Hestia Healthcare Properties Limited

Timperley Care Home

Inspection report

53d Mainwood Road
Timperley
Altrincham
Cheshire
WA15 7JW

Tel: 01619808001

Date of inspection visit:
23 January 2017
25 January 2017

Date of publication:
07 April 2017

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place over two days on 23 and 25 January 2017. The first day was unannounced, which meant the service did not know we were coming. The second day was by arrangement.

The previous inspection took place in July 2016 when we rated the service as "requires improvement". We found breaches in six areas of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. Following our previous inspection, the service submitted and action pal dated 15 July 2016 stating how they would meet the requirements identified. At this inspection we found improvements in these areas.

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, there is a hairdressing salon situated on the first floor next to the passenger left. All bedrooms are single with their own en-suite shower facilities. There is an enclosed accessible, secure garden off one of the lounges on the ground floor.

Timperley Care Home offers primarily nursing care for up to 56 people. The home specialises in care for people living with dementia. At the time of our inspection there were 55 people living at the service.

At the time of this inspection the home was managed by a registered manager who was registered with CQC in. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some people's medicines were not managed and administered in a safe and proper way, which meant there was a risk of people not receiving their medicines as required.

Waste management at the service was not being managed appropriately. This increased the risk of cross infection or vermin infestation.

There were sufficient staffing levels on duty throughout our inspection. The recruitment process was robust, however were found despite the staff receiving appropriate training. Staff were not receiving regular supervision which provides staff with the opportunity to raise concerns and identify any additional training needs they may have.

Staff knew how to keep people safe and people we spoke with felt they were safe with the care and support they received from staff at Timperley Care Home. Safeguarding incidents had been reported and accidents were recorded and action taken to minimise the risk of reoccurrence.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important

decisions for themselves.

We observed caring interactions between people and staff who knew them well. Care plans reflect people's current needs and were regularly reviewed and updated as required. People's care files contained details about their wishes in respect to end of life care.

At the time of inspection there was no activities coordinator in post due to outstanding checks to ensure they were safe to work with vulnerable people. This meant that at the time of the inspection there was limited activities being undertaken with people living at Timperley Care Home.

The service had a formal complaints procedure in place, but this was not available in different formats to support people living with dementia to understand. Any complaint received was recorded and acted on in a timely manner.

The service now had clear records detailing the audits which had been completed and showing any actions taken when issues had bene identified. We had received a high number of notifications in relation to people living at Timperley Care Home, having falls. We noted the service was now monitoring these falls, looking for possible causes and making referrals to the falls team in order to minimise the risk of reoccurrence.

During this inspection we found seven breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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.

The external waste area was not kept secure and we saw waste bins overflowing with rubbish bags being stored on the floor. This provided a cross infection and vermin infestation risk.

Medicines were not being administered in a timely manner which meant people may have received their medicines too close together.

People felt safe, staff knew what action to take if the suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not receiving adequate supervision to enable them to carry out their duties they were employed to perform .Staff said they felt supported by the registered manager.

Staff had an understanding in relation to consent and the Mental Capacity Act. Applications for Deprivation of Liberty Safeguards had been applied for as required.

Meals were not always a social able occasion as we observed people eating at tables which did not meet their needs. It meant that people's independence was being limited.

Some attempts had been made to make the service dementia friendly and we noted that changes to the décor were being made at the time of the inspection.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and kind. We observed caring interactions between staff and people living at Timperley Care Home.

People's privacy was respected and their dignity maintained.

The service provided end of life care and followed the Six Steps programme. We saw care files contained information about the person's end of life wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were insufficient activities provided to people living at Timperley Care Home. The service was aware that the activities coordinator would be going on leave, but had not sought to employ a replacement in time. We saw no meaningful activities during our inspection.

There was a formal complaints procedure in place and appropriate action and responses were made in relation to any complaints received. These were not available in formats to support people living with dementia, to understand.

We saw, whenever possible, people had been involved in the planning of their care. When it wasn't possible, we saw the service had documented this and sought information from family members.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post and also a deputy manager. Staff felt supported by the management team.

There were a number of processes in place to monitor the quality and safety of the service. The systems in place to assess and monitor the quality of service provided were not fully effective to ensure care provided was monitored, and that risks were managed safely.

Statutory notifications were being made and sent to CQC as required and the rating from our last inspection was being displayed.

