Hestia Healthcare Properties Limited

Timperley Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 4 and 5 July 2016. The first day was unannounced, which meant the service did not know we were coming in advance. The second day was by arrangement.

The previous inspection took place in February 2015 when we rated the service as "requires improvement". We found a breach of the regulation relating to failure to apply the principles of the Mental Capacity Act 2005. Following our report the manager at the time submitted an action plan dated 18 June 2015 stating how they would meet the requirements of the Mental Capacity Act 2005 in future. At this inspection we found improvements in this area.

Timperley Care Home is a purpose built home in a residential area of Timperley, near Altrincham. There are bedrooms on two floors. Each floor has its own dining area and two lounges. All bedrooms are single rooms with en-suite shower facilities. There are two enclosed accessible secure gardens.

Timperley Care Home offers primarily nursing care for up to 51 people. The home specialises in care for people living with dementia. On the first day of this inspection there were 50 people living in the home. There was building work in progress to create five additional bedrooms and expand the dining rooms.

At the date of this inspection there was no registered manager in post. 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.

We found that the staffing levels had decreased since our previous inspection, although the numbers of people and their needs had not changed. This was a breach of the regulation relating to staffing levels.

There had been a number of serious safeguarding incidents in the months prior to our visit. In one case a person living in the home had left the building unnoticed and been found several hours later. Two staff had falsely recorded that the person was present in the home, after they had left the building. This was a breach of the regulation relating to keeping people safe. There had also been a number of concerns raised about failure to prevent and treat pressure sores. Several of these concerns had been discussed at strategy meetings. At this inspection we checked and saw that appropriate action had been taken to make sure lessons had been learnt and risks to people reduced as a result of action taken by the provider.

The building was kept clean but we had received reliable information that a staff member's dog had been allowed to wander freely and soil the floor, on a regular basis. This was a breach of the regulation relating to infection control.

Medicines were administered and recorded appropriately.

Recruitment records showed that checks were made to ensure people who were unsuitable were not recruited. Staff were trained to recognise and report signs of abuse. Where necessary firm disciplinary action was taken against staff in order to protect people.

The building was well maintained. There was ongoing building work to extend the home.

In contrast with the previous inspection Timperley Care Home was now implementing the Mental Capacity Act 2005 and had applied for authorisations under the Deprivation of Liberty Safeguards (DoLS). Best interests meetings were held and well documented.

The home had been subject to criticism by a coroner in April 2016 for not keeping accurate records about whether a person had a DoLS authorisation, but we saw a file listing all applications and authorisations.

Training was arranged for new recruits and on an ongoing basis for existing staff. There was regular supervision and staff were supported with performance development plans.

The dining rooms were small but due to be extended. People were supported to eat appropriate diets and their weight was monitored. People's health needs were met.

The décor of the building was colourful. There were some adaptations to make the environment suitable for people living with dementia.

People living in the home and their relatives spoke highly of the care provided. There was high praise from families of some people who had passed away in the home.

An informal homely atmosphere was encouraged by staff not wearing uniforms, but some people including staff told us they would prefer for staff to wear name badges.

We saw some good examples of a caring approach by staff. However, we also saw some instances where the care should have been better. These were perhaps partly caused by the staffing levels. We also observed that care planning was not meeting everyone's needs. These examples were a breach of the regulation relating to meeting people's needs.

Advocates were used to represent people's interests when needed.

Timperley Care Home was validated to deliver end of life care, and arrangements were made when it was appropriate for people to die in the home rather than in hospital.

Care files were kept on the computer system which was designed to remind staff when documents needed to be updated and reviewed. On some people's files there was contradictory information. Some information we would have expected to see was absent.

Activities were organised but there was scope to devise some more suitable activities. There was an attractive garden but it was not being used to its full advantage.

There had been a lack of continuity in the leadership since January 2015. There had been a series of home managers, none of them had registered with the CQC. Several other senior staff had left. The operations manager had remained through this time but had other responsibilities in the region. A new deputy manager was now in post and a new home manager was about to start.

This lack of permanent leadership had affected staff morale and the quality of the care in the home. We saw evidence of stress amongst the nurses and poor leadership, which had contributed to the safeguarding issues in recent months.

There was an audit programme but audits had not been completed recently. This was a breach of the regulation relating to assessing and monitoring the quality of the service.

The provider was displaying the rating of our previous inspection on their website but not within the home. We were told it had been on display but had been moved because of the building works. This was a breach of the regulation regarding displaying of ratings.

We found breaches of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .You can see what action we told the provider to take at the end of the full version of the report.

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.

Staffing levels had decreased since the previous inspection although the needs of people living in the home had not changed.

A recent incident had been caused by an exit to the building not being secure during building work. The home had improved its procedures to prevent the development of pressure sores and to stop them getting worse.

Recruitment processes were safe and staff were trained in protecting people from abuse.

Is the service effective?

Good

The service was effective.

