Huntercombe Centre (Crewe) Limited

The Huntercombe Neurodisability Centre - Crewe

Inspection report

Sherbourne Road
Crewe
Cheshire
CW1 4LB

Tel: 01270531080
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 14 and 16 March 2016 and it was unannounced. At the last inspection on 19 June 2014 the registered provider was compliant with the regulations that we assessed.

The Huntercombe Neurodisability Centre is located in central Crewe. The centre provides care and treatment for people with long term neurological conditions and people with neurological conditions acquired through illness or injury. There is also a one bedded flat for people preparing to leave. The home is registered to provide a service for up to 40 people. On the day of our inspection there were 30 people living in the home.

At the time of the inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However a manager was in place and had made an application to become registered with CQC, which was near completion.

We identified two breaches of the relevant legislation in respect of nutritional needs and good governance. You can see what action we told the provider to take at the back of the full version of the report.

We found that there had been a period a time when the home had depended upon agency staff to ensure that there were sufficient staff and this meant that there was less consistency of care. There had been a recent focus on the recruitment of new staff and the manager told us that the home was now fully staffed. However during the inspection we found that staffing on the first day had been affected by staff sickness which impacted on the care provision. There has been some re-organisation within the home and a new allocation system implemented to support staff and enable them to meet people's care needs in a timely manner.

People received their medication in a way that protected them from harm. The staff were working with people's GPs, to ensure that appropriate protocols were in place for medication which was taken "as and when required". People had good support from health professionals based within the home such as psychology and speech therapy. The manager was also recruiting for an occupational therapist.

We found there were policies and procedures in place to guide staff in how to safeguard people who used the service from harm and abuse. Staff received safeguarding training and knew how to protect people from abuse. However we found that not all staff knew where they could report safeguarding concerns to outside of their organisation. Risk assessments were completed to guide staff in how to minimise risks and potential harm.

People lived in a safe environment and staff ensured equipment used within the service was regularly

checked and maintained. However we found that not all areas of the home were visibly clean and some areas appeared cluttered and untidy.

Arrangements for eating and drinking did not always take account of individual needs and requirements. We found that the dining experience was not a particular cheerful or sociable experience. People's views on the quality of the food were mixed. The manager had already acted upon feedback received about the food to make improvements.

Staff had completed a thorough induction before commencing their employment at the home and staff received on-going training. There had been a recent focus on staff training needs.

Staff had received training in legislation such as the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They were aware of the need to gain consent when delivering care and support and what to do if people lacked capacity to agree to care or treatment. Where a person was being restricted or deprived of their liberty, applications had been made to the supervisory body under the Deprivation of Liberty Safeguards.

People told us that staff were kind and treated them in a caring manner. However, we observed that staff did not always maintain people's privacy and dignity. Confidentiality was not always maintained with regards to the storage of records and where people's personal information was on display.

Care records were personalised and up to date, they reflected the support that people needed so that staff could understand how to care for the person appropriately. We saw that staff responded to people's changing needs and sought involvement from outside health professionals as required.

We found that in some care records and daily charts there were gaps in the information recorded and they had not always been completed at the time that the care had been provided.

People had access to activities both within the home and local community. People were encouraged to maintain their independence.

People and staff told us that the home was well led and that the management team were approachable and supportive. We found that the manager had taken steps to improve the quality of the care provided. We saw that regular team meetings and supervision with staff were held. People's feedback was sought and there had been four resident/relative meetings since the manager had come into post.

Quality assurance systems were in place and audits were carried out to highlight areas where improvements were needed. We asked for information about any quality assurance or monitoring visits carried out by the provider, but there were none available and we were unable to evidence that the organisation provided support to the management team to monitor the quality of the service provision.

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

We found that the service was not always safe.

There had been a period of recruitment which meant that the home was fully staffed. There were sufficient numbers of staff to meet the needs of people living at the home. However, we found that staff sickness could have an impact on staffing levels.

People felt safe and protected from the risk of harm or abuse. Processes were in place for staff to follow to ensure that people were not placed at the risk of abuse. However there had been one occasion when this process had not been followed.

Appropriate recruitment procedures were followed to prevent the risk of unsuitable staff being employed to work at the home.

Is the service effective?

Requires Improvement

We found that the service was not always effective.

People's nutritional needs were not always met, because some people did not receive food of their choice and people told us that the food needed to improve.

