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Honiton Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Honiton Manor Nursing Home offers accommodation with nursing care and support for up to 22 older people. There were 19 people using the service at the beginning of our inspection.

This inspection took place on 18, 27 and 28 February 2017. The first two days were unannounced and we arranged to go back on the third day to spend time with the registered manager and partners. We initially carried out a focussed inspection on 18 February 2017 to follow up on the findings of the previous inspection in August 2016 where we had found a breach of legal requirement. However because of concerns found at this inspection we changed the inspection to a comprehensive inspection.

The breach found at the August 2016 inspection related to people not being protected from unsafe and unsuitable premises. In particular, we highlighted scald risks from the hot water supply and windows on the first floor which were not restricted to prevent vulnerable people from the risk of falling out. Following the inspection we were sent an action plan which set out the actions the provider was going to take.

At this inspection we found the actions set out in the action plan had been taken regarding the concerns. However, the water temperature was still higher than the recommended temperature. The provider had followed their action plan by completing monthly room audits and fitting a temperature restrictor at the boiler. This had not been successful at keeping the water temperature at the recommended temperature. The registered manger was monitoring the water temperature each week and had found at times temperatures were above the recommended. The provider decided during the inspection to order thermostatic mixing valves (TMVs) and had arranged for a plumber to fit on all water outlets accessible to vulnerable people. We received confirmation after the inspection from the registered manager that TMV's had been fitted to all hot water taps accessible to vulnerable people.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had taken on additional responsibilities since our last inspection. They were now the area manager for the provider and were supporting the manager at the provider's other service. This had meant they had delegated some of their responsibilities to the deputy manager. The provider was planning for the deputy manager to apply to the Care Quality Commission (CQC) to be registered as joint registered manager of Honiton Manor. We discussed the delegated time allocated to the deputy manager to undertake these responsibilities.

Medicines were not always safely managed. On the first day of our visits we found the medicines room was not locked which meant medicines were not safely stored. We also observed poor administration techniques not in line with the provider's medicine policy by one registered nurse. The medicine fridge was unlocked, advance recording of the temperature of the medicine trolley had been documented and a

discrepancy in the recorded amount of one medicine. When we returned the medicine record was accurate. We were made aware of how the inaccuracy had occurred. We observed that on these days medicines were being safely administered and stored. The registered manager and partners were taking action in relation to the concerns we identified.

There were adequate staffing levels to meet people's needs. People felt there were enough numbers of staff on duty and that staff responded to bells promptly. Care staff received regular training, supervision and appraisals. However the registered nurses at the service had not received formal supervisions and appraisals since 2014. They had received the provider's mandatory training but had not had their competency assessed regarding medicine administration and training if required.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Care staff had received training and developed skills and knowledge to meet people's needs. However, registered nurses had not had their competency assessed in relation to medicine administration and their understanding. This would enable the registered manager to ensure they were competent to administer medicines and arrange training where there were concerns.

Measures to manage risk were in place to protect people's freedom in the least restrictive way.

Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate. Visitors were made welcome and kept informed.
Care plans were personalised and recognised people's health needs. At the last inspection the staff were transferring information from the provider's old care plan system onto a new one. At this inspection we raised concerns with the registered manager that information from the old system had not been transferred to the new care plans which were now in use. Therefore information regarding people's behavioural and psychological needs was not easily accessible. However, care staff had guidance from bedroom care plans which contained a synopsis of people's needs which was reviewed monthly.

People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to review and improve the service. However these had not identified areas of concern we identified. Where there were concerns or complaints, these were investigated and action taken. With the exception of the hot water the premises and equipment were managed to keep people safe.

There are breaches of regulation. You can see what action we have taken at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People remained exposed to the risk of accessing hot water above the recommended guidelines. Action has now been taken to resolve this.

Medicines were not always safely managed by all staff.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff received regular training, supervision and appraisals. However the registered nurses at the service had not received formal supervisions and appraisals. They had received the provider's mandatory training but had not had their competency assessed regarding medicine administration and training if required.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (2005) was followed.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

Staff were caring and kind. They respected people and treated them as individuals and included them in decision making.

Staff recognised the importance of maintaining family contact. Visitors and friends were welcomed.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed. Care plans were developed to meet people's needs. However improvements were needed to ensure information was transferred from the old care plan system to the new system.

People had been involved in planning their care.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was an audit program to monitor the quality of care provided and ensure the safe running of the service. However the provider had failed to identify some of the concerns we identified.