Timperley Care Home had improved its practice in complying with the Mental Capacity Act 2005. There had been criticism of its records of Deprivation of Liberty Safeguards applications, but this had recently improved.

Training of new recruits and existing staff was thorough. There were regular supervisions to support staff and a system of performance development.

The dining rooms were being extended. The food was well liked. People's weight was monitored. The environment had been designed to be suitable for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw some good examples of care, but we also saw some poor examples, perhaps associated with the number of staff on duty.

People living in the home stated they were on the whole pleased with the standard of care they received. Some relatives had been very complimentary about the care given to their family

members.

Timperley Care Home offered good end of life care and had been praised for its work in this area.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service used a computerised system for care plans and daily notes. This was potentially a good system but there were drawbacks to how it was currently being used.

There was a programme of activities but they were not all appropriate and the garden was not being used to its full potential.

The system for dealing with complaints had not always been used effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had not been a permanent manager since January 2015, and there had been a lack of continuity of leadership. This had affected staff morale and the quality of the service.

There was a system of audits and monitoring, but many of the audits had not been carried out in recent months. The provider had failed to identify and address the shortfalls we found at this inspection.

Timperley Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 July 2016. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert by experience had personal experience of supporting older people.

Before the inspection, the provider completed a Provider Information Return (PIR) in June 2016. 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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. During 2016 we had attended several safeguarding meetings led by the local authority relating to a number of concerns raised about Timperley Care Home. We used the information from these meetings to inform our planning.

We contacted Healthwatch to ask if they had any information about the home. They had no direct involvement with the home but had some indirect feedback from a relative. We contacted the commissioning team of the local authority and a senior nurse responsible for quality monitoring at Trafford Clinical Commissioning Group (CCG).

During the inspection we spoke with nine people living in the home, six relatives, the operations manager, deputy manager and six care staff. We spoke with a visiting professional. We observed the way people were supported in communal areas and looked at records relating to the service.

We conducted an observation known as a SOFI (Short Observational Framework Inspection). This is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

We looked at seven care records on the computer system and in paper form, four staff recruitment files, daily record notes, medication administration records (MARs), maintenance records, the audit file, records of complaints and compliments, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

We asked people living in Timperley Care Home whether they felt safe. We also asked visitors whether they felt their relatives were safe and well cared for. One person said, "Yes, I am in good hands." A visitor said, "My relative is in safe hands, the home is always clean." Most of the people we spoke with told us they felt happy in the home. However, when asked this question two people living in the home commented that there not always enough staff on duty. One said, "Like everywhere, they are short of staff."

The staffing rota stated there were four support workers and one nurse on each floor. Our observations of the staff on each floor confirmed this was the case. At night there was one nurse and three or four support workers covering both floors. The operations manager told us there was a plan to increase the levels to five support workers on each floor, and they had been seeking the provider's agreement to this. They explained this was due to higher numbers of people living in the home, and the need to safely manage them. However, the home was full at the time of our inspection. At the previous inspection in February 2015 there had been the same number of people living in the home. At that time we reported there had been nine or ten support workers on the morning shift across both floors, eight or nine on the afternoon shift and four or five at night. This meant that staff numbers in July 2016 had fallen since the previous year.

One person told us the home, "Does not always have staff to wheel me out to get some fresh air." They added, "Sometimes it takes longer than 10 minutes, probably 20 minutes at night for staff to respond to my call."

We asked staff whether they felt there were enough staff on duty. A senior member of staff said, "I would prefer five carers on each floor." Another member of staff told us, "We could always do with more. We could do with five staff on the floor for the whole day." They added that the numbers of staff at weekends were often lower, and that more agency staff were now being used because regular staff had left. The rotas for the week before and the week of our inspection showed that one or two agency workers were used each day. In a survey completed in February 2016 one member of staff wrote, "I do have concerns that there is a lack of staff on the units to adequately care for the service users which has a knock on effect on the updating of residents' information in particular the care plans which are not more personalised." A different member of staff had made the same point at a staff meeting in February 2016, but there was no record of a response by management. There was further evidence that staff had felt under pressure due to numbers in an exit interview form written by a member of staff who was leaving: "I have felt extremely stressed over the past few months due to short staffed and training overseas staff." There had been a programme in 2015 to recruit nurses and other staff abroad, although this had now ceased.

We considered that the decreased staffing levels had contributed to a number of problems and safeguarding incidents within Timperley Care Home. The failure to ensure adequate staffing levels was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One such incident related to a person who left the home unnoticed through an unsecured exit, during the building work in June 2016. Due to their support needs staff were required to check on their wellbeing every

15 minutes. Although subsequent investigations found the person had left the home at 7.15pm, staff had recorded they had completed checks on four occasions between the person leaving the home and the alarm being raised at 10pm. The fact staff recorded checks that had not been completed had meant the alarm had not been raised sooner.