Staff received induction training when they joined the service and staff had access to regular on-going training.

Staff had an awareness of the need for consent and understanding of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards were being applied appropriately to people within the home.

People had good access to health care professionals to ensure they received effective care and treatment.

Is the service caring?

Requires Improvement

We found that the service was not always caring.

Most people told us that they were treated in a kind and caring manner.

We observed that people's privacy, confidentiality and dignity had not always been maintained. People's personal information had not always been kept securely.

People were supported to express their views and were involved in making decisions about their care.

Is the service responsive?

Good

We found that the service was responsive.

People were able to contribute to the planning of their care. Care plans were personalised, detailed and reflected people's individual requirements. We found that there were some gaps in the recording on daily charts

People were able to make decisions about their daily activities and were offered a range of activities within the home, as well as within the community.

There was a complaints policy in place and people felt able to raise any concerns with staff. Appropriate action was taken in response to complaints.

Is the service well-led?

Requires Improvement

We found that the service was well -led.

There was a manager in place and she had applied to register with CQC.

People and staff told us that the management team were supportive and approachable, people knew who the manager was and felt about to raise any concerns.

People were asked for their views about the quality of the care provided and there were systems in place to receive feedback from people using the service, relatives and staff. Action plans were developed to improve the service.

The home had effective quality assurance systems in place to monitor the service and the manager had implemented new systems. We found that the provider had not carried out any recent quality monitoring visits to support the manager to highlight any possible areas for improvement.

The Huntercombe Neurodisability Centre - Crewe

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 over two days on the 14 and 16 March 2016 and was unannounced. The inspection was carried out by an adult social care inspector, expert by experience and specialist advisor on the first day and an adult social care inspector and inspection manager on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Specialist Advisors are senior clinicians and professionals, who bring specialist knowledge and expertise to the inspection. Both the ex by ex and specialist advisor had experience of caring for people with either learning disabilities or neurological conditions.

Before the inspection we reviewed the information the Care Quality Commission already held about the home. This included information from the provider, such as statutory notifications. Statutory notifications include important events and occurrences which the provider is required to send to us by law. We contacted the local authority contracts and quality assurance team prior to the inspection and they shared their current knowledge about the home. We also read the latest Healthwatch report available.

During the inspection we spoke with 13 of the people who lived at the home, together with two of their visiting relatives. We talked with 14 members of staff including five members of the care staff team, four nurses, the activities coordinator, a housekeeper, the maintenance person, the deputy and the home manager.

We reviewed four people's care records and inspected other documentation related to the day to day management of the service. These records included four staff files, staff rotas, quality audits, meeting minutes, training records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people in the communal areas and observed how people were supported over lunchtime.

Requires Improvement

Is the service safe?

Our findings

Most of the people living at Huntercombe told us that they felt safe and received safe care. One person told us that they had walked for the first time in a long time since moving to the home because they felt safe to do so. One person commented "It's lovely, I've been in a lot of homes and this is the best." However, some people told us that they did not always feel that there were enough staff.

The home was made up of two units. The manager told us that there had been some recent reorganisation whereby three units had been merged into two. Staff told us that whilst there had been some initial difficulties, this had improved the general organisation and staff were working well together on each unit.

We found that the home employed sufficient numbers of staff, but that at times staffing levels were affected by staff absences. The management team had been through a period of recruitment and told us that the home was now fully staffed. We reviewed staff rotas and spoke with people and staff about the staffing levels at the home. People's views were mixed. One person commented that there wasn't always enough staff and said "They are pushed sometimes", they also said that they thought the managers were trying to rectify the situation. Another person told us "Staff are always as helpful as they can be but they're always a couple of staff short particularly at night". However, other comments included "If I need anything there's always someone available any time".

On the first day of the inspection we saw that some people were waiting until late in the morning for assistance to get up out of bed. One visitor told us that their relative was waiting for assistance at 10.30am, which was late for them. We were told that there had been problems with staff sickness on that day and despite trying to organise extra staff to cover, the staff team were two members down. One person living at the home told us that there were "Not enough staff today". However, they also commented that this "Doesn't happen that often". Staff told us that they were particularly behind because of one person's specific care needs, which had been time consuming. We saw from the rota that extra staffing had been arranged to take this into account, however due to some staff not being able to come to work, this had impacted on the wider care provision.