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 23 and 25 January 2017 and the first day was unannounced. The second day was arranged by mutual agreement. The inspection team consisted of two inspectors and an expert by experience on day one and one inspector on day two. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience each had personal experience of caring for older people in their families.

The provider was not asked to complete a Provider Information Return (PIR) as the service had been recently inspected. 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 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.

Prior to the inspection we reviewed the information we held about the service, including communication with relatives and minutes of safeguarding meetings. We contacted the local authority as well as the local Health watch team about their recent monitoring visits. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The comments and feedback received was reviewed and used to assist with our inspection.

We looked around the building and observed mealtimes and interaction between staff and people living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

We spoke with eleven people, eight family members, the registered manager, the deputy manager, a nurse and ten staff members including care staff, the administrator, laundress, maintenance person and cook. We looked at records relating to the service. Including five care records, four staff recruitment files, daily record

notes, medication administration records (MAR), policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Due to the understanding and communication of some people living at the home, we were unable to gather people's views directly. Instead we spoke with people's relatives and used information gathered through our observations. People's family members told us, they believed their relatives were safe living at Timperley Care Home. Comments included; "[Relative] feels safe." And "Yes, feel [relative] is safe, I've found everything is okay."

At our previous inspection we found the service was in breach in relation to infection control. This was due to the dog which visited the home, being allowed to defecate on the floor. At this inspection we found the service had taken action to address this issue. We saw the service had produced a risk assessment for the dog being in the home and also kept a record of the times the dog was taken outside to allow it time to go to the toilet. This appeared to be working as we saw no evidence to suggest the dog was still defecating on the floor or causing a risk to people from the spread of infection.

We found that items were being stored in the stairwells which could pose a fire risk. We found this unsafe storage on both days of inspection.

The outside waste bin storage area had rubbish on the floor. On the second day of inspection, we noted that the front two bins of both the general waste and the clinical waste were overflowing and additional rubbish bags had been put on the floor. Yet there were two bins, one for clinical waste and one for general waste at the back of the waste storage area, which did not appear to be in use. This posed an increased risk of cross infection or vermin infestation. We raised this with the registered manager who immediately spoke with the maintenance person to sort this. They explained that it appeared that staff were only putting the rubbish bags in the front two bins instead of rotating the bins to ensure the area was kept safe and free from clutter. The registered manager stated that this area would now be added to the daily checks to ensure it was kept clean and tidy. The failure to ensure the rubbish was being kept appropriately until its collection and the items stored in the stairwells which posed an increased fire risk were a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe care and treatment.

As part of our inspection we look at whether medicines people required, were administered, stored and disposed of safely. We observed staff administering medicines to people and checked the medication administration records (MARs) for four people. We also checked to ensure medicines which required additional security (controlled drugs) were being stored safely and appropriate checks were being carried out as required. We saw the service had a separate secure area where the controlled drugs and documentation had been completed appropriately. We saw the service ensured people who may need 'as required' medicines had protocols in place and there were also protocols for people should they require homely medicines such as medicines for colds. We noted that two of the MARs we looked at, the number of stock medicines remaining did not match what was recorded on the MARs. The nurse on duty made note of this to raise it with the deputy manager and registered manager. We also noted that when people were given PRN medicines which means when required and not at prescribed times, the time they were given it was not recorded. This meant that a person could receive this medicine too close to a previous dose and

this could be a potential risk to their health and safety. The service had ensured that people, who may require their medicines to be administered covertly, had the correct documentation in place.

We were notified that one person had been given a yogurt containing the medicine intended for another person living at the home. We were notified that staff had then taken appropriate action by contacting the persons GP for advice. This information was shared with the local authority to investigate as a safeguarding concern.

This error showed the service did not have robust procedures in place for managing the administration of medicines covertly and had put other people at risk from harm.

We observed the nursing staff administering the medicines and saw that on one occasion the medicine trolley was left outside the lounge with the keys in the trolley whilst the nurse went into the lounge to administer the medicines. We noticed that both nurses, who were administering medicines on the second day of inspection, wore rings with large stones in which were an infection control concern. The service received people's medicines in pre-dispensed blister pack. Staff then signed the persons MARs to say when the person had taken their medicine. We saw that the service completed weekly medicine audits and actions taken when errors occurred. During the second day of inspection we noted that the morning medicine rounds were still on-going at 11:40am, this meant that people who were prescribed medicine to take at 8am, were receiving it nearly four hours late, which could have impact on a person's health and wellbeing and could also mean they received their next prescribed medicines too close to the one the one they had just taken. This meant that the administration of medicine was not being completed in a timely manner and may put people at risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe care and treatment.