Where they had identified some water temperatures were above the recommended guidance action had not been taken to protect people.

There had been changes to the registered manager's role and responsibilities. This meant the deputy manager had new designated responsibilities which had added additional pressure at the service.

People's views and suggestions were taken into account to improve the service.

Honiton Manor Nursing 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 was 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 18, 27 and 28 February 2017. The first two days were unannounced and we arranged to go back on the third day to spend time with the registered manager and partners. The inspection team consisted of an inspection manager on the first day and an adult social care inspector on the second and third day.

The provider was in the process of completing a Provider Information Return (PIR) as requested by the Care Quality commission (CQC). 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. They sent us the completed PIR after the inspection so we reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from two people who were able to tell us about their experiences. We also spoke with two visitors to ask their views about the service.

We spoke to 13 staff, including the registered manager, deputy manager, registered nurses, senior care workers, and care workers, the cook, kitchen assistant, housekeeping staff and three of the partners.

We reviewed information about people's care and how the service was managed. These included three

people's care records and five medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits, risk assessments and minutes of residents and staff meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Requires Improvement

Is the service safe?

Our findings

People were comfortable and settled at the home and one said they felt safe. They commented, "I feel safe here… if I had a concern, I could take it to anyone, they are all approachable."

At our last inspection in August 2016, there was a breach of regulation. This was because people were not protected from unsafe and unsuitable premises. In particular, we highlighted scald risks from the hot water supply and windows on the first floor which were not restricted to prevent vulnerable people from the risk of falling out. Following the inspection we were sent an action plan setting out the actions the provider was going to take. This included restricting the water temperature at the boiler and fitting window restrictors on first floor windows. At this inspection we found they had completed the actions set out in their action plan advised by their plumber but these had not resolved the issue. On the first day of our visit we identified eight water outlets with a hot water temperature of 50°C and the window on the main staircase was not restricted. We discussed this with the deputy manager on the day of the inspection to make them aware of our concerns.

On the second day of our visit the provider had ordered thermostatic mixing valves (TMVs) which had arrived at the service and were waiting to be fitted by a plumber. We were told the TMV's would be fitted to all water outlets accessible to vulnerable adults. They would be set to ensure the water did not exceed the Health and Safety Executive (HSE) recommended temperatures of being no hotter than 44°C. There had been weekly checks undertaken by the registered manager to ensure that water temperatures did not exceed the recommended guidance. On 30 January 2017 they had identified three rooms with a temperature of 48°C and on the 6 February 2017 they were all below 42°C. On the 20 February 2017 two days after our first day of inspection nine rooms were recorded at 48°C and all the rest were 42°C. The registered manager had put hot water warning signs to make people aware of the water temperature. They said they had discussed with the partners that the installation of the TMV's were prioritised to rooms where hot water temperatures had been identified. Following the inspection we were made aware that the TMVs had been fitted to all hot water outlets accessible to vulnerable people. The registered manager also said they ensured people were safe when they supported them to have a bath. Staff checked the water temperature using a thermometer to ensure the water was a suitable temperature to prevent people from being scalded. One person said, "I have a bath on Monday. They run it for me, the temperature is 35°C, they put in a thermometer to check."

We discussed the window on the staircase which was not restricted with one of the partners and the registered manager. The registered manager said there was nobody staying on the first floor at the service who used the stairs. They hadn't felt the window opening was a risk because it was quite high and not easy to get to. However, they discussed it with the partner and decided to have a restrictor placed on the window. This was in case someone new came to the service who might be at risk. This was put in place while we were at the service.

Medicine management at the home was not always safe. People's medicines were administered by registered nurses. On the first day of our visit we observed medicine administration practice not in line with the provider's policy. Medicines were administered without reference being made to three people's

medicine administration records (MAR). Once these medicines had been administered the registered nurse had not recorded on the MAR the medicines given. This meant people were at risk on that day of receiving incorrect medicines. Medicines at the home were stored in a designated medicine room and trolley. On the first day of our visit the medicine room and medicine fridge in the room was unlocked until we requested it was locked. This meant people's medicines were not safely stored. The provider's medicine policy required that the temperature of the medicine fridge, medicine room and medicine trolley were recorded each day to ensure medicines were stored at the correct temperature. On the first day we identified that the temperature recording for the medicine trolley had been populated for two days in advance. This meant poor practice could put people at risk of receiving medicines which had been stored at temperatures outside the recommended guidance. We also identified a discrepancy in the recorded amount of one medicine. When we returned on the second day the medicine record was accurate and we were made aware of how the inaccuracy had occurred. This was because a system was in place to monitor the receipt and disposal of people's medicines however an entry had been missed.

