Raynsford Limited

Harrington House

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

This inspection took place on 15, 16 and 21 May 2018. It was unannounced and was carried out by one inspector.

Harrington House provides residential care for up to 12 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Harrington House is registered for adults living with learning disability and/or mental health needs. At the time of this inspection 12 people were living there.

Accommodation at Harrington House is provided over three floors with bedrooms located on the ground and first floors; A self-contained flat housing one person was located in the basement. The ground floor and garden were wheelchair accessible. One bedroom had en-suite facilities, all bedrooms were equipped with a sink and adapted communal bathrooms were available to all. A shower was situated on the first floor. People had access to the kitchen and the open plan communal areas, including the lounge, dining area and conservatory. The garden was enclosed and complete with a barbeque and strawberry patch. Parking was available at the front of the house.

At our last inspection in 2015 the home was rated Good. The management of the home changed twice since our last inspection. The new manager has been in post since January 2018 and has applied to become registered manager of the home. 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 care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen."

During this inspection we identified one breach of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. The service has been rated 'Requires Improvement' overall.

Principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had not always been adhered to. Not all people living at Harrington House could consent to the arrangements in place to keep them safe; Continuous supervision and control, combined with lack of freedom to leave, indicated a deprivation of liberty for some people. However applications to authorise these arrangements under DoLS had not been made for all people who may require this. It was evident the restrictions in place were appropriate and in people's best interests and would have been legally authorised under the MCA had DoLS authorisations been requested.

People's support plans did not always reflect their needs and these were in the process of being updated.

When people's needs changed, a referral for re-assessment by a health care professional had not always been requested to ensure they remained safe. Some improvements had been made since the new manager came into post. However, when shortfalls had been identified by the provider prompt action had not always been taken to ensure the required improvements were made.

People benefitted from a caring staff team who knew them well. They were supported to access appropriate health care. Staff took a personalised approach to meeting people's needs and outcomes for people were good. People's preferences were taken into account by staff when providing care and people were offered choices in their day to day lives. People's privacy was respected and they were treated with dignity and kindness. People were supported to maintain relationships with others who were important to them. People received good end of life care.

People's views about the service they received were sought and these were used to improve the service. People were able to raise complaints and these were responded to promptly. The culture at the home was person centred and the manager as open about improvements needed. Staff and managers worked together to provide a friendly service where people told us they felt at home.

This is the first time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version 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 were not always protected against health and well-being related risks as support plans did not always reflect their needs. When people's needs changed reassessment of their needs was not always carried out.

There were enough staff to meet people's needs.

People were protected from the risk of being supported by unsuitable staff because required recruitment checks were completed and staff understood how to safeguard vulnerable people.

People's medicines were managed appropriately to reduce risks to them.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made.

People's ability to consent to care had not always been assessed in line with the Mental Capacity Act 2005. People were supported and enabled to make decisions about their day to day care.

People were supported by staff that had the skills and knowledge to meet their needs. Staff were suitably trained and supported in their roles.

People's health and nutritional needs were met and they had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring, engaging

and supportive.

People were treated with respect, kindness and compassion. People and their close relatives were listened to and were involved in decisions about their care.

People's dignity and privacy was maintained and their independence in daily activities was promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care and were routinely consulted about the support they received.

Staff knew people well and worked flexibly to help them follow their interests and hobbies. People were enabled to maintain relationships with those who mattered to them.

People were able to raise complaints and these were responded to.

People received good end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Oversight and monitoring of the service was not always effective in identifying improvements needed. Actions needed to improve the service were not always completed in a timely manner.

People benefitted from an inclusive service where they were valued as individuals.

The provider and management team worked openly and transparently with others, seeking their feedback, to improve the service.

Harrington House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 15, 16 and 21 May 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we reviewed information we held about the service including notifications. A notification is a report about important events which the service is required to send us by law. We reviewed information sent to us in the provider's 2017 Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We spoke with commissioners about the service and read three reports, (dated February, March and May 2018), from their quality monitoring visits. These visits had started in November 2017 and were ongoing.