At our last inspection we found the service was in breach of regulation 18 in relation to adequate staffing levels. At this inspection we looked at the staff roster, spoke with relatives of people using the service and spoke with staff to determine how they felt about the current level of staff working at Timperley Care Home. We received mixed feedback in relation to the current staffing levels. One person told us that they felt, "There was not enough staff on at night." Family members we spoke with told us their relative, "Did not have to wait too long if their [relative] needed something." Staff we spoke with told us they believed the staffing levels to be sufficient. One staff member said, "I think staffing levels are fine." From our observations during both days of inspection, their appeared to be sufficient staff to meet the current needs of people living at the home. We saw that when the call bell was used, staff answered the bell in a timely manner meaning people were not waiting long periods to have their needs met. Staff rosters we viewed showed that there was always one nurse on each floor of the service, along with either four or five care staff on each floor. Overnight we saw there was a nurse on each floor along with two carers and an additional carer between the floors as necessary. We noted that on one occasion there were less staff on duty than other days. We spoke with the registered manager about this who told us they tried to ensure there was always one nurse and five carers on duty on each floor, but sometimes this wasn't possible. In addition to these staff there was the deputy manager who was qualified nurse who could provide additional support and also other ancillary staff who had been trained to provide care and support when required. This meant the service had taken action to address the previous concerns about staffing levels and there were sufficient staff in place to support those people living at Timperley Care Home.

We looked at whether a service had undertaken appropriate checks on the recruitment of the staff who worked for them. We looked at the recruitment files for four staff members and found that all the required checks had been completed. We saw that each file contained an application for, interview notes and we saw that checks had been made with the disclosure and baring service (DBS). The DBS helps providers make

safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support service. We also looked at how the service ensured that the registered nurses who worked at the service maintained the registration. We saw the service kept a record of the nurses Nursing and Midwifery Council (NMC) pin numbers and when their revalidation was due. Records showed all the registered nurses who worked at Timperley Care Home were registered and had a valid pin. People living at Timperley Care Home, were also invited to be involved in the recruitment process of new staff. This allowed people the opportunity to meet candidates and discuss their suitability, afterwards. We saw recorded in one staff members recruitment file; "'The residents discussed [staff members name] and said they would like her to work here'." This showed the service ensured the recruitment of staff to work at the service involved people in the decision making about who provided their care and support and was safe.

We viewed five care records and the risk assessments recorded in them. The service used an online system called, 'Care Docs'. This system produced automated care plans and risk assessments, which could then be tailor made to the person's individual needs. This system showed when the risk assessments had been reviewed and updated and when they were next due to be reviewed. We saw the information's recorded provided staff with sufficient information about the risks posed to the person. For example, we saw that for two people, their nurse assist call bells had been removed from their bedrooms as these had been identified as a possible strangulation risk. We saw that everyone who lived at Timperley Care home had a personal emergency evacuation plan (PEEP) in place, which provided details about the support they would need in the event of an emergency. We saw equipment which made be required during an emergency was stored in an accessible place and was checked regularly. Prior to inspecting the service, we had been notified about a high number of falls of people living at the home.

We saw the service had environmental risk assessments in place for areas such as fire, and staff knew what to do to keep people safe in an emergency. The fire risk assessment was undertaken by and external company and audits were completed by the operational manager for the service. We noted that the home had keypad coded doors, which were secure at all times. There was appropriate assessments in place for the use of the coded doors, which was in line with legislation. They were used to ensure the safety of the people using the service. Records of maintenance checks had been completed by both internal staff and external contractors. Repairs were recorded in a book held by maintenance staff and records showed these repairs had been dealt with in a timely manner. The staff member, who was responsible for safety checks on the equipment and facilities, utilised a white board in the staff room. This was used as a tool to indicate what safety checks were required, for example checks for the lift, wheelchairs, equipment and the nurse call bell system. It also recorded the frequency of these safety checks, for example weekly or monthly. We saw the board was updated to indicate when safety checks had been completed and this kept other staff informed about the maintenance aspects within the home.