Staff told us that ordinarily they felt there were enough staff to support people's needs, apart from some occasions when staff went off sick. One person commented "It only needs one person to be on annual leave or sick and we're in trouble". The home had been through a period whereby it had been necessary to use agency staff to cover some of the shifts. These are staff who are employed by a separate organisation which provides staff to any service which requires them. People told us that agency staff were sometimes less knowledgeable than the permanent staff and that this affected the consistency of the care. The manager said that due to the recruitment of new staff, the use of agency staff had been reduced and should eventually be no longer required.

The manager and deputy manager told us that there had been a recent focus upon the recruitment of new staff. They had recently appointed a nurse, which meant that the home was now fully staffed for nursing and

care staff. The home also employed a psychologist, a physiotherapist and speech and language therapist. Two new physiotherapy assistants' roles had been developed and two people were due to start in these roles very shortly. The manager told us that they were also in the process of recruiting an occupational therapist and occupational therapy assistant's post.

We saw that there were two unit managers in place and the manager had introduced a senior care role to help with the organisation of staff and to help ensure that appropriate records were kept. The management team told us that there were now more consistent staff available, which they believed had had a positive effect on people living at the home. They gave an example of positive feedback from one person's family, who had commented that their relative had improved and appeared more settled over recent weeks.

On the second day of the inspection, staff on duty were as planned on the rota. There were two nurses and five care staff on duty on the Alex unit and two nurses and seven care staff on duty on the Charlotte unit. Two of these carers were providing one to one support to people. Staff told us that staff levels would sometimes change dependent upon whether extra people were staying for respite care. We saw that the home appeared more relaxed and organised on the second day, and people's needs were being met in a timely manner. A staff member told us "Yes we have enough staff".

We asked the manager how staffing levels were determined. We were informed that the management used their judgement based on their knowledge of people's needs. We saw that staffing had been increased when more people were being supported within the home or if it was deemed necessary for a person to have one to one support at all times. However the manager told us that each person had an assessment of their needs and that some of these were being reviewed. The management team had started to use a tool to help determine the amount of staff time required to support people. This had been used for some people over the past two months and they intended to use this tool for all people living at the home, to help ensure that there were sufficient staff deployed in the home at all times. The manager also demonstrated that active steps were being taken to address issues related to some staff absences.

We found that the manager understood her responsibility to identify and report any suspicion of abuse. She had started to maintain a safeguarding file, and had access to guidance and procedures from the local authority about how to report any suspicion or allegations of abuse. We saw that a log had been kept for any referrals which had been made to the local authority. Most referrals had been made to the local authority, where necessary, to report any concerns and we found that these had been investigated fully with any necessary action carried out and recorded. However during the inspection we reviewed information about a person which potentially should have been reported to the local authority as a safeguarding concern. The provider had looked into the issue and concluded that it was unlikely to be a safeguarding matter; however they had not referred this to the local authority as outlined in the procedures. We discussed this with the manager who acknowledged that this should have been referred at the time.

Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. The provider had recently updated its own safeguarding policy, although we noticed that out of date procedures were on display on the notice board. Discussions with staff identified that they knew the importance of keeping people safe, including being safe from abuse and harassment. Staff told us and we saw from the records that they had been provided with safeguarding training, discussions with staff identified that they understood the mandatory requirements around adult safeguarding. One member of staff gave us an example where they had appropriately identified and reported a safeguarding concern. However, we found that not all of the staff spoken with were clear about where they could report safeguarding concerns to outside of their organisation. However they told us that they would know where to find this information should they need to. The manager told us that the need for

safeguarding training had already been identified and we saw that this had been arranged for two dates in April 2016.

We saw the home's whistle blowing policy and that the provider had a dedicated "Speak up" whistleblowing helpline in place which encouraged staff to speak out where necessary. Discussions with staff demonstrated their understanding of the process involved and that they understood how to raise concerns if necessary. One staff member told us "If I see something wrong I will speak up".

We looked at arrangements for administering medicines in the home. We spoke to staff and made some observations whilst they administered medications. We saw that there was a "Control and Administration of Medications" policy in place and staff knew where they could access this policy. Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation; these medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. They were stored in a special cabinet. Medicines were mainly kept safely in a lockable trolley within a locked room. However we found that in one of the clinic rooms, two cupboards containing medication as well as the clinic fridge had not been locked. There were appropriate arrangements to store medicines within their recommended temperature ranges.