Throughout the inspection we observed the support being provided to people. We spoke with four people who use the service and another four people's relatives. We spoke with the provider's representative, the area manager, the home manager, the two deputy managers and four other members of the care staff team. We sat in on a staff handover meeting and toured the premises. We sought the views of six health and social care professionals and received feedback from one of those we approached.

We checked three people's care records which included pre-admission assessments, care plans, risk assessments and documents relating to assessment of mental capacity and Deprivation of Liberty Safeguards (DoLS). We checked medicines records for five people and observed a staff member administering medicines. We reviewed the processes in place for managing medicines, including the use of 'as required' medicines and medicines with additional storage and recording requirements. We looked at recruitment records for three staff, staff training and supervision records, complaints, accident and incident records, maintenance records and reviewed provider policies and quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

The home was clean and free of malodours. Harrington House had been awarded a food hygiene rating of four (good) in February 2017. Staff had completed training in food hygiene. Training in infection control had not been provided to date, however staff followed the infection control measures in place. For example, wearing protective aprons in the kitchen and completing required cleaning schedules. Staff meeting records demonstrated staff were reminded of infection control requirements, including use of gloves and aprons when delivering personal care. An audit which included some infection control checks was carried out in December 2017. However, this audit was not sufficiently comprehensive to ensure the manager would always identify when infection control practices did not meet current best practice standards. The manager planned to introduce a dedicated infection control audit and provided a copy of the audit tool for this. This included reference to policies, hand-washing, laundry and waste management. During the inspection we drew their attention to The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. There had been no recent outbreaks of infection at the home. A staff member showed us colour coded cleaning equipment, used to minimise the risk of cross infection and told us a replacement kit had been ordered to manage body fluid spillages.

We recommend that the service review good practice guidance for infection control in care homes and take action to update their practice accordingly.

The provider's quality audit in December 2017 and quality visits by commissioners revealed that risk assessments and care plans did not always reflect people's needs. They were not up to date, had not been reviewed regularly and did not incorporate all relevant advice from health care professionals. This had been identified in the provider's audit and action plan as requiring urgent action. We saw progress was being made to complete this work.

New care plans demonstrated people and their families had been involved in the process and restrictions on people to reduce risks had been minimised. However, Mental Capacity Act (MCA) assessments had not been completed to support risk assessments, decision making and the management of risk for people whose capacity to understand those risks was in question.

Where advice had been provided by health care professionals, for example, to manage specific risks such as choking, the relevant care plan referred to this. A summary of the advice was included in the care plan but a copy of the detailed advice provided by Speech and Language Therapists (SLT) was not kept with the care plan for staff to refer to. There was a risk that some aspects of SLT advice would be missed and not acted upon. We discussed this with the home's management team who agreed to store specific health professional advice with the care plan. During the inspection, a reference folder for SLT advice was put in the kitchen for staff to refer to when preparing meals for people with special dietary needs or restrictions. A provider quality audit was due to be carried out in June 2018, which included a review of care plans.

We identified discrepancies in the support provided to two people, when compared to the advice given by Speech and Language Therapists (SLT), in relation to managing choking risks. There had been no impact

from this, for example, staff noted one of these people was well and had not any recent chest infections. We asked staff to contact the SLT for advice about these discrepancies during the inspection. We spoke with the SLT following the inspection who advised a review for both people; They said they would contact the manager about this. The people and relatives we spoke with had no concerns about people's safety at Harrington House.

Risk assessments in place for people included accessing the community, specific activities people participated in and risks relating to health needs, including epilepsy. Monthly reviews of people's needs and experience of care were being carried out.

A personal fire evacuation plan was in place for each person. The safety of equipment and the home environment was maintained. Regular checks protected people against risks associated with fire, legionella and equipment failure. There had been no recent serious injuries or incidents at the service. We saw there was a good reporting culture and minor incidents such as slips and trips, including those occurring in the community or during an activity, were reported on. Accident and incident records were reviewed by the manager and where possible, action was taken to reduce the risk of a repeat incident. This included review of risk assessments and reminders to staff. A monthly summary was produced and an analysis of this information enabled trends to be identified and responded to.