Staff knew how to keep people safe from abuse; they were able to describe different types of abuse and knew how to report any concerns they may have. Staff had received training in the safeguarding of vulnerable adults. We saw the service kept a record of when accident and incidents had occurred. Audits were being completed to monitor the incidents. We noted from our last inspection and also from notifications we had received, that there was consistently a high number of people falling within the service. The falls audit showed the number of falls and the action taken by the service. For example, we saw referrals had been made to the GP for a referral to the falls team, We saw people's beds had been fitted with pressure mats, to alert staff to a person trying to get up. People had been assessed for bed rails, to minimise the risk from falls and the service also used falls mats next to people's beds to try and prevent a fall by staff being alerted to a person's room if they mobilised from bed at night. This showed the service had recognised the people living at the home were high risk from falls and were taking action to minimise those risks.

Requires Improvement

Is the service effective?

Our findings

We looked at whether people who live at Timperley Care Home had their nutritional and hydration needs met. We spoke with the cook about the meals they provided and with people who lived at the home, their relatives and staff members about the quality and choice of the meals provided. On the day of inspection we saw one person had chosen potato skins served with chips, we discussed this with the registered manager who acknowledged that it was potato with potato and this was not a balanced meal, however it was the persons choice and there were other options to have, such as soup or a sandwich as this was not the main meal of the day. We asked one person what they thought of the meal they were having and they told us, "It was good." A family member told us, "The food is improving. For lunchtime there is soup or a sandwich and more substantial dinner. [Person] has gained weight." There was a three week rolling menu in place, and the cook told us they used their own judgement when cooking meals from the menu which was set by the wider company. For example, they told us that eating and cutting beef was more difficult for some people, so they substituted with braising steak as this could be slow cooked and was more tender. This meant people did not 'miss out' and were still able to eat independently. They also explained how they would fortify meals with cream and butter if a person was losing weight and also ensure people who required a specialised diet received it. For example, if a person required a diabetic diet they would ensure their meals were adjusted accordingly to minimise the persons sugar intake.

We observed mealtimes on both floors of the home and found that the meal time experience on both floors could be improved. On the first floor we saw there was only one member of staff working in the dining areas with 10 people seated at different table. Everyone was wearing a paper apron were at different stages in their meals. People had been assisted to wear an apron before they started eating their meal, but staff were not observed 'asking' people' if they wanted an apron. This did not uphold the person's dignity. . We observed one person, who had soup given to them in a cup with a spout in order for them to eat independently, had managed to turn the cup upside down and was trying to drink from the bottom. This resulted in the person spilling their soup down the clothes protector. The staff member in the dining area was too busy to notice and it was unclear as to how much of the soup the person had actually eaten. We did observe the staff member was always polite and did not rush people. We noted that on the first floor, the staff member who was serving on their own left the 10 people on their own for two minutes whilst they took another person's meal to their room. This put the people at risk from potential harm as some of the people were at risk of choking, they had access to the hot soup, sharp knives and the hostess trolley was left uncovered. We discussed this with the registered manager who told us that this should not be happening and they would speak to the staff member in question as well as all of the staff as they were not sure why this was occurring as there should have been other staff available to support. They told us they would look at whether they needed additional support on that floor during the meal times, or whether this was a one off isolated incident.

Meal times could have been improved for some of the people living on the ground floor. We observed two people eating their meals at low tables; these could not be manoeuvred into place and people were seen to be stretching across and down to reach their lunchtime meal. As soup was being served to two people trying to eat independently they spilt their meal onto the clothes and onto the floor. This was not dignified for the

individuals and one person was then assisted by care staff to eat the remainder of their meal. This meant their independence was taken away from them because of the lunchtime environment. We brought this to the attention of the registered manager as we noted that a quiet lounge was set up with tables and chairs but was not being utilised for meal times. Not supporting people to eat is a breach of Regulation 14 (4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Meeting nutritional and hydration needs.

We viewed the supervision records and spoke to staff members. We found that supervisions were not carried out regularly and were sporadic. The maximum number of supervisions care staff received was two during the year of 2016. One person employed as a nurse received four supervisions. We identified that two support workers employed for the whole of 2016 did not receive any supervisions. One staff said ,"I've not had one yet." Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop.