The failure to realise the person was missing increased the risk to the person concerned, because Timperley Care Home did not contact the authorities to notify them of the person's absence. There was a swift disciplinary process which resulted in the two members of staff being dismissed. This showed that the provider appreciated the seriousness of the incident. The operations manager had reminded the builders to keep the building secure. Nevertheless, the failure to keep the person using the service safe, aggravated by the false recording, was a breach of Regulation 12(1) and 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we had also been made aware of an injury that had occurred to a person who had been assessed as requiring specific equipment prior to their admission to the home. The subsequent investigation identified these aid and adaptations had not been provided in time for the person moving into the home. The delays in implementing the agreed adaptations to keep the person safe were a further example of not doing everything reasonably practicable to mitigate risks.

During late 2015 and early 2016 we had received concerns about how Timperley Care Home was protecting people from the development and deterioration of pressure sores. These can occur when the skin breaks down and are often caused when people remain in the same position for too long. Treatment includes regularly turning people in bed and providing special cushions. Some of the concerns were raised by tissue viability nurses, who are nurses from outside the home who specialise in the treatment of pressure sores. Among other concerns they stated that the home had been slow to summon tissue viability nurses.

The cumulative evidence about pressure sores was that for a period Timperley Care Home had failed to respond to and treat pressure sores appropriately. We discussed this finding with the operations manager who stated that things had improved since the early part of 2016. Training sessions had been delivered to all care staff. Staff had been reminded to look out for pressure sores and to ensure correct treatment. We were not aware of any new issues regarding pressure sores, since April 2016.

On the days we visited the home was clean and tidy, but we noticed an unpleasant odour at one point near the nurses' station on the ground floor. We observed this in some bedrooms and lounges at intervals during our inspection. Cleaners were busy throughout the day, and the operations manager told us that new flooring would be installed once the building work was finished, which would be easier to clean.

We had received information from a senior nurse responsible for quality monitoring at Trafford CCG who had visited the home twice in June 2016. They commented, "I have some reservations about the general cleanliness. There have been occasions where the environmental odour has been unpleasant and a lack of staff awareness of need to use air freshener." They also described seeing a staff member's dog wandering freely around the corridors on the first floor. Although the dog was not present when we visited because the staff member was on leave, we had met the dog on previous inspections and knew that it was allowed to wander round, and indeed many people living in the home were pleased to see the dog. However the senior nurse informed us that they found the dog had left faeces on the carpet in someone's bedroom, while the person was asleep on their bed. The senior nurse continued, "The staff responded immediately to my request to clean the area. Once completed they commented that the dog defecating on the carpet is a regular occurrence and that they were fed up of complaining about it. A visitor commented to me that she had also observed this happening and stated that she could tell by the odour that the dog had 'done her

business' somewhere. "

We discussed this with the operations manager who had received the same complaint from the senior nurse. They stated they were unaware this was a regular occurrence, but they would speak to the caretaker on their return and insist that the dog remained under control or not be allowed into the home. They confirmed shortly after the inspection that they had done so, and also reminded all staff about their cleaning duties. Nevertheless we considered that allowing the dog to defecate in indoor areas had constituted a risk of infection to the people in the home. This was a breach of Regulation 12(1) and 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were administered. They were dealt with separately on each floor. We observed the morning administration round on one floor. We noticed that the medication administration records (MARs) recorded all the medicines were given at 9am, although some were administered much later than this. This created the risk that some people who received lunchtime medicines might receive them too close to their morning dose. The nurse told us that they knew which people received medicines at lunchtime, and ensured they got their morning dose early. But a more accurate system of recording the time given on the MAR sheet might reduce the risks.

At our previous inspection we noted that there was a zero tolerance approach towards medication errors. This meant that all medication errors were reported, investigated and action taken.

Since the last inspection there had been two instances when incorrect doses of medicines had been given to the same person for three months and one month respectively. These incidents had been investigated and steps taken to prevent a recurrence. Although those errors were potentially serious, they were both primarily not the fault of Timperley Care Home and the home had acted promptly to rectify them when they came to light. We were not aware of any other medication errors since the previous inspection.

We saw that medicines including controlled drugs were stored safely and securely, and there was a reliable system of ordering medicines to avoid people running out.

Accidents and incidents were reported and we saw a record of falls over a 12 month period. At a staff meeting in April 2016 staff were reminded to record details of accidents in full. The reports that we saw at this inspection had sufficient detail.

We examined the recruitment records of three members of staff to see whether appropriate steps had been taken to ensure suitable members of staff were appointed. The application forms required people to state their employment record and account for any gaps in their employment history. References and evidence of identity had been obtained. There was a note of the Disclosure and Barring Service (DBS) certificate reference number. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. Employers can also obtain an Adult First check which allows people to work under supervision until the DBS certificate arrives. We saw a note on the personnel file stating that employment could not commence until either the Adult First check or the DBS certificate had been obtained. One staff member who had started recently confirmed to us that this had been the case for them. These measures meant that Timperley Care Home was acting appropriately to ensure that only suitable people were employed.