We found that there were three bottles containing medication on one of the trolleys and a number of bottles on another trolley, which had been opened but the date that they had been opened had not been recorded on the bottle. We saw that other bottles did have the date recorded when they had been opened but did not have the expiry date recorded. This meant that staff may not easily identify when medicines had expired.

We looked at the administration and recording of medicines. The administration of medicines was recorded including the administration of creams as part of people's personal care We inspected nine Medication Administration Records (MARs) and saw evidence which indicated that medicines had been administered and recorded correctly. Staff spoken with knew the importance of giving medicines at the prescribed time, for example, some medicines were given once a week and others were required an hour before food. However, we saw that some medicines had been prescribed on a PRN or "as when required" basis. We found that there were no written protocols in place which would help staff to know when these medicines should be administered. The manager was clearly aware of this and advised us that they had been in communication with the pharmacist to address this and were arranging for people's GPs to update individual prescriptions to include specific instructions for PRN medicines.

Safe recruitment processes were in place. We reviewed four staff files which evidenced that recruitment procedures were followed and applicants were checked for their suitability, skills and experience. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. A minimum of two references were sought and staff did not start working alone before all relevant checks were undertaken. The provider had a disciplinary procedure and other policies relating to staff employment. This meant people could be confident that they were cared for by staff who were safe to work with them.

Risk assessments were in place which were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to kept people safe. They included risks specific to the person such as for falls, use of a wheelchair, pressure area care and nutrition. A personal emergency evacuation plan (PEEP) was available for each person, taking into account their mobility and moving needs. This was for if the building needed to be evacuated in an emergency. Records reviewed evidence that fire drills had been

carried out on a regular basis.

Systems were in place to manage and report incidents and accidents. The manager told us that the provider used a Datix system where information would be inputted, we looked at these records and saw that incident and accident forms were completed, with action identified to reduce the risk of further incidents occurring in future. However we found that there was no wider audit of incidents and accidents to identify whether there were any themes or trends which could be highlighted. The manager told us that this was something that she had been planning to implement and assured us that this would be carried out in future.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. We spoke with the maintenance person who demonstrated that routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. Arrangements were in place for equipment used at the home was to be regularly checked and serviced, including the passenger lift, hoists and specialist baths. However we saw that in one person's bedroom where bedrails were fitted to the bed, the material surrounding these was slightly ripped and stained, it appeared to be ill fitted with a gap between the bed and rail. We pointed this out to the manager who advised that the bedrails were not used when the person was in bed, only when personal care was carried out and a staff member would be present, however they would ensure that this was addressed.

The home was purpose built and modern. During the inspection we found that a few areas of the home did not appear to be visibly clean. We saw that carpets in some of the corridors and bedrooms were stained and observed some splattered stains to the walls of a person's bedroom. We pointed this out to the manager who arranged for a deep clean to be carried out in this bedroom and explained that some of these stains had been cleaned but were difficult to remove and parts of the home were due for re-decoration. We were told that new flooring was already on order, for some areas. We spoke with one of the housekeepers who told us that they were responsible for one of the units and worked 37.5 hours per week. They told us that they had received training in infection control and were required to carry out daily cleaning of all bedrooms plus a deep clean once per month. However, we were unable to see details of cleaning schedules and the requirements for a deep clean. The manager confirmed that cleaning schedules were in place.

We found that a number of the bathrooms were used for storage and appeared cluttered and untidy. In one of these bathrooms we saw that clean linen was stored on an open trolley next to the soiled linen bins, which could present the risk of cross contamination. The manager informed us that they did have some difficulties with storage throughout the building. On the second day of the inspection the manager had arranged for the clean linen to be stored more appropriately in a closed cupboard. We saw that staff had access to and used gloves and aprons to help reduce the risk of infection.

Requires Improvement

Is the service effective?

Our findings

We asked people living at Huntercombe whether they found the care and support to be effective. Most people spoken with told us that they found that the care provided was effective. One relative told us that they were "very happy with the care" that their relative received. However, some people told us that they were unhappy with regards to the food provision.