Staff we spoke with were complimentary of the manager and the changes they had brought into the service. One referred to "a fabulous team." Manager "will let the staff have their say. Then make a decision." One staff member told us when asked about support from the manager, "One of the best manager's I've worked for." One staff member was complimentary about the manager and their role and said, "I think it's great."

The lack of consistent staff supervision means there is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that there were correct assessments in place in relation to people's capacity and decisions to restrict someone's liberty were being followed.

Staff understood about asking a person for their consent prior to carrying out any care or support needs. They also understood about the least restrictive approach. We saw staff asking people for their consent and waiting for a response before carrying out a task. Where possible, we saw the service had recorded if the person had consented to their care and support needs. When the person was unable to consent, we saw the service had discussed the persons care needs with family members or people who knew them well. There was information for people to access the advocate service if there was no one to speak on the persons behalf.

At the time of this inspection we saw a file containing information about DoLS applications which had been made to the local authority, information about who had an authorisation in place and whether this was a standard authorisation or not. We saw evidence of best interest decisions being made and recorded. For example, where a person had required bed rails in order to minimise the risks to them but was not able to consent to this. We saw there had been a discussion with the person's family member, staff who knew the person well, and a record of the rationale for making the decision was recorded on file.

We observed people receiving care from staff who knew them well. Discussions with staff, who worked at the home, showed they had a good understand of peoples care and support needs. Staff knew people's abilities and what they were and were not able to do as well as their preference in relation to their daily activities.

As part of our inspection process, we looked at whether staff received essential training and support to ensure they have the required knowledge and skills to support them to meet the needs of people living at Timperley Care Home. We looked at how staff were supported to develop their knowledge and skills and whether they were provided with regular supervision sessions in order to allow them time to discuss and identify any training needs. We looked at the training records for the staff and noted that the service kept a record for all staff as to when they received the training and the score they obtained at the end of it. The training matrix also showed the time taken to complete to complete the training.

We asked staff if they had received and induction to the service at the start of their employment. We were told by the registered manager that new staff were assigned a mentor and the staff members first week of employment involved an induction to the service as well as essential training in areas such as safeguarding, moving and handling, infection control and health and safety. Elements of staff training was undertaken in the classroom or online (E-Learning). All new staff were signed up to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. The registered manager told us that one member of care staff, was being seconded to undertake a nursing associate programme. This meant they would obtain their nursing qualification and then be employed by the service as a nurse. This showed the service was looking at ways of supporting their staff to progress their careers within the care sector and was also looking at a way of ensuring their staff were trained appropriately.

From our observations of the service, we noted there had been some attempt in making the home a dementia friendly environment. Large signs to the ground floor indicated communal areas such as lounge and toilet/bathroom areas. The service was in the process of redecorating the ground floor to make it more dementia friendly. Upstairs we noted the signage continued and the dining room had been laid out at meal times with table cloths and flowers on the table. We noted that tables on the ground floor had not been set out the same way. People's bedroom doors were of different colours and had the person's name and a picture on them to identify each person's room. These improvements to the environment will aid people living with dementia to recognise their location in the home and find their way around.

Good

Is the service caring?

Our findings

Relatives we spoke with all told us that staff working at Timperley Care Home were kind and caring. Comments we received included; "I chose Timperley because the care is good, person centred care and the staff are caring." "I'm confident that (person) will be well looked after when I am away." "I can only sing praises about this place." And "The best thing is the staff. All so lovely."

During our inspection we observed caring interactions between people living at the home and staff. Although we did hear one comment with a negative tone from one care staff member soon after our arrival. One entering the ground floor lounge area a staff member saw an individual sitting in a chair and said, "Oh, I forgot you were up." After this comment the member of staff asked the person if they wanted the lights on in the lounge area and provided them with breakfast choices. All staff were observed knocking on people's bedroom doors before entering. One staff member was observed knocking and then saying, "Are you alright [person's name]." This showed staff respected people's privacy.

We spoke with staff about how they maintained people's dignity. They told us they ensured doors and blinds were kept closed when providing any personal care. People we saw were all wearing clean clothing and we saw when a person spilt something on their clothes, staff supported that person to go and change into clean clothing. The service had a staff member who was a dignity champion; this role is meant to provide guidance and support to other staff.