Staff were trained in safeguarding as part of their induction and told us they had regular refresher training. We confirmed this from the training record. We asked staff about their understanding of safeguarding and

they were able to describe to us the various forms of abuse that might occur in the home. One person said, "Yes I know what to look out for and I would immediately report it to the management. I never have had cause to suspect anything." □

We obtained a copy of the provider's policy on "Adult Abuse" and saw that it focussed on preventing abuse, identifying abuse and how to investigate any allegations of abuse. It emphasised that all staff shared the responsibility to report any suspicions they might have. We knew from notifications received that the operations manager and other managers in the home were prompt to report safeguarding issues to the local authority and to the CQC. This meant they realised the importance of the safeguarding investigation process as a means of driving improvement in keeping people safe.

Good

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 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our previous inspection in February 2015 we found that the provider did not have suitable arrangements in place to meet the requirements of the Mental Capacity Act 2005. This was because mental capacity assessments had not been completed or correctly completed in all cases where people needed them. We also found that an application for a DoLS authorisation had been submitted incorrectly. The home submitted an action plan stating, "The operations manager will monitor and record that mental capacity assessments have been completed and DoLS authorisations applied for."

In May 2015 we were informed by Trafford Council that they had not received any valid DoLS applications from Timperley Care Home. The Council stated this was a matter of concern.

Timperley Care Home in June 2015 notified us that they had applied for a number of DoLS authorisations at the same time. At this inspection we saw a file which recorded that the majority of people in the home now had either DoLS applications or authorisations. In the PIR submitted before this inspection they stated they were planning an improvement to "Ensure all residents have a DoLS in place." However this was not the correct approach to DoLS. Not everyone needs a DoLS authorisation simply because they are living in a care home, it depends whether there is or needs to be a restriction on their liberty. Moreover not everyone would be assessed as lacking capacity to consent to restrictions. We drew this to the attention of the operations manager and deputy manager.

When a person who is the subject of a DoLS authorisation dies their death must by law be referred to the coroner. This had happened in December 2015. The coroner held an inquest in April 2016 and found fault with Timperley Care Home because they had not kept proper records. The operations manager at the inquest was unable to confirm whether or not the deceased had been subject to a DoLS authorisation. The coroner required the provider to report what action they would take in response to their finding, which the provider did. By the date of our inspection we saw that the DoLS file did contain information about all the DoLS applications or authorisations within the home. This provided us with assurances the provider had acted on the instruction of the coroner to make improvements in this area.

We saw an example of a best interests decision that had been taken in June 2016 regarding giving medicines to a person covertly, which means without their knowledge. The decision included a mental capacity

assessment to determine whether the person could give consent to this practice. The assessment concluded they could not. This was followed by a best interests meeting which decided that giving the medicines covertly was in the person's best interest. The GP had been consulted and the meeting was attended by the operations manager, clinical lead, a solicitor acting for the person and the best interests assessor appointed by the local authority, the Supervisory body. The paperwork gave a clear rationale for the decision.

We saw in records of best interests meetings that advocates were brought in to represent people when they were unable to express their wishes. In one person's case there had been a best interests decision relating to personal care, eating in the dining room, what assistance staff should give, and what cutlery they should use. It was recorded that they had used an independent mental capacity advocate (IMCA). This meant that their interests were expressed at the meeting.

Although there had been some issues with DoLS since the last inspection we were satisfied the provider had taken steps to become compliant with the relevant regulation in respect of MCA and DoLS.

A record of induction training was kept on the files of new recruits. At the date of the PIR in June 2016 no staff had completed the Care Certificate which is a nationally recognised induction for staff new to care. However, the training record showed that recent new starters had commenced the Care Certificate. We were informed they also followed the provider's own induction programme. Staff we spoke with told us they received regular training and refresher training in all areas. We confirmed this from the training matrix. Some training was done by e-learning (in other words on the computer) and some in a classroom setting. Moving and handling training for example was delivered in the classroom. We saw the schedule of classroom training planned for July and August 2016. This included sessions on first aid, infection control, care planning and documentation, MCA and DoLS, and two sessions on dementia awareness. These two sessions were a week apart and designed so the maximum number of staff could attend. One member of staff told us there used to be more e-learning but it there was now more face to face training. They received a schedule in advance telling them which classes to attend.

Following the issues regarding a number of people whose pressure sores had deteriorated, the home had organised additional wound care training, delivered by a tissue viability nurse. This showed that training was arranged to reflect the needs in the home.

One member of staff told us they were supported and encouraged to take national vocational qualifications (NVQs). They had done Level 2 and Level 3 in 'health and social care with dementia' and were embarking on Level 3 in leadership and management. This showed that staff were enabled to develop their skills.

