to guide staff on best practice. The service had recently signed up to an external company which provided up-to-date policies to social care providers. They were in the process of reviewing these to ensure they were relevant and appropriate for Middleton Hall. Policies were available in printed format, so that they were accessible to staff, but were also stored electronically. The registered manager told us they were in the process of making the electronic copies available to staff and that the system would identify when staff had accessed and read the policies. This would give the registered manager oversight of staff use of policies and ensure all necessary policies were read and understood.

The service had carried out a survey in May 2017 to gather opinions and views about the home and the care provided. Questionnaires were sent to people who used the service, relatives, staff and external health professionals. We saw that responses had been analysed and a report and action plan developed. This showed that the service was receptive to feedback. The survey report was displayed in the reception area.

The service had links with local schools. Some children had recently completed a work experience placement at the home, helping out with activities. They had hand drawn a large Christmas mural which

was on display in the dining room. A school choir was booked to visit the home during the Christmas period to lead carol singing.

The service had a statement of purpose which was displayed in entrance hall. This document provided information about the home's core values, objectives and the services and facilities it offered. It provided people with the information needed to make an informed decision about the suitability of the service for themselves or a relative.

The registered manager was aware of their responsibilities and ensured statutory notifications were sent to the Care Quality Commission when required. Statutory notifications are changes, events or incidents providers must tell us about.

This service cannot be judged as good in the well-led domain because we have identified a breach of one of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where a breach has been identified in a domain the well-led section cannot be rated as good.

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 Documentation for recording diet and fluids was not always completed accurately.