On the second day of our visit we looked to see if there were systems to ensure medicines were safely managed at the home. The registered nurses had all signed that they had read and understood the provider's medicine policy. Medicines had storage arrangements at the service in accordance with the relevant legislation. On the second day the medicine room and medicine fridge were locked and no inaccuracies in stock were found. The temperatures of the medicine fridge, medicine room and medicine trolley all reflected the temperatures found. The deputy manager and registered nurse were seen during our visit on the second and third day administering medicines in a safe way. They had a good understanding of the medicines they were giving out to people and followed the provider's policy.

Prescribed creams were recorded on people's medicine administration records (MAR). The information was transferred on to a topical cream chart to be signed when topical creams had been administered. This guided staff which cream to use, where it should be applied and the frequency of the cream application. The deputy manager undertook monthly medicine and cream audits. These included checking that creams had recorded the date of when they were opened and within the recommended usage time and accurately reflected people's prescriptions.

Our observations and discussions with people, visitors and staff showed there were sufficient numbers of staff on duty to keep people safe. During our visits there were very few call bells ringing but these were answered in a timely way and staff were busy but not rushed. One person said, "Staff get here quite quickly." The staff schedule showed during the morning and afternoon there was a nurse on duty with four care staff; they were joined by the activity person on week days between 8am and 10am who undertook care duties supporting people to get up. At weekends when the activity person was not working care staff started at 7am and hour earlier so people's needs were still met. At night there was a nurse and one care worker. In addition to the nurses and care staff there were housekeeping staff who also undertook laundry duties. There was also a maintenance team led by one of the partners, a cook, a kitchen assistant, an activity person all of whom interacted with people while undertaking their roles. Staff told us agency staff weren't used if there was sickness, but that staff were willing to provide cover.

At the time of our inspection the deputy manager and staff confirmed there were 11 people who required help with their continence and at times and required two staff to assist them to transfer. This could mean at night if the registered nurse was busy administering medicines and these people required assistance, they would have to wait until the nurse was free to assist. We discussed the night cover with the registered manager, two partners and the deputy manager. They said they monitored the staff levels and spoke with staff. The registered manager had completed a night shift on the morning of our second visit, the deputy manager had undertaken shifts the previous weekend and a partner's family member also undertook

regular night duties. They all confirmed the staff level was enough to meet people's needs. The registered manager and partners said if they felt there was a need they would implement a twilight shift as they had in one of the provider's other homes.

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. Staff were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the registered manager or the deputy manager about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. Staff said "We wouldn't wish to have people being treated badly". The registered manager was aware of their responsibilities in regard to safeguarding people.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, nutrition and manual handling. People assessed as at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. Risk assessment were also undertaken for the environment. For example, risks were assessed regarding trip hazards, hot trolleys, kitchen equipment, laundry and storage of chemicals. The assessor looked at the hazard, the location of the hazard and assessed the risk. They then put in place control measures to reduce the risk of injury.

With the exception of the hot water and the window on the staircase the environment was safe and secure for people who used the service and staff. One of the partners with a team of maintenance staff over saw the maintenance at the service. They undertook regular checks of the service which included checking bed rails, portable appliance testing (PAT) and checking wheelchairs. The maintenance team also undertook a monthly room checklist. This looked at whether doors closed fully, condition of carpets, whether wardrobes were secure, drawers were running smoothly and window restrictors were in place. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance team.

External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. During our visit on the third day an unscheduled fire alarm was activated. Staff all attended the fire point promptly and staff were sent to investigate in line with the provider's policy. On this occasion it was found to be a false alarm due to a smoke detector being removed.

The home had recently been refurbished in the main lounge and entrance hall as part of the provider's redecoration programme. This included new curtains, carpets and appropriate chairs to meet people's needs. The provider information return (PIR) said, "New lounge furniture in place, all chairs have inbuilt pressure reliving cushions built in to them." The home was clean throughout without any odours present and had a pleasant homely atmosphere. Staff had access to appropriate cleaning materials and to personal

protective equipment (PPE) such as gloves and aprons. The laundry was tidy and clean and had adequate chemicals and processes to ensure the lint filters were cleaned regularly. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal emergency evacuation plans (PEEP's) which took account of people's abilities, the assistance they required, room location and equipment needed. These were held in people's care files and a synopsis for quick access was in the fire book accessible to the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

Accidents and incidents were reported in accordance with the organisation's policies and procedures. They were reviewed by the registered manager to identify ways to reduce risks as much as possible and relevant health professionals and relatives were informed. Since our last inspection there had been two falls. The registered manager was aware of both of these and had ensured appropriate action was taken to reduce the risks.