Staff working at Timperley Care Home did not wear a formal uniform. This had been tried and tested and we were told by the registered manager that people were not as anxious with aspects of their personal care with staff wearing more informal clothing.

The care files we looked at, recorded when people had been involved in their assessments and whether their family members had been involved. We saw that people were involved with their assessments when this was possible and that family members or people who knew the person well had been consulted with regards to the persons care and support needs. We asked people and their relatives if they had been involved in planning their care, people confirmed they had. When we spoke with one family member, they told us they hadn't been consulted at the formal assessment, but they had been invited to the persons review. We saw in the care files whether people had capacity or whether there was someone holding Lasting Power of Attorney for Health and Welfare as well as finance. The registered manager told us, that where possible they saw a copy of this and kept a copy on file. We also saw people had access to the local advocacy service, when required and had been supported to access them if they had no other family to support. This showed the service ensured people's views were considered before decisions were made.

We saw on a noticeboard on the first floor of the service, dedicated to information about 'palliative care'. This provided information about End of Life care and the Six Steps. The six step end of life pathway was produced by The National End of Life Strategy (DH 2008), to highlight the six steps required to provide good end of life care. We noted that the service used butterflies on the outside of people's doors to inform staff that the person was end of life in a more sensitive way.

All the care plans we looked at contained information about the person's end of life care and treatment. Not everyone had agreed to this section being completed and we saw the service had documented if a person had refused to discuss and there was a note to ask again at the next review. This showed the service considered people's end of life wishes.

Requires Improvement

Is the service responsive?

Our findings

Nurses and care staff received a handover at the start of each shift where they were given information about the health and wellbeing of each person and any changes were noted. The deployment of staff was agreed between the nurse and senior care staff to ensure fair distribution of staff support to meet identified needs. Care staff then reported back to the nurse in charge throughout the day, reporting any changes or concerns as identified.

There were no activities coordinators on shift during our inspection. This was due to the service awaiting for checks to be completed on a newly appointed staff member. We saw there were no activities on offer on either of the days we inspected. People were walking up and down the corridors on the ground floor with a few people sitting in the main lounge area. We observed one person 'bounce their chair out of their bedroom to try and get to the lounge'. We were told by the registered manager, that the local primary school children visited every week to sing, dance, read and do yoga. They went on to tell us how much people enjoyed this. There were insufficient activities provided to people living at Timperley Care Home. The service was aware that the activities coordinator would be going on leave, but had not sought to employ a replacement in time. We saw no meaningful activities during our inspection or people going out to provide stimulation or social interaction within the local community. This meant that the service had not met the needs of people living at Timperley Care Home..

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection we found the service did not have an adequate complaints procedure in place. At this inspection we saw the service kept a file of any complaints they received. There was documentation detailing the response to the complaint and the action taken along with any feedback the service had given to the complainant. The complaints procedure was not displayed in a dementia friendly way, such as picture form. This meant the service had not considered all the needs of people living at the home by ensuring the complaints procedure was available in a format people could understand. This showed the service had a complaints procedure in place but it did not meet the needs of everyone living at the home. This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We viewed the care files for six people to see if they support the persons needs/ wishes/likes and dislikes. The service used an electronic system called 'Care Docs', this came with pre-populated information which staff were then able to add to and expand to make it personal to the individual person. From the care files we viewed we saw care plans had been made personal to each person. For example, we saw one person was high risk of falls from bed. Their file contained information about the risk posed to them and a risk assessment had been completed for bed rails in order to minimise the risk. We also saw that due to their medical condition they were prone to develop pressure sores. The service had assessed the person as requiring a specialist mattress as well implementing regular changes of position of the person in order to minimise the risks of skin breakdown. We saw the care files had been reviewed and where possible, people

had been involved in this process. One care file we saw had recorded that the person was no longer able to be involved in the review of their care needs due to their cognitive impairment. However, we saw that the service had involved a family member in the review.

The registered manager had introduced a scheme called 'Resident of the Day'. This meant that every day, a small team of staff from the service, representing different skills within the home visited the room of one person who lived at the service. Each floor of the home had their own 'Resident of the Day' meaning that once a month their room was reviewed and checked to see if anything required repairing. The person whose room it was, also had their care file reviewed that day and changes were made when required. This showed the service had implemented regular checks on people living at the service, and their room. Meaning they were able to respond to issues in a timely manner.