Staff told us that they received regular supervision. This was confirmed by the schedule which showed that staff received supervision roughly every three months. We saw records of supervision sessions which confirmed that they were meaningful discussions between staff and their line manager. The operations manager told us that the provider did not conduct annual appraisals but instead used a "performance development plan" throughout the year. This meant that staff were supported to think about their aims and career development plans.

In our last report we commented that the dining rooms on each floor at Timperley Care Home were relatively small with room for only 12 people to sit, so that people had to eat in sittings. At this inspection we learnt that part of the purpose of the building works was to extend the dining areas to accommodate more tables. We observed breakfast on the first floor and lunchtime in both dining rooms. Lunch on one floor became quite chaotic with food and cutlery being thrown at some stages. We saw that the staff handled

things well, calming people down and enabling the meal to continue.

Our observation in the other dining room was there was a good choice of food and people evidently enjoyed their meals. People were given appropriate help to eat when needed. We asked people about the food and received positive comments. One person said "The food is good," another said "Yes there's always enough to eat."

People's consumption of food and drink was recorded on a chart. We asked how accurate this was since staff had to recall the information at the end of the meal, but they assured us they could remember what each person had eaten and drunk. This information would be particularly relevant if there was a concern about a person's weight loss. People were weighed weekly or more often as required and their weight recorded on their electronic care file. The records we saw were up to date. We saw evidence that people were referred to a dietician when needed.

The building was decorated colourfully and there were items on the walls for people to touch or look at. Bedroom doors were made to look like the front doors of houses with door knockers and large numbers, and were painted different colours to help people recognise them. One of the lounges was an imitation of an old-fashioned tea room. There were bright colours but there were no zigzags or stripes which can be disorientating. The colour scheme in the main lounges and in people's bedrooms was less complicated. The operations manager told us that the décor had been chosen carefully based on research at Stirling University. The provider had put some research and resources into creating a suitable environment for people living with dementia.

We saw from care records that people's health needs were met. One relative told us staff escorted their relative on hospital specialist appointments, and that they saw the chiropodist regularly. The speech and language therapy team (SALT) were involved where needed to give advice when people had swallowing difficulties.

Requires Improvement

Is the service caring?

Our findings

We saw some examples where the care could have been better. Our observations showed there was no staff presence in the downstairs lounge for about 15 minutes during the morning period. One of the people called for help, but was not given help to get to the toilet in time and urinated in their chair. This was both undignified and potentially unhealthy. It might have been avoided if the staff had been in the room and either asked or observed that the person needed assistance. We have already reported that staffing levels had reduced, and this may have contributed to the absence of staff on this occasion. A second person was not helped with their breakfast until a domestic worker helped them with their food later on. The lack of attention to people's needs was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living in Timperley Care Home whether they felt well looked after. The responses were positive: "Very good", "The care is excellent. Staff are kinder here than they were in [some other homes]", "Better than I expected. The staff are very obliging, helpful." Another person said, "I am treated well as a person, with courtesy and respect." They added, "But sometimes I have to remind staff to shut the bathroom door when I am using the urinal." We discussed this comment with the operations manager at the end of our inspection. They explained that this person needed assistance to get into the ensuite bathroom but could then be left alone. They agreed to remind staff to ensure this person's privacy was fully respected.

Healthwatch Trafford told us they had received positive feedback in relation to end of life care.

We looked at a file of compliments received by the home. Several relatives during 2016 had expressed gratitude for the quality of care: "Thank you for the care you gave and the compassion you showed. The staff were brilliant with dad and would always ensure dad's needs were met. You made sure he was continually assessed by the relevant agencies and care plans were adapted to suit dad right to the very end. Our journey and dad's has been difficult but was made easier by you all."

Other relatives had written, "We can cope much better with [relative's] situation knowing you are there to care and help." Another relative wrote of the staff, "They have provided a high standard of care in all areas and this has been and continues to be a tremendous comfort to me and my family."

People were cleanly and smartly dressed, and generally well groomed. The operations manager confirmed that people were offered a shower daily, and we saw this was recorded in the daily notes on their care plan. There was a relaxed and informal atmosphere in the home, and it did not feel institutional. This was partly because staff were not wearing uniforms. We had commented in our last report that this made it difficult to distinguish staff from visitors, and suggested it might be a good idea for staff to wear badges to enable people in the home and visitors to identify them. We saw this had been discussed at a recent staff meeting in April 2016 when it was recorded in the minutes, "Relatives like the idea of a name badge and a uniform." A nurse administering medicines told us they thought people who were occasionally reluctant to take medicines might be more willing if they were wearing a uniform. The same was stated as the view of an external professional on one person's behavioural care plan.

We saw some examples of a good caring approach by staff. One person sitting in the lounge was upset, and saying repeatedly "I want to go home." A support worker sat with them patiently holding their hand and offering reassurance. When staff were moving people from their wheelchair to an armchair, using a hoist, they explained what they were doing in order to reassure people. We observed that staff were gentle and patient with people living in the home, although most of the time staff were busy and did not have the opportunity simply to spend time with people.