Recruitment requirements were discussed with the provider's representative and the manager, as the provider's quality audit in December 2017 and quality visits by commissioners revealed potential shortfalls in this area. Improvements to recruitment practices had been made and these were being monitored by commissioners. Our checks demonstrated staff had been recruited safely; however, appropriate records had not been maintained for two applicants who had previously worked for the manager at another residential care service. The manager assured us the missing information would be added to these records. New staff worked a three month probationary period to determine their suitability for the role.

There were enough staff to meet people's needs. Staff were relaxed and unhurried in their approach and had time to meet people's needs. A staff member described their work environment as, "laid back and relaxed" where people needed more "activity based support." The management team were recruiting to two full-time vacancies; one application was in progress. The provider had a team of 'bank staff' who worked across their services. The two bank staff we spoke with worked at Harrington House regularly. Known agency staff were used as a last resort, they worked alongside regular staff and an information pack was in place for additional reference. An on call system was in place to support staff out of office hours.

People were protected from the risk of abuse as staff understood their role in protecting people and how to safeguard them. People confirmed they felt safe living at Harrington House and we observed they were relaxed and at ease when interacting with staff. Managers responded appropriately to any concerns or incidents, including involving external agencies. Staff told were confident managers would act if they raised concerns but they were happy to speak with the area manager, director or external agencies if needed. Comments from people and their relatives included, "I like living here. Staff are friendly" and "I have no concerns about the staff's attitude."

People's medicines were managed safely. The systems in place reduced potential risks to people and medicines were ordered, stored and disposed of in line with current guidance and legislation. Regular checks meant appropriate stock levels and storage temperatures were maintained. Protocols were in place for 'as required' medicines. Staff understood when these medicines should be given and this was included in people's support plans. This included medicines for managing anxiety and distress, which were only given as a last resort, if other methods had been ineffective.

Requires Improvement

Is the service effective?

Our findings

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 who lack capacity to consent to their care can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care and nursing homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and had applied for the necessary authorisation when depriving a person of their liberty.

A deputy had been appointed to manage one person's finances, as they lacked the mental capacity to do this independently. This person had been assessed as lacking capacity to consent to receiving care and treatment at Harrington House in 2015. Their MCA assessment had been reviewed in 2016 and 2017, with the same outcome. A DoLS application had not been submitted for this person. The manager told us one other person may also require DoLS authorisation, as the manager believed they lacked capacity to consent to the arrangements in place for them. However, no MCA assessments had been completed and no DoLS applications had been made in the six months this person had lived at Harrington House. Neither of these people were free to leave the home and both were under 24 hour supervision at the home which indicate a deprivation of liberty. Advice had not been sought to clarify whether an application for DoLS authorisation was needed for either of these people prior to our inspection.

People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A DoLS application had been submitted for one person living at the home.

Where people were able to consent to their care and treatment their involvement in decisions was evident. For example, one person had written comments in their care plan. MCA assessments needed to be carried out for some people and reviewed for others. This work was being supported by commissioners. For example, to establish what support people needed with managing their finances. Once completed, appropriate arrangements, with a financial advocacy service, would be put in place for people who needed support. Templates for MCA assessment and Best Interests decisions had been provided by commissioners and training in DoLS and MCA assessment was booked for the home's management team.

One person who had been recommended a modified diet and fluid intake, to manage choking risks, had independent access to the community. The Speech and Language Therapist's (SLT) letter of recommendations included the offer to participate in MCA assessment and Best Interest discussions for this

person. They believed this person lacked capacity to understand the risk of eating or drinking foodstuffs that were not the recommended consistency, which they may buy while shopping alone. Following the inspection, the SLT told us they would reassess this person's needs and support staff with completing an MCA assessment in relation to choking risks.

People were cared for by staff who received appropriate training and support to enable them to fulfil their role. Training included food hygiene, first aid and moving and handling. Training specific to needs of people using the service was provided, including dementia and epilepsy care. Dates were booked for staff who had not yet received training in the MCA. Staff had regular individual meetings known as 'supervision', as well as annual performance appraisals. They told us they felt confident in meeting people's support needs. Two staff members had recently been promoted to deputy manager roles and were to receive additional training, for example in risk assessment.

Staff who were new to care completed the Care Certificate. This is a set of national standards that health and social care workers adhere to in their daily working life. All staff were encouraged to go on to complete Qualification and Credit Framework (QCFs) awards in health and social care.

