Care UK Community Partnerships Ltd

Ponteland Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 2, 3 and 4 May 2017. The first day of the inspection was unannounced and the second and third day was announced. This meant staff did not know we were visiting on the first day.

We last inspected the service in September 2016 to follow up concerns from the previous inspection where improvements were required in the safe domain of the report. At the inspection in September we found that improvements had been made in the areas we found previously but we found further issues that needed to be addressed so the domain remained as requiring improvement. We returned to check all areas were now meeting the regulations fully.

Ponteland Manor provides nursing and residential care for up to 52 older people, some of whom were living with dementia. At the time of this inspection there were 33 people living at the home, including 18 with nursing needs

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager who was in the process of registering with the Commission no longer worked for the provider.

People said they received good care from kind, caring and considerate care workers. They also confirmed they felt safe living at the home. Relatives and care workers also told us the home was safe.

Care workers knew how to report safeguarding concerns. We found the provider had dealt with previous safeguarding concerns appropriately.

Where potential risks had been identified, an assessment had been completed to keep people as safe as possible. Accidents and incidents were logged and investigated with appropriate action taken to help keep people safe. Health and safety checks were completed and procedures were in place to deal with emergency situations.

Medicines were managed safely. Only trained nurses and senior care workers administered medicines. People confirmed they received their medicines at the correct time and they were always made available to them.

We found there were sufficient care workers deployed to provide people's care in a timely manner. However a number of people and relatives felt staffing levels were not appropriate at times. We have made a recommendation to the provider regarding review of staffing numbers.

Effective recruitment checks were in place to help ensure new care workers were suitable to be employed at the service. Staff received the support and training they required. Records confirmed training, supervisions and appraisals were up to date and pre planned for the future.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People gave positive feedback about the meals they were served at the home, although some attention was required for those people with special dietary needs. People received the support they needed with eating and drinking. Some people had been referred to external healthcare professionals for additional specialist support, for example those at risk of choking. We have made a recommendation with regards to food choices for people with diabetes.

People and their relatives were positive about the kind and caring nature of staff. People were supported by care staff who were aware of how to protect their privacy and dignity and show them respect at all times.

People's needs were assessed before they came to live at the service and then personalised care plans were developed and regularly reviewed to support staff in caring for people the way they preferred.

A new activity coordinator had just started work at the service in the same week as the inspection and was in the process of getting to know people and their likes and dislikes in terms of the activities they liked to participate in.

'Residents' and relative meetings were held so that people could share their views and suggestions.

People knew how to complain. Previous complaints were investigated and resolved in line with the registered provider's complaint's policy.

We received mixed views regarding the previous manager. Some people and relatives said they were good and seemed to get "things" done, but many staff said that they were not very person centred and many felt they could not approach them with any concerns for fear of repercussions. There was a consensus that other senior staff at the service were supportive and approachable.

There was a range of internal and external quality assurance audits in place to check on the quality of people's care and make improvements where necessary.

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.

People, relatives and staff told us the service was safe.

Staffing levels were sufficient to meet people's needs. The provider had effective recruitment checks in place.

The management of medicines was in line with safe practice.

Staff knew how to report safeguarding and whistle blowing concerns. Safeguarding referrals had been submitted to the local authority when needed.

Is the service effective?

Good

The service was effective.

Staff received the training and support they required. Records confirmed supervisions, appraisals and training were mostly up to date or planned.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA).

People were provided with food and refreshments which met their nutritional and health care needs.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and respectful of the people they supported.

Staff treated people with dignity and supported them to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and individualised care plans developed. People had choice in their day to day lives.

There were opportunities for people to take part in activities.

People knew how to complain and complaints were investigated in line with the provider's complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service did not have a registered manager in place and the recent manager no longer worked at the service.

There were mixed views about the previous manager, although everyone agreed that other senior staff were supportive and approachable.

A range of internal and external audits were carried out to check on the quality of people's care.

Ponteland Manor 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2, 3 and 4 May 2017 and was initially unannounced with the following days being announced.

One inspector, one specialist advisor and an expert-by-experience carried out the inspection. A specialist advisor focusses on a particular area within the service. For example, this specialist advisor was a nurse by background specialising in older people's care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let the Commission know about.

We contacted the local authority safeguarding and commissioning teams. We also contacted the clinical commissioning group (CCG) and the local Healthwatch. We contacted community nurses and nutrition and infection control leads for care homes in the area. We used their comments to support the planning of the inspection.