We looked at the arrangements for eating and drinking. People's views about the food were mixed. There was a menu with a choice of food available each day. Staff told us that if people didn't like the food on the menu then alternatives could be offered. On the day of the inspection we saw that the options were chicken curry and rice or sandwiches, with steam sponge or yoghurt for pudding. One person told us "The meals are ok. They give you extra helpings if you want, you can always have an egg or cheese sandwich or sausages". Other comments included "It would be nicer to have more home cooked food" and "The food is a bit stodgy and not desperately healthy". But we were also told "It's lovely, if you want anything they'll do their best".

The manager told us that feedback from people and their relatives had already identified that the food needed to improve. Plans had already been made to address this issue and staff had been speaking to people about what they would like to see on the menu and taster days had been arranged. We saw that drinks were available to people throughout the day, as well as snacks such as fresh fruit. There were facilities for making tea and coffee which people used if they wanted to and were able to. We saw a person making themselves a cup of tea.

During the inspection, we observed lunch being served in the downstairs dining room. During our observation we saw that three people were being supported by staff to eat their lunch. Two of the tables had table cloths but in the main the tables were bare and we saw that some used plastic aprons had been left on a table. The atmosphere during lunchtime was very quiet and people were sat at separate tables. There was some staff interaction with the people they were supporting, but this was minimal and we observed that staff tended to talk to each other. We saw that one member of staff was standing up and leaning over the table whilst assisting one person, which didn't give the impression that this person was being supported in a caring or unrushed manner. Similar observations were noted in the upstairs dining room, with little quality social interaction observed. Overall we found the dining experience to be mainly functional with little that could be described as sociable or cheerful.

We observed that all of the meals were plated up individually by the kitchen staff. Two people commented that they did not like the choice on offer, but we saw that neither was offered an alternative. We heard a staff member suggest to one person that they should try the meal anyway, the person did eat some but later commented again that they didn't like chicken curry. The staff member took this to mean that the person had eaten enough and then asked another member of staff whether the person would normally eat all of their meal. This suggested that the member of staff was unfamiliar with this person's needs. We discussed this with the home manager who told us that she had arranged for night staff to work some shifts during the day to support them with extra training, which was why this staff member was less familiar with this person's eating needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nutritious needs of people who used the service were not always met.

Some staff spoken with were clear about people's needs around eating and drinking and were able to tell us for example which people required their drinks to be thickened or required a pureed diet. Some people chose to eat their meals in their bedroom and staff respected these choices. We saw from the records that people's nutritional and hydration needs were recorded. There was evidence that staff were monitoring those people who were at risk of losing weight and nursing staff were able to identify people who were weighed monthly and those that required more frequent weighing.

We looked around the home and found the environment to be conducive to the needs of the people who lived there. The building had been purpose built and had the feel of a small hospital, with wide corridors and large bedrooms with en-suite bathrooms. People had been encouraged to bring in personal items from home, many were very personalised and some people had telephones in their bedrooms. We saw that some people had individual name plates on their bedroom doors but not all of the bedrooms displayed people's names.

The manager told us that there had been a recent focus on training for all staff. Staff completed a range of training that they felt was appropriate to their roles including training in safeguarding, moving and handling, stoma care, challenging behaviour and the Mental Capacity Act. Also more bespoke training around people's specific complex needs was provided when needed. For example there were some people who required support with the management of a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help people breathe. The manager told us that it was particularly important for staff including agency staff to have the appropriate training to support people with these in place. Some of the clinical staff also provided training for staff. For example, the home's speech and language therapist had a session planned for the following day on the subject of dysphasia (impairment of communication). The psychologist had also been carrying out specific training with staff around communication and brain injury.

Training records demonstrated that a programme of training and induction was in place for all staff. Staff members told us that they had received induction training when joining the home, as well as regular on-going training. Training was provided through e-learning as well as face to face training sessions. One member of staff told us that they received "Really good training". The manager told us that induction training was in line with the Care Certificate and that all staff would be enrolled to complete this qualification. The Care Certificate provides a national set of standards which all social care staff should adhere to in their daily work. We saw evidence that staff worked through induction packs which included a checklist for new starters for completion within 12 weeks of commencing employment.

During the inspection, some people raised concerns about the support that staff provided to them during the night. One person told us that there were sometimes communication/attitudinal issues and gave examples where the night staff had not provided the required support. The manager told us that steps had been taken to support the night staff as well as a reduction in the amount of agency staff used. Some staff will be working during the day for a period of time to gain further experience. The aim of this is to support these staff and enable them to access training, as well as giving them the experience of working with the multi-disciplinary team during the day.