Although we saw some people were supported by formal advocates we noted that the term 'advocate' was used to refer to any family member in the computerised records, and pointed out to the operations manager this could create a false impression, as not all family members are advocates. In the provider's complaints policy it was stressed, rightly, that it should not be assumed that someone complaining on behalf of a person using the service necessarily had permission to speak on their behalf or to be given confidential information about them.

The care records kept on computer were in a secure system to which only staff and authorised visitors had access. This meant that the confidential records were kept securely. Many of the documents were duplicated in paper files for ease of access. These were kept in a locked room at both nurses' stations. This meant people's right to confidentiality was respected.

Timperley Care Home allowed people to remain in the home until the end of life, rather than transferring them to hospital. There was a policy developed within the home to deliver end of life care. We saw evidence that an end of life care facilitator from a local hospital had visited the home on 1 June 2016 and revalidated the home as a 'Six Steps' home. The Six Steps is a nationally recognised programme, developed in the North West, for providing high quality end of life care. The facilitator in their report confirmed that Six Steps training was introduced for new staff, and that there was an effective planning process for people as they approached the end of life. Arrangements were made to obtain specialised end of life drugs when needed. The facilitator confirmed that the home offered privacy, dignity and respect for individuals and their families as the end of life approached. They concluded their covering letter with their report by commending the home, "You have done well with your Six Steps training, cascading and revalidation."

At the date of the PIR in June 2016, 30 people had a DNACPR form in place. DNACPR stands for "Do not attempt cardio-pulmonary resuscitation" and is a form, signed by a doctor, which allows care workers or paramedics not to attempt resuscitation in the event of a cardiac arrest. Where people had these forms in place it was clearly marked on their paper care files, which was important as paramedics would need to see the form quickly in the event of an emergency. 30 people had a care plan setting out their advance care preferences. At the date of our visit there was one person who was being treated as approaching the end of life. We saw their end of life care plan which covered all the necessary elements. We saw that the person was being nursed in bed and appeared to be comfortable.

Requires Improvement

Is the service responsive?

Our findings

We reviewed the provider's complaints policy, dated November 2014. This stated that any verbal complaint should be taken seriously and details of the complaint and its resolution should be recorded. A target of 28 days was set for responding to any complaint, or an explanation should be given if more time was needed. The policy added that complaints and their outcomes should be discussed with a view to learning lessons from them.

Timperley Care Home had its own complaints procedure which was given to families. It included contact details for the local council and the Local Government Ombudsman whom families could contact if they were unhappy with the initial outcome of their complaint.

In the PIR the operations manager stated Timperley Care Home had received four complaints within the last 12 months. We knew about several of these because the people involved had also contacted us. In one case the family had chased a response seven weeks after their initial complaint. We saw the response provided did not fully address the issues raised in the complaint. Nor could the provider demonstrate a full investigation had taken place.

In the complaints file there was a complaint by another family member from early May 2016. We could not see a reply. The operations manager told us the home manager at the time had held a meeting with two family members and the complaint had been resolved. There was no record of this meeting on the file. The handling of the complaint therefore did not conform with the provider's policy. This meant the provider could not demonstrate they had appropriately responded to the complaint.

These failings to handle complaints effectively amounted to a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found conflicting information in one person's care records. The list of medication was not up to date compared with what was on their MAR chart. Also, they had a history of falls and their initial assessment on mobility on transfer into the home stated, "requires assistance of one staff and may require the use of transfer aids." This did not correspond with the care plan which stated "fully ambulant and safely mobile without aids – no history of falling from bed." This contradiction might confuse staff, especially staff unfamiliar with the person, and cause additional risks relating to moving and handling. These inaccuracies in the records were a breach of Regulation 17(1) and 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At breakfast we witnessed staff talking loudly into one person's ear. This appeared undignified, although it was clear that the person was very hard of hearing and this was an attempt to ensure they could hear what was being said. Later in the morning we observed a different member of staff shouting into the person's other ear. It appeared there was uncertainty as to which was their 'good' ear. We checked the person's computerised records but there was no information about hearing loss or any plan for compensating for it. This meant that the care planning process had not addressed this important aspect of care and staff were

left to improvise. The care and treatment of this person did not meet their needs. This was a further breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Timperley Care Home used a computerised care file system. Staff created and updated care plans and daily notes on the computer. There were desktop computers at each of the nurses' stations and several laptops available to access the system. The nurses' stations were in the main corridor on each floor just outside the main lounge which meant that staff could work on the care plans while also keeping observation on the people in the lounge.

The home page of the system was a list of all the current people in the home. From here staff could press a button to print off an urgent admission pack if someone needed to be transferred to hospital. This included a summary of their care needs and a list of current medication. This was a useful resource which meant that vital information could accompany the person to hospital.