During the inspection we spoke with 11 people who used the service and nine relatives/visitors. We also spoke with the regional director, a manager supporting the service, the deputy, the clinical lead, two nurses, two senior care staff, five care staff, the activity coordinator, the housekeeper, one domestic, one chef and one kitchen assistant. We looked at a range of records which included the care and medicines records for six

people. Recruitment records for five care workers and other records relating to the management of the service.

During the inspection we also spoke with a GP and a district nurse who were visiting the service.

During this inspection we carried out two observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We placed a poster in reception so that people and any visitors would be aware an inspection was taking place and who to contact.

Good

Is the service safe?

Our findings

People felt safe living at the service. Comments included, "Absolutely"; "Oh yes, I feel quite safe"; "Safe, yes they are very good"; "I feel it is a safe environment…the carers come and check on you every few hours to see how you are."

Relatives also felt the service provided a safe environment for the family member and comments included, "My relative is very safe"; "Absolutely safe beyond doubt, day and night"; "It is safe…there is someone here twenty four hours, if needed"; "It is safer here (opposed to at the person's home)…staff are here (meaning close by) all the time."

One visiting district nurse told us, "I like coming here it is one of my favourite care homes. This is because of the cleanliness and the patients seem happy here. I do not have any concerns."

The service was kept clean and tidy and people and their relatives agreed with our observations and commented, "It is clean and tidy"; "It is always fresh and clean"; "It is very clean and tidy here, they clean every day"; "Couldn't be better, clean and hygienic" and "The cleaners are very good and they will get a nurse for me if I need one."

At the last inspection we found lancets were sometimes reused throughout the day for the same person. Lancets are used to make punctures to obtain small blood specimens. At this inspection we found this was no longer the case. The clinical lead told us they were now using 'Unistix' (type of lancet) which she demonstrated. She explained they cannot be re-used as they were one fixed unit. The information on the box stated, 'The twist-off protective cap keeps the lancet sterile. After use, the lancets retract to eliminate chances of any accidents happening'.

Care workers had a good understanding of safeguarding and the importance of raising concerns. They said any concerns would be reported to management without delay. One care worker said, "I would go to the clinical lead or deputy. I would go straight to the manager and report it." Previous safeguarding concerns had been referred to the local authority safeguarding team appropriately in line with the agreed local procedures.

The provider carried out a range of assessments using recognised tools to help protect people from potential risks. For example, the risks associated with poor nutrition, skin damage and falling. Where a person was assessed as being at risk, measures were in place to help keep people safe.

Accidents and incidents were logged and investigated. Information recorded the details of accidents, injuries sustained and whether relatives had been notified. Actions taken included, increased observations and referrals to a specialist falls team.

Regular health and safety checks were carried out to help ensure the premises, environment and specialist equipment were safe for people and care workers. This included fire safety checks as well as checks of the

electrical installation, gas safety, water safety and portable appliance testing. Health and safety checks were up to date when we visited the service. Specific health and safety related risk assessments had been completed where potential risks had been identified. For example, a fire risk assessment and chemical risk assessments. The provider also had up to date procedures to deal with emergency situations. These were documented in a business continuity plan. Personal emergency evacuation plans (PEEPs) had also been written for each person to help ensure they received personalised support in an emergency.

We took the regional manager outside to show them a pot hole which was located at the front of the property in the position where ambulances would stop to collect or return people to/from the service. They told us they would have this repaired as soon as possible.

Various pieces of equipment, including hoists and wheelchairs were found in corridors throughout the inspection. Although there was space to get past, this posed a potential risk if the service needed to be evacuated particularly in areas where the corridor was narrower. One relative told us, "Wheelchairs are everywhere, I have raised the concern… I think they need a storage area." We raised this issue with the regional director who said they were looking into the matter already and were looking at the possibility of utilising some existing space to accommodate additional pieces of equipment and told us that wheelchairs should be put back into people's bedrooms when not in use.

Nurses and senior care workers had completed relevant medicines training and had been assessed as competent. People confirmed they received their medicines in a timely manner. Comments included, "My medication is taken care of, I have no reason to doubt it is done incorrectly"; "I get my tablets at the right time and the right amount"; "The carers give me my medicine at different times of day…it's all getting a bit complicated for me now as I forget…so it's good knowing they see to it all" and "Medication is done correctly." One relative told us, "The medication is fine… I have no concerns."