Requires Improvement

Is the service effective?

Our findings

People received care and support from care staff that received training and support on how to undertake their role safely and effectively. The mandatory training staff and registered nurses completed included, Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), equality and diversity, fire safety, food hygiene, basic first aid, health and safety, infection control, moving and handling, person centred approach and safeguarding vulnerable adults. Staff were positive about the training they received. One visitor said, "I am quite impressed with the staff."

The Nursing and Midwifery Council (NMC) is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. In order for registered nurses to remain on the NMC registered they are required to complete a revalidation process which involves demonstrating they have kept up to date with their registration requirement regarding competence and knowledge. The registered nurses at the service had completed the provider's mandatory training and undertook refresher training. They had taken some additional training to support them to undertake their roles. These included syringe driver training (a small infusion pump used to administer medicines under the skin often to keep people comfortable at the end of life), venepuncture (taking blood), catheterisation and verification of death.

There was no system used by the provider to assess the registered nurses competency regarding their medicine management skills and if required provide training to update and improve their practice. No registered nurses at the home had completed medicine training with the exception of the registered manager. Therefore the provider could not be sure that all registered nurses employed at the service were following current guidance by their professional registered organisation in relation to medicine management.

Care and support staff confirmed they received supervision on a regular basis. Staff had regular supervisions and an annual appraisal. The registered nurses had not received an annual appraisal since 2014 and had also not had regular formal supervisions. However, the registered manager said they were a small team of six and they worked alongside them and discussed concerns on an on going basis.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager wrote to us to make us aware they were undertaking appraisals with all of the registered nurses at the service. The action plan also sent said all registered nurses would have a supervision to commence in March 2017. They were undertaking medicine competency assessments on all of the registered nurses and medicine administration training had been arranged for one registered nurse who had demonstrated poor practice.

Checks were made by the registered manager to ensure nurses working at the home were registered with the NMC. The registered manager was aware of the NMC revalidation process and said they would be

meeting with the registered nurses to support them.

New staff were supported to complete an induction programme before working on their own. Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. New care workers who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. The provider said in their provider information return (PIR), "New staff have an induction process and work with an experienced care staff member for as long as required with the minimum being one week. Induction period lasts for up to three months where the (training provider) books are completed." When staff did not feel they had the skills to undertake a task there was no pressure on them to do so. For example, one care worker felt they did not have the skills necessary to support a person with their meal due to their complex care needs.

The MCA provides a legal framework for making particular decisions on behalf of people who 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 authorisation procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home was meeting these requirements. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

The registered manager had a clear understanding about the principles of the MCA. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions. Staff had completed capacity assessments for people and considered people's capacity to make particular decisions. Best interest decisions had been undertaken regarding the use of bedrails.

People, or their legal representatives, were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. People's rights were protected because the staff acted in accordance with the MCA

People had access to healthcare services for on going healthcare support. The local health centre had a designated GP who undertook regular weekly visits to the home. They said it had been helpful with the continuity and they had no concerns. Staff also supported people to have regular health appointments such as with the dentist, optician, and chiropodist. People's care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Staff worked with health professionals such as the community nurses, dietician, speech and language therapist (SALT), occupational therapists and physiotherapists. For example, staff had been working very closely with a diabetic nurse to help stabilise a person's blood sugar level. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately.

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu plan and people had a choice of two main meal options at lunchtime. When a new person came into the home, staff informed the cook about their likes, dislikes and meal requirements. There was also a white board in the kitchen and a laminated card for people's trays where their dietary requirements were recorded so all staff would be aware. Staff asked people the day before about their meal choices.