We saw that the manager had implemented a supervision schedule, which meant that the manager and other clinical staff carried out one to one meetings with staff to enable them to discuss their development and provide the opportunity for the staff to discuss any issues. We saw from meeting minutes that the

manager had supported senior staff and emphasized the importance of staff receiving these regular support sessions. Staff confirmed that they had regular supervision meetings and found these to be supportive. The manager and staff we spoke with confirmed regular staff meetings were also held. These were used to discuss any number of topics including; changes in practice, care plans, rotas and training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were five people living at the home who were subject to a DoLS authorisation and the manager informed us that applications had been made to the supervisory body for 13 other people living at the home. They were awaiting best interest assessments to be completed for these people. Prior to the inspection we had received information from the local authority that one person's authorisation had expired in December 2015 and the home had not requested another authorisation in a timely manner, this meant that the person had in effect been unlawfully deprived of their liberty, as the appropriate safeguards were not in place. The manager told us that they had learnt from this and had since implemented a "tracca" form, as well as including information in the diary to highlight well in advance when authorisations were due to expire so that further applications could be made in a timely manner. We saw that information about MCA and DoLS was on display and available for people and their relatives to access.

Staff demonstrated an understanding of the MCA and that decisions may need to be made in a person's best interests. We saw that mental capacity assessments had been completed appropriately and recorded in people's care plans. We heard that people were supported by staff to make decisions and consent was gained to provide care. People also told us that staff sought their permission to provide care and support. One person told us that staff respected their wishes when they sometimes did not consent to a care intervention. Where people were unable to provide consent because they lacked capacity to do so the home staff were clear that best interest decisions should be made. For example we saw that the home had followed the correct procedures with regards to administering a person's medication in a covert manner, it was recorded that this was in the person's best interests.

We found that people were supported to maintain good health. Records maintained showed staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's needs. We saw that people had access to their GP. The home provided good support from a number of professions including psychology, speech therapy, and physiotherapy. We saw that referrals were made to other health professionals such as tissue viability nurses or dieticians where necessary.

Requires Improvement

Is the service caring?

Our findings

Most people spoken with told us that they were well cared for and found that staff were kind and caring. Comments included "It's a lovely place to be. You can ask any of the staff for anything." Another person said that they were treated "Very, very well, staff are very kind." Although some people told us that this varied and was dependent upon particular staff.

We found that most of the staff were friendly and had a caring approach towards the people they cared for. The management team told us that the staff were very dedicated and we saw from meeting minutes that there had been a focus on supporting staff to consider the experience of people living at the home and on ensuring that people were always treated with dignity and respect.

We found that staff were very busy particularly on the first day of the inspection, they appeared to have limited time to spend talking with people and were focused on getting tasks completed. There were times when we saw a number of staff talking together in the corridors whilst call bells were ringing. We discussed this with the manager and were told that there was one person in particular who used the call bell very frequently, even when the staff were with them and it may have appeared that staff were not responding but this was not the case. The manager told us that the home's psychologist was doing some specific work with this person to support them with this issue.

During our observation in the dining room at lunch time, we saw that there was a person who was seated in a reclining chair, we saw that they were only wearing one sock and their top was stained with food. We observed that a member of staff came to assist the person to move out of the dining room using the wheeled recliner. However the member of staff did not speak to the person or explain to them what they were doing. We saw that the staff member continued to have a conversation with another member of staff and ignored the person who they were supporting.

We did observe some positive caring interventions between staff and people living at the home. For example whilst we spoke with staff they ensured that a person was included in the conversation. We heard staff chatting to people in a friendly manner whist supporting them with care tasks. We also observed a member of staff take a drink to a person who had just woken, they were caring and asked whether they had slept well. One person told us that they preferred living at Huntercombe in comparison to where they had lived previously and said that staff were being very supportive with aspects of their care.

We found that people's privacy and dignity wasn't always maintained. During a walk around of the building we noticed that some people were nursed in bed and their bedroom doors were left open. We asked the staff why one person's door was left open and were told it was so that staff "could check on him". There was no record in this person's care plan that they preferred to have their door left open and this meant that at times their dignity was compromised, as visitors walking past could see that this person's chest was exposed whist they were receiving treatment.