Records supported the appropriate and safe management of medicines. We found medicines administration records (MARs) accurately accounted for the medicines people had received from staff. Where medicines had not been given a non-administration code was input onto MARs to show the reason for this. Other records confirmed medicines were received, stored and disposed of effectively. This included medicines liable to misuse or controlled drugs (CD). CD's are prescribed medicines used to treat, for example, severe pain. However some people abuse them by taking them when there is no clinical reason to, and for that reason have more stringent storage requirements. One person who managed their own medicines was in need of an updated locked cabinet. We brought this to the attention of the regional manager who said they would address this immediately. We found the medicines room had been refurbished and was now spacious and allowed staff to complete medicine related tasks in a very suitable environment.

Care workers confirmed staffing levels were sufficient to meet people's needs. One care worker said, "Better now, they have taken staff on." Another care worker told us, "We are okay at the minute." A third care worker commented, "They are fine at the moment." The previous manager had monitored staffing levels in the service using a recognised dependency based staffing tool. Previous calculations using this tool showed suitable staffing numbers were in place and from rotas we checked this was confirmed.

During our inspection call bells were answered in a timely manner. One relative told us, "She has to be encouraged to ring the bell, as she tends to shout. They [care staff] have ordered a pendant as she is used to having one, this was all done within four or five days." A number of people felt that staff took too long to respond to their calls for support, particularly in the evening and during the night. Comments included, "How quickly they answer the buzzer can depend on how busy they are"; "Depends…sometimes they will

come quickly or sometimes not"; "When you ring the buzzer mainly in the evening they can be short staffed. You have to be patient and shout in good time" and "They don't come very quickly."
The provider should note that some people consulted raised concerns regarding the number of staff present during the evenings. A few stated the service employed agency staff and they preferred regular staff as they were more familiar with their needs. One person said, "The staff can be busy sometimes if people [care staff] are off sick. The agency staff don't know how the place runs." The provider had covered all of the care hour's necessary and were in the process of recruiting additional permanent staff.

We recommend that the provider review evening staffing ratios to ensure that suitable numbers of care staff were continually deployed.

The provider had effective recruitment procedures to ensure new care workers were suitable to work at the home. These included carrying out a range of pre-employment checks. For example, requesting and receiving two references and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with vulnerable people.

Good

Is the service effective?

Our findings

People considered staff to be competent and felt their needs were met by efficient nurses and care staff. Comments included, "If I ask anything, they know what they are doing"; "I am progressing more here. It is very efficient you can tell by looking around, they make it pleasant and as congenial as possible"; "They watch over me. The carers come and check on me every hour during the night. I have a catheter and they change it every two hours, even through the night."

Relatives confirmed their family members views regarding staff efficiency and competency and said, "I have seen an improvement in her health since she has been here"; "They are aware of all her needs"; "There are particular ones [care staff] who have regular contact with her. They do understand her and told me they would come in the room more if we were not around as I visit a lot."

Care workers told us they were well supported whilst working at the service. One care worker said, "Support is fine. Communication is good with the nurse, clinical leads as well." Another care worker told us, "I feel very supported." Records confirmed supervisions and appraisals had taken place. Supervisions are meetings which take place between a supervisor and an employee and offers both parties a change to review work and discuss any issues arising. Appraisals are a formal assessment of the performance of an employee over a particular period (usually one year).

Care workers received relevant training to help them carry out their caring role effectively. One care worker commented, "My training is up to date." Records showed training mostly up to date at the time of our inspection, with further training planned. New staff were required to complete an induction programme based on the Care Certificate. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards. This included supporting new staff through shadowing and key training for each staff role. For example, care workers had to complete safeguarding and moving and handling training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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 Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people lacked capacity, nine out of 13 DoLS applications had been authorised with the others waiting for the outcome of the application.

We saw with care records, examples of MCA assessments and best interest decisions made on behalf of people. These had been made involving relatives where possible.

Consent or agreement was gained before any action was taken. One person was assessed as not requiring bed rails from a safety perspective however a decision was made to put these in place as the person said she felt much safer with them fitted.

Care workers had completed specific training on MCA including DoLS. Care workers described how they supported people with decision making. One care worker said, "We have a good rapport with families, we talk to families. We try to give a choice of meals for example. We know in the care plan what sort of food they [people] like." Another care worker told us, "We look in care plans for people's preferences (to support them with making decisions)" One relative commented, "[My family member] has a lack of communication. Staff work hard to find out what they want. [Person's name] says no to everything. They know what [person's name] likes and ask if they mean yes or no and they delve for an answer. It's tricky for them."