The care plan had multiple sections. Each section outlined the level of need: low medium or high in relation to physical need, health need and emotional need. This was a clear and easily accessible system. The plans we saw on the system were for the most part thorough and up to date. Staff had been reminded in a recent staff meeting to utilise all aspects of the system and complete the care plans fully. They were also reminded not to copy and paste from one care plan to another, which suggested this was an ongoing problem (we had commented on the use of similar phrases in different care plans in our last report). We did not see evidence of this happening in the records we looked at it in this inspection.

The system flagged up when reviews needed doing which meant in theory that reviews would be completed when due. We saw that care plans were being updated and reviewed at regular intervals. At the same staff meeting, in April 2016, staff were reminded to watch out for the notification that an urgent update was required and to take action. It also reminded staff when regular tasks needed completing, such as weight measurement, Waterlow (risk of pressure sores) charts or daily notes. Provided staff responded to these prompts this was a system which should ensure tasks were completed on time.

In many cases paper versions of some documents were printed out and kept in files by the nurses' stations. We observed this had the potential to cause confusion because the paper versions did not always correspond with the version on the computer, which was more likely to be up to date. However sometimes there was information on the paper files which was not on the computer system. There was one person whose paper care file recorded that they were receiving s117 aftercare. This is care given to someone who has previously been detained under a section of the Mental Health Act 1983. There was no reference to this on the computer system, which meant there was no record that this aspect of their care was being followed up. There was also some out of date information. One file that we saw on the system recorded that a person's keyworker was a nurse who had left Timperley Care Home about six months earlier. This was corrected at once.

One person had a "This is me" plan which gave a personal history of them and their close family members. It described how a doll could be used with this person in a therapeutic way. Often a doll can be used to comfort or calm people living with dementia. We saw this in practice at lunchtime when the person became upset and threw their food. A support worker gave them the doll which served as a distraction. The person began happily talking to the doll and was able to continue their meal. This was a good example of person-centred dementia care both in the care plan and in action.

In one case the "This is me" plan was blank on the computer system, and was not present in the paper file. We asked the operations manager about this who told us they would have had a "This is me" completed

when they moved in, but it must have been archived. This meant it was no longer available to inform staff. For another person the "This is me" document included a lot of contribution by family members, which meant that personal history about the person could be included.

There was a system of keyworkers intended to enable staff to build up special knowledge of particular people living in the home and also to liaise with their family. We were given a list showing who staff were keyworkers for. The system had fallen out of use. The computer records were not always correct. One member of staff did not know who they were a keyworker for, and told us, "I have been a keyworker in the past. At the moment I am not sure if I am. Perhaps a new manager will sort it."

Timperley Care Home had an activities organiser and there was a weekly plan of activities. We saw these activities taking place during our inspection. We noted however that not all of the activities appealed to the people living in the home. For example a giant game of Connect 4 was brought into the lounge but people did not become engaged with it. We considered there was scope for the staff to develop more suitable activities. At another point while we were conducting our observation in the downstairs lounge, an agency member of staff came in and started clapping in front of one person and saying "music". The person made no response. Later on, however, we saw some people were dancing and singing along to a Neil Diamond CD. One person who had previously appeared withdrawn was singing and knew all the words. This was an example of an enjoyable and meaningful activity.

There was an attractive garden with chickens and rabbits, and access was not affected by the current building work. Several people expressed the desire to go into the garden, and we saw a staff member taking one person out in a wheelchair. They asked if anyone else wanted to go, and one person went out and collected some eggs. The garden was evidently a great asset to the home. However, later in the day the door was closed even though some people were asking to go out. We asked the operations manager why the door was closed and they said it was because some people complained of the cold.

One person, who was able to conduct a conversation with us, told us that they felt isolated and had no-one to speak to. They spent most of the time in their bedroom, because they said they did not have a lot in common with other people living in the home. They said, "I do get a bit lonely. I don't join the others for meals as they are not like me mentally. I would like to be able to play a game of chess with somebody." The operations manager told us later that staff did spend time with this person and played chess and card games, but evidently the person's perception was that this was not enough.

Residents' meetings were held. We were unable to see the minutes of the last one because, we were told, they had been taken by the previous home manager but not typed up, and they had not left their notes behind.

Requires Improvement

Is the service well-led?

Our findings

The operations manager had previously been registered manager until they deregistered in May 2016. In practice they had not acted as full time registered manager since January 2015, when they became operations manager for the region. There had been a succession of four home managers since then, none of whom had registered with the CQC. There had also been short gaps without a home manager. In February 2016 the home manager and the deputy manager resigned at the same time. The operations manager had retained close oversight of Timperley Care Home, while also being responsible for other homes in the region. They were present during this inspection. A new deputy manager had been in post for a week, and we were informed that a new manager was due to start in two weeks. There was also a new clinical lead in post, and attempts being made to recruit another.