We asked people and their family members if the service held resident meetings and relative meetings. We were told there had been a couple since the new manager was appointed. We saw copies from one meeting had been recorded. The registered manager told us and family members confirmed, there was an open door so they were able to discuss any changes with the registered manager at any time.

We viewed a number of thank you cards which were on display on the wall in the downstairs hallway. Comments written included, 'all kind and caring staff' and 'Many thanks for your kindness and care'.

Requires Improvement

Is the service well-led?

Our findings

The home was managed by a registered manager who was registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Since we last inspected we found improvements to the quality monitoring to check and audit the running of the home. The service was now keeping records of the checks they were completing and any actions they were taking. At our previous inspection, we found the service was not carrying out audits and had no oversight of the care and service being delivered. We saw the service now completed regular audits in areas such has medicines, environment, and care files. These were easily accessible in files kept in the registered manager's office. We knew from notifications the service had sent to the Care Quality Commission that there had been a high number of people having falls. Previously the service had not kept a record of these and therefore were unable to complete a root cause analysis to see if there were any trends. We saw the service was now keeping a recorded of any falls which occurred, the time of day it occurred, where it occurred and what action was taken. Referrals were being made the GP for referrals to the falls team and the manager was looking at whether there were any trends to the falls. For example, if one person was continually falling at a particular time of day. We noted that the service had put equipment in place, such as pressure mats, to try and minimise the risks to people. Pressures mats alert staff when a person moves from their bed/chair and can make staff aware that the person is trying to get up which could put them at risk of falls. Staff can then go and check on the person and redirect them so they reduce the risk posed to them.

The service had policies and procedures in place which were up to date and available to staff. We saw that in one of the policies with regards to staff, if stated that staff were not to wear false nails, nail varnish or gel nails. They could wear one wedding band style ring but not large rings with stones and no wrist watches. On day two of our inspection we noted that two of the nursing staff were wearing engagement style rings with large stones in them and four staff members were wearing wrist watches. We discussed this with the registered manager who stated they would address this immediately and raise it in the next staff meeting. The registered manager told us that one staff member had been dismissed due to not following these rules and action would be taken if staff continued to flout the rules.

Despite these improvements the systems in place to assess and monitor the quality of service provided. We found these four breaches which the service had not identified meaning they were not fully effective to ensure care provided was monitored, and that risks were managed safely, and the service achieved compliance with all the regulations.

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

The registered manager told us they had an 'open door policy' and family members we spoke with

confirmed this. They told us if they had any concerns or needed to discuss anything about their loved ones care, they just needed to call in the office and the registered manager would speak with them.

We asked staff and family members, what they thought of the registered manager. A family member told us, "She's very approachable. Well organised and responds quickly." Staff we spoke with told us that things had improved since the new registered manager had come into post and they felt supported by her. The service had also appointed a deputy manager who supported the registered manager and was responsible for managing some of the audits the service completed as well as other aspects of the clinical areas such as medicines. This showed the service had addressed previous concerns in relation to the lack of leadership. We are aware that this is still early days and needs time to embed, we will check on this at our next inspection.

At our last inspection we found there to be uncertainty within the leadership of the service. Minutes from previous nurse meetings had indicated that the lack of leadership was causing stress. We saw minutes from recent staff meetings which were more positive about the service. We also saw the service was holding departmental meetings every one to two months, in order to discuss issues within each specific department. The registered manager explained that the lack of supervisions had been discussed at these meetings and the plan was for nurses to supervise senior care staff and senior care staff to supervise care staff members. The registered manager recognised the 'there was still a lot of work to do in that area'.

The registered the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. We saw the registered manager informed CQC via a statutory notification of all notifiable incidents within a timely manner.

It is a requirement of the regulations that providers display the rating they received at their last inspection, within the home and on their website if they have one. The rating of 'requires improvement' from our last inspection was clearly on display on the foyer to the service and also on their website. This showed the service was ensuring people using the service or considering using the service, had access to the most recent report.

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 No meaningful activities were available to people living at the service during our inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not managing medicines in a timely manner. Failure to ensure the waste storage area was kept clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Not providing sufficient support to enable people to eat.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The complaints procedure was not available in an accessible format for people living at the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Quality assurance monitoring had not identified the areas which have breached.
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Lack of consistent staff supervisions.