People were asked for and gave consent before receiving care. One person said, "If I don't like anything I tell them." Another person told us, "Oh yes (staff asked for consent) One relative commented, "[Person's name] made his own choice regarding his end of life. He made that a while ago." Another relative said, "[Person's name] didn't want any breakfast and staff provided an alternative to try and encourage him."

Generally people were complimentary about the food prepared for them at the service. Comments included, "Generally the food is very good… I always have a choice. At breakfast you can have anything including a cooked breakfast. It is at 9am this time is good for me"; "I really like the food here. You can have soup, dinner and desert. They ask what you would like…you don't have to eat anything you don't like" and "You can have a meal in your room if you like." One person was less positive and said, "Not terribly organised, they can be slow getting a meal and bringing it to me." We did not see evidence of this during the inspection.

We made observations over lunchtime to help us understand people's dining experience. We saw tables were set with tablecloths, condiments, placemats and a menu. We noted care staff interacted well with people during lunch. People requiring physical assistance received this without interruption and in a calm and unhurried manner, having one staff member per person sitting next to them providing support and encouragement.

Refreshments were available throughout the day, including those brought to people on morning and afternoon 'tea' trolleys. We also found juice dispensers in dining areas where people or staff could help themselves to freshly made diluted juices. We noted that a small selection of decanted food types in dining areas had not been dated. Dating decanted produce ensures it is not used after the 'use by' date. We brought this to the attention of the regional director who noted this issue and said she would address.

Where people required special diets or support with allergies this was provided appropriately. For example, one person had a pureed diet and another person required their drinks thickened. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. We saw these people received the required support. One relative said, "They are aware of her allergies." Another relative said, "The food is very very good…very good choice She has a soft diet, they are doing this now fork mashable diet. She has improved massively since she arrived, put two kilos on. She is eating everything put in front of her and she is happy."

A number of staff raised concerns with us about the choices given to people who were diabetic. We attended a meeting with senior staff, including one of the chefs. This issue was discussed. Staff agreed that support

from the local NHS trust nutrition team would be useful.

We recommend that the provider ensures that a choice of meals and desserts are made available to everyone including those people with diabetes.

People were supported to meet their health care needs with appropriate and timely referrals. One person had been supported by the Speech and Language Team (SALT) to ensure they received suitable support because of their risk of choking. We spoke to a GP who was visiting the service. They told us, "Staff appropriately raise issues with us, they know people well, are familiar and have a good rapport. The system here works very well for patients." We saw people were supported by other specialist teams, for example the specialist diabetic team in the local NHS trust to ensure one person received optimum care. One person told us, "An optician came yesterday." Another person said, "I can see anyone I need to."

Some people had an emergency health care plan (EHCP) in place. These documents provided details of anticipated emergencies and what action to take. They supported decisions for future care and treatment including whether or not admission to hospital was to be considered. We saw that these documents were tailored to each individual, for example one person wished to receive all treatment, including admission to hospital, while another wished to remain at Ponteland Manor and not be admitted to hospital.

Good

Is the service caring?

Our findings

People and their relatives felt all staff at Ponteland Manor were kind, caring and considerate. People's comments included, "The carers are very nice"; "I am perfectly happy, it is a home from home, I feel more relaxed here"; "The carer here is wonderful. It is definitely the most caring place, they care about me" and "I am quite satisfied with the carers." Relatives told us, "The care is brilliant, I am really happy"; "The staff spoil you. I spend a lot of time here. They [care staff] are very caring towards me. If I tell them I don't want any lunch they still bring me a sweet (dessert). They always bring me cups of tea and coffee. I am like part of the furniture."

All the relatives we spoke with stated they felt welcome at the service and were encouraged to contact and visit the home. One told us, "I come and visit nearly every day." Another told us, "They have a mobile telephone and bring it to her so I can speak to her." People confirmed this was the case and said, "My friends and family visit"; "My son was invited for lunch" and "There is never a problem…my family can visit when they want…any time any day."

We saw positive and caring interactions between people and care workers. For example, we overheard a care worker say to one person, "Sweetheart I'll get these bit's [biscuit crumbs] off you." We found there was a lot of friendly interaction in the communal lounges.