We saw that the uncertainty over the leadership had caused stress. The local authority had obtained a copy of the minutes of a nurses' meeting in November 2015. This was in relation to one of the serious safeguarding issues over pressure sores, mentioned earlier in this report. The operations manager rebuked the nursing staff in no uncertain terms, using intemperate language. The following is an extract from the minutes: "I have seen you sat around the nurses' station. Make time for the residents as they pay your wages. If you don't want to care for them then leave now. The residents are being neglected. If you want to go, go but we will help you if you want to stay, don't take the [use of expletive] is that clear?" Addressing senior staff in these terms indicated problems in the leadership of the home.

The lack of continuity had impacted on the staff and on the quality of care provided at Timperley Care Home. One member of staff commented, "We work well as a team, but I would like to have one manager." In March 2016 officers from the local authority conducted a visit following concerns raised about the service. They reported: "The care documents were recorded but appeared sloppy with unnecessary mistakes in parts … [the operations manager] did advise that ...there had been a lot of staff leave for reasons of their own or due to concerns."

At a staff meeting in April 2016 a new home manager introduced themselves. The minutes recorded their assessment of the home: "Due to the lack of permanent leadership [they] can see where there have been issues and inconsistencies and want to make it better and will be relying on the staff to bring to their attention any problems." This home manager resigned after a couple of months which was why there was no home manager at the time of our inspection. There had not been another staff meeting since April but one was scheduled shortly after our inspection.

Despite these problems, we saw some positive feedback about the quality of leadership within the home. A survey was sent to professionals in contact with the home in February 2016 to ask their opinion of the home. One replied, "Both the staff and the management at Timperley Care Home offer a well thought out and professional service. I cannot recommend it highly enough."

The same survey was sent out to relatives of people living in the home, although the record showed that only 10 surveys were sent out (of which five were returned), which made it less representative of the views of

relatives of around 50 people living in the home. One relative responded, "I think the staff do a wonderful job and I would recommend Timperley Care Home to anyone looking for the best care."

We looked at the 2016 audit file and saw there was a comprehensive schedule of audits, but not all of them had been carried out recently. The call bells were supposed to be checked daily. Weekly audits were planned of medication (by floor), care plans, first aid supplies, skin condition and room cleaning. Monthly audits were scheduled of medication (overall), infection control, mealtime experience, accidents and falls and the environment.

However, the audits had not all been regularly carried out. In May 2016 the only audit was a first aid equipment check. In June 2016 there had been a medication audit but nothing else. No environment audit had taken place during 2016. We requested to see an audit or analysis of falls. The operations manager told us there was no such audit, although it was listed in the schedule of monthly audits. They added that they were planning to introduce one. These lapses were doubtless due to the lack of continuity in the management team, but they represented a failure to assess and monitor the quality of the service. This was a breach of Regulation 17(1) and 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a good example of a care plan audit which had resulted in action. It had been carried out by the former deputy manager, who identified that a person's weight loss had not been reflected in their care plan. Action was required at the end of the audit, to re-weigh the person and refer them to the dietician. Similarly the operations manager had carried out an infection control audit resulting in an action plan to speak to the staff about cleaning the carpets more thoroughly. An audit of the computerised care records resulted in a request to keyworkers to complete care plans by a certain date (the keyworker system was still operative at that point). These were all examples of an effective audit system.

It is a requirement of the regulations that providers display the rating received in their last inspection conspicuously within the home and also on their website. The rating of 'requires improvement' from the last inspection in February 2015 was visible on the Timperley Care Home website. It was not on display in the home on the days of our inspection. The operations manager assured us it had been displayed in the porch behind the front door, which was currently not in use due to the building work in progress. The rating had not been moved to the temporary entrance at the back of the home. We were informed the rating would be displayed again immediately. However, the building work had been in progress for several months. Failure to display the rating was a breach of Regulation 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to notify the CQC of certain events within the home, including deaths, serious injuries and safeguarding incidents. As far as we could tell from our records Timperley Care Home was fulfilling this requirement in terms of making notifications. We had however noticed that half a dozen death notifications during the winter of 2015-16 had been very similar or identical in their wording, and not very informative about the circumstances surrounding the death. We mentioned this to the operations manager who agreed they were not acceptable. They had been written by a former home manager. Recent notifications had been more informative.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs. Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to mitigate risks to service users by keeping the building secure at all times and keeping accurate records of where people were. Regulation 12(1) and 12(2)(d) The provider had failed to assess and control the risk of the spread of infection. Regulation 12(1) and 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not always operating effectively a system for handling complaints. Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not maintaining accurate and complete records in respect of each service

user.
Regulation 17(1) and 17(2)(c)

The provider had not provided enough resources to assess, monitor and improve the quality of the service.
Regulation 17(1) and 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying the rating of the previous CQC inspection within the premises. Regulation 20A(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of staff were deployed to ensure the service could meet the care and treatment needs of service users. Regulation 18(1)