People's need were assessed before they were offered a place at Harrington House. Assessments took into account recommendations by health and social care professionals and the wishes of the person and their close relatives or advocate. People's diverse needs and any adjustments needed in the delivery of their care were considered. People's needs were reviewed with them regularly and in response to any changes. When indicated, technology was used to support people's independence. For example, laser technology was used to alert staff when a person at risk of falling got out of bed.

Annual health checks were being arranged with the GP surgery, which would include measuring people's height and weight. From this, a healthy target weight range would be established for each person. The manager planned to use the Malnutrition Universal Screening Tool (MUST), to identify people at risk of becoming malnourished. People's weight was monitored monthly to ensure the measures in place were effective. Healthy options were encouraged, including fresh fruit and vegetables. A staff member told us they tried to give people fresh vegetables every day and we saw people eating banana and avocado as snacks.

The menus were discussed at resident meetings. People had continual access to drinks and all were able to eat independently, with supervision. Staff were aware of how much coffee and/or fizzy drinks people were drinking and encouraged them to moderate this when indicated. Staff knew which people had difficulty with swallowing and how their food and drinks should be provided to reduce risks to them. For example, staff told us some people needed their meals cut into small pieces and moistened with a sauce or gravy. On one of the days we visited, people needing soft diets weren't served vegetables with their meal as staff considered the vegetables they had prepared were unsuitable for them.

We recommend that the service review menus to ensure suitable alternatives are always prepared for people requiring special diets.

People's health was monitored in conjunction with health care professionals. For example, a record was kept relating to one person's epilepsy which enabled health care professionals to review the effectiveness of the person's epilepsy treatment. Staff knew to support this person to get enough rest, how to support them when they became unwell and when to seek emergency support. Staff worked with specialist services, including the community learning disability team, to manage people's more complex needs.

Annual health checks were being arranged with the GP's surgery. People were supported to access to variety

of health care professionals to ensure their needs were met, including specialist and community based services. One person's relative told us it was particularly important their relative maintain a healthy weight and active lifestyle, due to their medical condition. Staff had taken note of this, managing portion sizes and involving the person in exercise based activities. People regularly attended aqua aerobics, trampolining and rambling sessions. Another relative told us that staff had "gone to great lengths" to ensure their relative accessed preventative services they needed. They added, "They've looked after her".

The people living at Harrington House were relatively mobile but downstairs bedrooms were available to people with limited mobility. Upstairs was accessed via stairs, further bedrooms and a standard bathroom and shower were available on this floor. The ground floor had an adapted bath with a chair hoist and the garden was accessible via ramps. The kitchen was accessed via steps. The home was relatively spacious with large living areas, decorated in a comfortable and homely style. People chose how their room was decorated.

Good

Is the service caring?

Our findings

Feedback about staff was positive and included the following comments from people and their relatives, "I like all the staff. They're kind" and "I find the care exemplary. They go above and beyond". People's relatives told us about kind things staff had done, including coming in on their day off to support their relative and transporting them to attend a family event. A relative of one person who had recently moved in to Harrington House said, "Every week [name's] showing more positive signs and becoming more cheeky which shows [person's] feeling at home".

These observations complemented our own. We observed warm exchanges between staff and people living at Harrington House. Staff quietly checked people were managing what they were doing and helped them to refocus when needed. When completing a puzzle, a staff member said, "You've done really well there. We're getting there. Give me a high five". Both people the staff member was supporting responded well to this positive feedback, with smiles and laughter.

Staff were aware of people's mood states and acted to support them as needed. When staff saw another person was becoming anxious, they responded quickly to help resolve the person's frustration. A staff member observing the interaction with us understood what was bothering the person, without need of asking. Staff observations of people's mood states were noted in care records. A relative said, "If [person] is in a bad mood and they [staff] couldn't understand why, they would ask questions or ask me to pop in." One person told us, "They [staff] can be quite supportive. They recognise when I'm feeling low."