One GP whom we spoke with during their visit to the service said, "There is a stable team of nurses and care staff. They go to people's funerals which is a really nice gesture. I have no issues with the staff here." When asked if they would have a relative of theirs living at the service, they said, "Yes, people are well cared for."

Care records contained information to show consideration had been given to people's preferences. For example, in one person's records it specified that the person had demonstrated 'no preference to male or female care staff carrying out personal care' and that all personal care should take place 'behind closed doors to preserve dignity'.

Everyone consulted considered the staff respected their dignity and privacy. We observed staff knocking on bedrooms doors and requesting access before entering. One care worker described the practical steps they took to maintain people's privacy such as keeping them covered, talking to them and explaining what was happening. At one point we observed a care worker maintaining the dignity of one person by ensuring their skirt was adjusted when they got up from a chair.

During the lunch time experience we overheard one member of care staff promoting one visually impaired person's independence by saying, "The pie is at twelve o'clock the vegetables at two o'clock." This worked well and the person was able to eat the majority of the meal themselves and when they asked for help, staff responded straight away.

One of the chef's was present throughout the lunch time experience and chatted freely and cheerfully to people. One person was a retired cook who asked the chef if the other chef had tried their recipe for plain

scones taken from the old 'Bero' cook book. They had a long conversation reminiscing about this particular person's past days as a cook which made them very happy.

As the chef served desserts, tea and coffee, they told us there was a 'residents' meeting on 8 May to establish views around "summer options on the menu such as salads and summer desserts". We found her to be clearly enthusiastic about her role.

People's individual bedrooms were personalised with many items brought from their family home, including photographs and pictures. One person had soft toys on their bed and a special dementia blanket which contained a variety of different textures for example buttons and zips. A dementia blanket is a piece of material which looks similar to a small blanket which has a range of textures and gadgets attached to it which has been specifically designed for people living with dementia to use for stimulation.

Laundry staff took care of people's clothing. One person said, "The laundry is excellent the clothes… very clean." A relative said, "Staff seem to take care of [person's] clothes…I visit a friend in another home and you could not say the same there."

Regular resident and relatives' meetings were held. Topics discussed at previous meetings included gathering people's views about care delivery, dignity and respect, menu choices and meal portion sizes. People were encouraged to express their views and actively supported to give suggestions to the staff team regarding their care, treatment and support.

We observed the activities co-ordinator inviting people to a meeting to be held on the forthcoming Thursday afternoon to discuss the menu for the summer. We overheard them asking one person if they wanted them to visit them on the day before the meeting in case they were not able to attend. This was an attempt to gather their views; and the person accepted their offer. One person told us, "I am involved in meetings and discussions, there is a meeting about menus." A relative told us, "There is a new chef on board, we are invited to a meeting on Thursday afternoon to talk about changing the menu."

People told us they felt care workers treated them equally. One person commented, "Yes I do definitely (get treated fairly)." Another person told us, "Oh yes I'm sure, they have to be just the same as with me, they make sure people are happy."

Written compliments had been received from relatives about the care provided at the service and were displayed. For example, one relative had written a card expressing their thanks and gratitude to the whole staff team for caring for their family member.

Good

Is the service responsive?

Our findings

People's needs had been assessed both before and shortly after their admission to the service. The assessment was used to develop detailed and personalised care plans. These clearly detailed the individual care and support people needed. For example, one person had clear information in a challenging behaviour care plan as they had a tendency to resist personal care interventions from care staff. It was recorded the person may be uncooperative during personal care or refuse it all together; it detailed tactics staff should use, including returning after a short while to try again. It also detailed what action staff should take if they suspected a urinary infection or other health related cause may be the reason for refusal. Care plans were in place to support people with all their identified needs, including for example, their mobility, skin integrity and nutritional requirements. Records were reviewed regularly and maintained electronically with paper copies as back up.

Documentation was in place to record procedures and care and support offered throughout the day. For example, in relation to electronic bed and mattress settings which stipulated clearly what this should be and also included a photograph of the settings unit on the bed. A 'welfare check record sheet' was completed and signed by care staff when interventions occurred, for example drinks given or general checks made. A welfare check is general checks on a person's wellbeing and may include whether the person was asleep or awake or if a drink had been given. We noted through the day that not all nurse staff completed the welfare check when one had been made, including when they had given a person a drink. A 'residents 24hour repositioning record' recorded individual positional changes required for each person who was unable to move themselves while either in bed or in a chair.