We observed two lunchtime meals in the dining room during our visit. There were five or six people using the

dining room. There was also a white board in the dining room to advise people of the mealtime option while they were waiting for service. One person said, "Sometimes they don't serve lunch in the dining room if not enough staff … happens frequently and makes me cross because I like a change of scenery." We discussed this with the registered manager that the dining room was not being used by so many people as it was at our last inspection. They confirmed this was because of people's needs and choice but would look into the concern. On the first day of our visit the meals were served in the kitchen and taken to the dining room and there was not always a staff member present. This was changed on the third day of our visit where the cook served people's meals in the dining room with a staff member present. Having the kitchen staff in the dining room enabled them to ask people about quantities, and condiments they wanted, likes and dislikes and whether people wanted any more.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented. Staff were aware of action to take in the event of someone having a choking incident. This included ringing the emergency bell and back slapping. Where people had specialist dietary requirements these were catered for. These included meals for diabetes and lactose intolerant.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people. People were seen positively interacting with staff, chatting and laughing. People said they were happy at the home. One person commented, "They look after me in a happy jolly way." One member of care staff said, "It's a family atmosphere here." A relative commented "Very happy, no problems, things get sorted if needed. Staff are very good". Another said "Staff have been very good, caring, keeping their eye on (name of person), no issues at all".

People received care and support from staff who had got to know them well. The relationships between staff and people demonstrated dignity and respect at all times. When staff were supporting people to the dining area. They were patient and took their time and were seen happily chatting on the way. Staff spoke to people in a caring, respectful and compassionate way. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care.

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted us and people with a warm welcome and positive body language. The atmosphere at the home was calm throughout our visits.

Staff knew people's individual communication skills, abilities and preferences. One person was unable to use a call bell and so a monitor had been placed in their room so they could call out if they required assistance. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews, daily chats with the management team and annual surveys.

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors were made to feel welcome when they came to the home. People's rooms were personalised with their personal possessions, photographs and furniture.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. The provider said in their provider information return (PIR), "This is often our resident's last home and we feel we give excellent end of life care to them in the final stage of their life. Family often tell us how supported they felt through this difficult time. When one of our residents is dying, the families are welcome to stay for as long as they wish with their relative and we provide extra support during this time."

Good

Is the service responsive?

Our findings

People received personalised care that aimed to meet their individual needs. People confirmed the daily routines were flexible and they were able to make decisions about the times they got up and went to bed, how and where they spent their day and what activities they participated in.

People's individual needs had been identified by staff and were having those needs supported. At the last inspection the provider was in the process of changing the care recording system they used. At this inspection we identified some care plans had not been transferred onto the new system. These included, behavioural and psychological care plans. The registered manager and two partners had already identified that the new system did not have a place to record these needs and were putting in place a new format to record these areas for people. This would ensure staff had clear guidance about how to support people with behavioural and psychological needs. We also identified that because the care plans had been written on the computer, they were not always signed and dated to demonstrate who had written the information and when. The registered manager said they would request that the registered nurses review everyone's files to ensure they were all signed and dated.

Care plans were held in a main file in the office. There were also care worker care plans which were held in people's rooms. These contained information to the care staff about how to meet people's needs. These were reviewed each month by the deputy manager to ensure they accurately reflected the care support people required and included behavioural and psychological needs. Care staff were able to describe the care needs of people at the home and how they should support them.

The registered manager and deputy manager had identified staff had only recorded information related to care delivery and clinical tasks in the care files. They had given staff guidance to ensure these were written in a more person centred way to determine the person's views, mood, wishes and events of the day. We saw daily entries the week leading up to the inspection were more person centred.

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop care plans. Care files included personal information and identified the relevant people involved in people's care, such as their GP. Care plans gave information about people's activities of daily living and showed that staff had involved other health and social care professionals when necessary.

Nurses completed monthly reviews of people's risk assessments and care plan reviews of designated individual people's needs. Care plans had been reviewed in a timely way. People and their families were given the opportunity to be involved in reviewing their care plans.

Staff had a staff handover meeting at the changeover of each shift. Key information about each person's care was shared any issues brought forward. Staff also used a handover sheet which was populated with

people's information which included their dietary needs, allergies and health needs. For example, one person's identified the person had no verbal communication and another had no self-movement due to a health need. This meant staff were kept up to date about people's changing needs and risks.

People were supported to take part in social activities. A designated activity person was employed to undertake ten hours a week of activities. They undertook care duties at the beginning of their shifts from 8am to 10am.

A newsletter was produced each month for people to be aware of the activities arranged. Time was also dedicated to visit people on a one to one basis who did not want to, or were unable to, be involved in group activities.

People had the opportunity to join in group activities. The activity person used a tick sheet to record activities people had been involved in. This enabled the registered manager to have an oversight all people had the opportunity to partake in regular meaningful activities. However, there was no means for the activity person to record how people had found the activities and the exact activity they had undertaken. The registered manager and partner said they were looking to introduce an activity folder. This would be used to record more detail about activities people had taken part in and the outcome of the activity, for example had they enjoyed it.