Care records demonstrated people's involvement in planning and reviewing their care. One person's record we checked had been signed by them to say they agreed with it. Their wishes and views about what was working (and not working) for them had been recorded. Comments from relatives included, "They [staff] have listened and asked. We are working together towards the best end" and "Moving to the home gave [name] a new independence."

Staff worked at the pace of the people they were supporting and encouraged them to take the lead where possible. For example, they used prompts which put the person in charge such as, "Would you like to..." and "Shall we…" When staff were unable to give one person the breakfast cereal they requested, they apologised and showed them the options available to them.

People's privacy and dignity was respected and promoted. Personal care was given in private and staff prompted people to close bathroom doors when using facilities independently. Staff helped people to present themselves well, for example, blow drying and straightening one person's hair before they went out. Some people were able to catch the bus into town and regularly met friends or shopped independently. Staff understood the importance of promoting and respecting people's independence. This included encouraging people to do things for themselves when at home, such as helping with their laundry or cooking. A staff member said about one person, "[Name] loves to go to the shop and into town. She would struggle without her independence". One person told us, "My room can be untidy at times. I'm just that sort of person that keeps it cluttered. They [staff] don't come in and move things. They respect my privacy".

Good

Is the service responsive?

Our findings

People's records contained information about their life history, things that interested them and people and activities that were important to them. Details to support staff to provide care in a person centred way were included in care plans. People living at Harrington House had variable levels of need, this and their wishes, were reflected in the support they received from staff. One person was living independently in a self-contained flat; Staff ordered their medicines and the person could access their support if needed. This person had a paid job. Another person worked, in a voluntary capacity, Monday to Friday. Staff supported them to prepare a packed lunch and transported them to and from work each day. The home was located on a bus route and two people regularly caught the bus into town to meet friends or shop independently.

People's relatives had been involved in planning care when appropriate. One relative spoke highly of the personalised approach followed. They said about the manager, "She has really listened to the little things I've passed on. For example, the kind of (sandwich) fillings [the person] would like. They [staff] haven't hesitated to ask and have worked really closely with me. I have very much felt a partnership developing. I couldn't be happier." Another person enjoyed sports and preferred to spend more time in their room; They had a subscription to a sports channel and read their preferred newspaper there in the mornings. Staff regularly told this person what activities were planned and respected their wish to join in or not. People were encouraged and supported to plan a summer holiday and their preferences for days out were acted upon.

We saw that 'as required' medications to manage anxiety were rarely needed. Staff told us people who had previously needed intervention to manage their anxieties were now "settled"; No anxiety related incidents had been recorded since February 2018. Incident records demonstrated care and treatment plans had been reviewed and updated after an incident. The manager explained that one person's "behaviours" had previously been "rewarded" with staff attention, but this had been turned around to reward their positive responses. They had an agreement with this person around going out and having a treat together, if they had both been "happy" and "tolerant" of others. A relative said, "[Person's] very happy and settled." They told us when the person visited them, they talked about things they would do when they went "home" to Harrington House.

People were encouraged and supported to maintain relationships that were important to them. This included sending cards on special occasions, telephone calls, family visits and social events. People that did not have relatives were supported to use 'Building Circles'. This charity offers friendship and support to people with learning disabilities who are socially isolated. We observed some people had formed friendships with others in the home, expressed by kind words and a hug.

Technology was used to ensure people received timely support. Sensors were used to alert staff when people who may be at risk of falling, including falls due to epilepsy, required assistance.

Two complaints had been logged in 2017 and none in 2018. Records demonstrated complaints had been investigated and resolved. People and their relatives told us they could approach the manager or provider if

they had any concerns. A relative said, "I've always had complete confidence in them. I know they will talk to me. I can go straight to the manager or a carer". Residents' meeting records demonstrated people were encouraged to "keep in contact with staff and raise any concerns with them."

Where people had expressed their wishes about the end of their life, information including their religious or spiritual beliefs and any arrangements in place were recorded. Staff worked closely with the GP and community nurses to ensure people had a dignified and comfortable death. This included clear identification of people for whom a 'do not attempt cardiopulmonary resuscitation' decision had been made and support in provision of specialist medicines to control unwanted symptoms. End of life care had been provided to one person in 2017. Following this, staff met with the community nurse to review the care and support provided and to identify any areas for improvement.