It was clear from records that staff worked with people and their families to fully meet their needs and involve them. Everyone spoken with knew they had a care plan and felt they or their family had been involved in the planning of their care. Comments from people or their relatives included, "I have a care plan… am involved in meetings"; "I have a care plan… I am involved in my care"; "They go through the care plan quite thoroughly and they are meeting her [person's] needs" and "The care plan is superb, is spot on. The end of life plan is all set up and done." One person's care records identified concerns that food was not hot enough and not the consistency they would like it to be. In response the chef had chatted with the person and offered more choices on a daily basis to accommodate their wishes.

Some people who lived at the service received meals and refreshments in their bedrooms due to their complex health conditions. Food and fluid was recorded by care staff after it was given. Fluid intake targets were discussed and agreed by GP's, nurses, the person and their family. The clinical lead informed us, "Each day at 7pm nurse and care staff calculates intake for the day and any deficits are handed over to the night staff to try and reach the target by midnight where appropriate" and "This meant that unrealistic targets were not being set for frail residents and any deficits identified in a timely manner."

Staff monitored and recorded changes in people's health. One person's weight recordings over several weeks showed an increase of 5kg. This had been noted and a comment added 'this could be attributed to legs being very swollen'. The person had received additional support to address this. One relative told us,

"What impressed me is I detected she may have a UTI. The nurses upstairs tested her. They called the doctor who confirmed it and she had antibiotics within forty eight hours." Another relative said, "They have called for a consultation with the Doctor today as she has a cough."

Arranged activities were a regular occurrence at the service, although a change in staff had meant that activity arrangements had been slightly effected. One relative confirmed this and said, "Activities used to be every week they have gone quiet." Another relative told us, "They used to bring in animals, play bowls and bingo… since Christmas it has gone quiet." A Member of care staff said, "There has been a blip with this (activities) but it will soon be back to normal."

The activities coordinator informed us he had commenced his employment the day before and had taken time to meet with a number of the people and their relatives. A number of people we spoke with told us they had met him and said he seemed very "nice". There was a main activity room which was well stocked with a range of various craft and activity items. Comments from people and their families included, "They have a concert… they are amateurs. It is very good and makes me laugh"; "A singer sometimes comes, I like this"; "Activities are aimed at older people" and "Every day I get out in the garden to get some fresh air."

The activities coordinator stated he had circulated the 'Daily Sparkle' which detailed happening from year's gone by. He said he used this as an aid to reminisce and to open conversations with people. We observed the Daily Sparkle in people's rooms and in lounges. On the second day of the inspection there was an 'exercise to music' session taking place. People seemed to really enjoy this activity, particularly when care staff supported them to join in. We noted, however, that care staff left the lounge soon after it began and the 'teacher' was left alone with the seven people who had joined in. When this happened people became less active. We also were not convinced that all people who may have been interested in participating in this activity had been asked. We brought this to the attention of the regional director who said that she would address these issues.

The service had two 'adopted budgies' on the top floor lounge. Staff told us that some people particularly enjoyed visiting and watching them.

People stated they had choices about their care and autonomy. Comments included, "I usually choose to have a bath"; "The carer's do ask if I would like a bath or a shower" and "The carers do look after me. In the morning they wash and dress me…I have a shower as I prefer this." Relatives told us, "She [person] gets a choice and gets everything she wants" and "They give her breakfast after she wakes up naturally and wash and dress her and she has this [breakfast] in her room which is her choice." People informed us they had choices for example in when they got up, went to bed or whether they had a bath a shower or bed bath. Staff respected the choices that people had made. For example one person did not want to complete 'My life' booklet, but preferred to talk to staff about their background. 'My life' booklet is a way for staff to capture details of a person's previous life history. The clinical lead told us, "She does not wish to have her life story recorded but will happily discuss this with staff."

Without exception all of the people and relatives we spoke with stated they had not made a formal complaint and felt staff listened to them and acted on any minor issues they had. They stated they would feel comfortable in raising a concern or complaint if they felt this necessary. People's comments included, "If I had a problem I would talk to the carers, then the manager"; "The staff listen, I can ask them questions"; "As far as staff go they listen." Relatives commented, "They [nurses and care staff] are very open and honest and tell me what is happening"; The Senior [senior member of care staff] is very obliging and helpful…if can't go to her, there is always someone to approach"; "Always someone [care staff] to talk to" and "If I have any concerns… senior is my first port of call." There had been 4 complaints made in 2016 and 1 in 2017 which

had all been dealt with in a timely manner, including complainants being written to and the date of when the complaint was resolved.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post and the previous manager who was in the process of applying to become registered with the Commission had recently left employment with the provider. The regional director told us that recruitment for a new manager would be classed as priority and once in post would be asked to register with the Commission immediately.