People and their relatives knew how to share their experiences and raise a concern or complaint. People were confident the registered manager would listen and take action if required. There was a complaints procedure displayed in the main corridor at the service. The procedure included information about the external agencies people could contact if they were not satisfied with the response from the service. There had been no complaints since our last inspection. The registered manager said "We encourage residents and their families to come and see us when it is a niggle before it becomes a problem."

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. The provider had a range of quality monitoring systems which were used to review and improve the service. The quality assurance systems used at the home had identified some areas of concern but not all. The provider had not identified poor medicine administration practice, no system for registered nurses working at the service to have a formal supervision and an annual appraisal and not all care plans were signed and dated. The provider had recognised that all care records information had not been transferred to the new care documentation system but had not taken action to put this in place. The registered manager had identified risks regarding the temperature of some hot water outlets which posed a risk to vulnerable adults but had not acted upon the concern identified. This meant people were exposed to risk of scalding.

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

Audits which were carried out included an infection control audit, monthly air mattress audit and profile bed audits. This looked at the air mattresses, their setting and staff were guided regarding the settings required for each person. Wheelchair audits, to check footplates, brakes and safety strap. Where concerns were identified these were reported to the maintenance team. The deputy manager reviewed the audits at the end of the month to ensure actions had been carried out. A three monthly bedrails audit was completed to look at gaps and check positioning in line with health and safety guidance. The registered manager and deputy manager had put in place a care records audit which they were implementing at the time of the inspection.

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager was supported by a deputy manager. Since our last inspection the registered manager had taken on an additional role for the provider as an area manager. This meant they supported the manager at one of the provider's other services and was at Honiton Manor for two days a week. They had therefore needed to delegate some of their responsibilities to the deputy manager.

The deputy manager had increased their working hours since our last inspection but undertook nursing duties for the majority of the time they were working. During our visit we identified they needed to answer the telephone, deal with health professionals, prioritise their work and deal with managerial issues as well as be responsible for dealing with day to day clinical issues. At the last inspection we discussed the fact the registered manager had undertaken a lot of additional shifts which had meant they had to prioritise their managerial duties. The partners had taken action and had increased the deputy manager's hours. We discussed this with the registered manager and two partners. They said the role of area manager the registered manager had undertaken, had needed more input than originally thought. They said they would look at ways to ensure the deputy manager had time to undertake their delegated responsibilities and to undertake their nursing shifts safely.

The deputy manager and registered nurses had a clear understanding of their clinical responsibilities and

referred people appropriately to outside healthcare professionals when required. The service had an on call system which was shared by the registered manager and deputy manager. This meant at all times staff were able to have someone they could contact if there were concerns at the service they were unsure how to deal with. The staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care.

There are four partners who are the registered provider. The registered manager was supported by the partners of the service who undertook different roles. One was at the service most days and oversaw maintenance. Two others visited most weeks and spoke with people and staff to ascertain their views; however they did not formally record this. The fourth partner dealt with financial responsibilities. The registered manager, deputy manager and staff confirmed they were supportive and listened to concerns and issues and took action when needed. One staff member said, "Good relationship with them. Everything ticks along very nicely."

The registered manager had been working with the local authority, Quality Assurance and Improvement Team (QAIT) at one of the provider's other services. They were intending to implement some of the documents they had recommended at Honiton Manor.

There were accident and incident reporting systems in place at the service. The registered manager checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

People and staff were actively involved in developing the service. A residents and relatives meeting was held twice a year. The last meeting held in February 2017 discussed the progress of the refurbishment of the lounge, menus and trips. It was recorded that people said "They could talk to (the registered manager and deputy manager) at any time."

Staff meetings were held every three to four months. The registered manager also met with the kitchen and housekeeping staff to discuss issues specific to these roles. Records of these meetings showed staff were able to express their views, ideas and concerns. The record of the last staff meeting in February 2017 showed staff discussed topics including, care plans not being task orientated, infection control concerns, uniforms, staff sickness and maintenance. The registered manager had fed back to the staff positive comments made by people at the residents meeting.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person, occurred. They notified the CQC as required and provided additional information promptly when requested.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes which were effective to ensure the safety of the service provided. 17 (1)(2)(a)(b)

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 RA Regulations 2014 Staffing The provider had not ensured all staff had received appropriate supervision and appraisal to enable them to carry out the duties they are employed to perform. The provider had not supported registered nurses employed at the service to demonstrate to their regulator that they continued to meet professional standards required in order to practice. 18(2)(a)(c)