Requires Improvement

Is the service well-led?

Our findings

There had been several significant changes in the in the management and oversight of Harrington House in the past six months. This included changes to the area manager and registered manager of the home. The current manager had been in post since January 2018. The area manager role had been taken on by the registered manager of another of the provider's homes, in addition to their registered manager role, from November 2017.

Commissioners completed a quality visit in December 2017, in which they identified concerns about the running of the service. The area manager told us when they arrived to carry out the provider's quarterly quality audit the following week, shortfalls in the management of the service were discovered. The area manager said, "We found too many problems within the first 20 minutes. It became very apparent that things weren't in place that should have been in place." Since their arrival, the new home manager had been working through an extensive action plan issued by commissioners and progress with this had been made. Staff said about the above changes, "It's been very unsettled [for staff] and unsettling on the residents." Staff were positive about the new manager's approach, one said, "It is lot more structured. There's been a massive change."

A provider quality audit had not completed since the one carried out in December 2017. The area manager told us their findings at that audit echoed those of commissioners and they had monitored progress against the commissioner's action plan. The area manager told us they and the provider had discussed the area manager role being a full time role the week before our inspection. We found areas for improvement which were not included in the commissioner's action plan, such as need for regular health and safety and infection control audits and need for improved monitoring of soft diets, to ensure staff adherence to SLT recommendations. We discussed the importance of continuing to carry out provider quality audits in addition to working on the commissioner's action plan with the area manager, to ensure expected standards were met in all areas. The area manager told us another provider quality audit was planned for June 2018.

The provider's representative and area manager demonstrated commitment to improving the services provided to people. However, the area manager was dividing their time between two roles and some improvements needed, such as to MCA assessments, had not been completed five months after the need for improvement had been identified.

We recommend that the provider review their capacity for quality monitoring and acting on improvements needed and adjust their management structure accordingly.

The manager's application to become registered manager of the service was in progress. 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 provider's representative and the former manager of the service were both listed as registered

manager with CQC at the time of the inspection. We discussed action to take with the provider's representative, to ensure our register was accurate.

Staff meeting records demonstrated the manager had set out their expectations with staff soon after starting in post. This included reminders about good communication, professionalism, promoting healthy eating and independence and new cleaning rotas for the home. Two deputy managers had been appointed and their job role and expectations of them were being defined.

The manager said, "I come to work happy. I really like the resident group. I'm quite hands on and will do breakfast, assist with bathing or take people out into the community." Staff said, "The office door is left open. People come in and sit with [manager's name]. It has more of a homely atmosphere" and "The residents have all got on with her [manager] really well". A relative said, "I've met the manager on many occasions. [Manager's name] has a can do attitude." We observed that people approached the manager readily. For example, one person went straight in to see them after returning from a shopping trip, they were excited about new clothing they'd bought and wanted to show them. People and their relatives told us they would be happy to approach the manager with any concerns and they were confident they would listen. One said, "[Manager's name] is understanding; She's someone you can go to if you have any problems."

In their conversations with us, the manager demonstrated their knowledge of people living at Harrington House and their commitment to a person centred approach. They understood people's needs and were involved in reviewing and updating care plans to ensure they accurately reflected the support provided. The manager was working collaboratively with commissioners to complete their action plan. They were open and transparent when discussing areas that required improvement and the work completed to date. They responded positively to our feedback at the inspection and informed us of action they had taken in response to this after the inspection. Safeguarding incidents had been reported appropriately to the local authority.

Feedback was sought from people and their relatives in an annual survey. The 2017 survey had been completed in March, results were positive and indicated people were happy with the service they were receiving. A survey for 2018 was to be arranged. Resident meetings had been recommenced in March 2018 and were held monthly thereafter. These were chaired by a retired manager of the home, on a voluntary basis. This arrangement gave people an opportunity to speak with someone outside the home who had influence and could advocate for them. One person said about the meetings, "They are worthwhile. It's important to know what's going on. I do have a say." Social events and open days were held at Harrington House, to which relatives and friends were welcomed. Relatives were happy with communication between themselves and staff. They told us they could approach the manager or provider's representative with any suggestions, including "day to day things that could be done differently."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made.