People and their family members thought the service was well led. Comments included, "I think the home is well led"; "I do not have any reason to think otherwise"; "Yes it seems to be very well organised"; "More than happy I know she is in good hands and has good care"; "It is beautiful, I am 95% happy"; "We haven't found anything wrong"; "The operation seems to be okay"; "I have been very pleased with it (service delivery)" and "The whole thing is superb, I have made recommendations to other people."

Some relatives were aware that the recent manager had left but were unaware of who was taking their place or what was happening. We spoke with the regional director who told us that a meeting was planned to take place soon to communicate the changes within the service and to give reassurances regarding management cover which had already been arranged.

We received mixed views about the previous manager of the service by nursing and care staff with many commenting that they felt their management style was not good and that they made little contact with people at the service. Poor communication was raised as an issue and one example was given "Residents were not even asked what colour they wanted the lounges painted when that was done recently." A member of care staff told us, "They [manager] used to go around and not really look at people…did not do it with everyone…but they should not have been like that with anyone really, including staff."

Staff told us that they felt supported by the provider. Care staff told us that the clinical lead, deputy and senior care staff were supportive and that the service was managing "okay" since the manager had left.

There were a number of staff incentive systems in place, including what was called the 'GEM' award for going the extra mile. We saw records of staff who had received commendations from colleagues for completing particularly good pieces of work or supporting people and their families who used the service. One staff member had been commended by the clinical lead for supporting a family whose loved one had passed away. We were also made aware that one of the Chefs had, last year been a finalist in a 'chef of the year' competition via the provider and one of the companies the provider works with. The chef told us they were going to enter again this year.

Senior staff had implemented a 'resident of the day' system which was marked on a board outside of the medicines room. This involved one person being chosen each day to have a full review of their needs checked, including discussions with heads of department. For example, we saw records confirming that a chef and the housekeeper had reviewed dietary and environmental needs to ensure these were being met. The housekeeper said, "It's been done to make sure nothing get missed and another chance to make sure everything is ok."

The provider encouraged relatives to be fully involved in the service. Two relatives informed us they were aware of a 'residents committee' and one confirmed they were a recent member. One said, "There are three prime movers (on committee)…they have bi -monthly meetings. I have been asked to look at the draft for the Manor news, newsletter produced by the committee." They confirmed that the previous manager had attended committee meetings.

Care workers had opportunities to give their views and suggestions about the service. One care worker told us, "If I thought anything could be improved I would go and see [clinical lead] or [deputy]. I have done." Regular staff meetings were held which covered a range of topics such as care planning, safe management of medicines and staff development.

The provider carried out a range of internal and external checks of the service. Findings from external audits were reported to the previous manager and an action plan was formulated. Checks included those in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding and nutrition. Senior management had carried out regular checks which included gathering the views of people which records showed had been positive.

The previous manager, clinical lead and deputy then supplemented these audits with other internal audits of the service. For examples, checks of medicines, complaints, care plans and training. All checks had been completed regularly and were up to date when we inspected. We saw action had been taken following these checks where areas for improvement had been identified. A clinical risk register was completed every week and monitored. This included, for example, details of people who were at risk of malnutrition or those at risk of pressure damage. Monitoring ensured that any increase was easily identified and acted upon. Accidents were also monitored and the clinical lead was aware and overheard discussion one person who had had incidents at a particular time over a period of time. They made staff aware and were told to monitor the situation and look for triggers.

Senior staff had impressed on staff internet security and the misuse of their passwords. We asked staff if they could log us on to the providers ID system so we could view records. We were told that they could not use their own password but would have to speak with senior staff. This meant staff were aware of the need to secure people's personal information and protect confidentiality. Records were all kept securely in cabinets and behind locked doors.

The previous manager had submitted required notifications to CQC in a timely manner. Notifications are changes, events or incidents that the provider is legally obliged to tell us about. We saw the provider was displaying the performance rating from the last CQC inspection within the service and on their website for people and visitors to view. They had made copies of inspection report summaries available.