Care records were kept in locked cabinets in the main offices. However throughout the inspection we saw

personal information on display or left in public areas. We saw that there were a number of signs in people's bedrooms and there was a notice in the dining room about a person's individual care support. There was also a white board in the dining room which recorded when people who needed support with positional turns were next due for this support. These signs mainly highlighted information about the person's care needs and provided a prompt to staff. However, these signs did not maintain people's dignity and were unnecessary, as the information should have been included in people's care plan records. We also saw that personal information about a person had been accidentally left in one of the lounges, which meant that their confidentiality had been compromised. We saw that folders with information about people's daily care were kept in the corridors outside people's bedrooms doors, but this meant that passing visitors could potentially access this information. We raised these issues with the manager who assured us that they would be addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not maintain secure records in respect of each service user.

We found that people were supported to express their views and involved in making decisions about their care. We could also see that staff encouraged and supported people to have some independence. Staff told us that they recognised the importance of promoting people's choices and independence. All the staff we spoke with were able to tell us about the importance of taking time to involve people as much as possible in their care and support. We saw that the one person had been supported to write clear guidance for staff about how they wanted to be supported in certain circumstances, which was an excellent example of person- centred care planning. Staff held one to one sessions with people to involve them in making decisions about their care. We saw an example of this where a person had stated that they would like to be supported to carry out their own blood sugar monitoring.

Information and advice was available in written format at the entrance to the home and on notice boards. This included information about the regulators and how to make a complaint, which ensured that people living at the home and their relatives had access to information in a way that could be understood.

Good

Is the service responsive?

Our findings

We found that the home provided care which was responsive to people's needs. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. People told us that they were able to make choices, such as when they would like to get up and what they would like to do during the day. One person told us "They know how I like things done".

We saw that each person had a care plan. We inspected the care records of four people who lived at the home. We saw that assessments of people's needs were made prior to them moving into the home which were thorough and detailed. The care plans included an "all about me" document and reflected how people would like to receive their care, including their individual preferences. For example we saw in one person's records that the person preferred to be supported by a male carer and another highlighted that someone preferred sweet food to savoury. The manager told us that they had started to focus on the way that the care plans were written to ensure that they were as person centred as possible. One person told us that they were aware of their care plan and felt that it was personalised for them.

The home supported people with a range of needs, some of which were complex and high dependency. People's care needs were reviewed on a regular basis. However we found that people's care plans had not always been re-written when people's needs had changed significantly. For example we saw that a person's eating and drinking requirements had changed. The home had sought appropriate advice from the dietician, but the changes to the plan of care were only written in the evaluation sheets, the main care plan had not been updated with the most current information, which potentially could lead to confusion.

The manager told us that the team were introducing a new model to measure outcomes for people, called a Fim+Fam (functional independence and assessment measure) which will assist to plan and decide on areas to focus upon to support people with their rehabilitation needs. People's individual outcomes were discussed by the multi-disciplinary team and meetings were held twice weekly. The manager told us that they had started to include people living at the home and relatives within these meetings and were planning to roll this out for all people living at the home.

We saw that people were encouraged to regain and maintain as much independence as possible. For example we saw that staff had supported one person to look at the options for securing voluntary work. As well as individual bedrooms, the home had one self-contained flat, which aimed to support people to achieve independent living. The manager told us that they were looking towards creating another flat, as other people living at the home may benefit from living in this type of environment and benefit from support to move on to more independence. One of the rooms within the home had also been adapted into a café and this was run by people living at the home, which again provided an opportunity for people to develop their skills and abilities.

Staff maintained records of the support that people received each day. Any changes or updates were shared at shift handover. We saw that staff completed charts and recorded when people had received care, such as

positional turns, bedrails checks or the amount of fluid that someone had taken. However we also identified that there were sometimes gaps in these charts and they did not always evidence the care that had been provided. For example, we saw that on one person's positional turns form was left blank, however when we spoke to staff they were able to tell us when the person had last been assisted to move position and when this was next due. Another example was that people's personal care such as a bath or shower had not always been recorded.

We also found that the charts were not always completed at the time that the care had been provided. We discussed this with the manager and she told us that the appropriate completion of records was an area that they were working on. She advised that an aspect of the new role senior care role would be to check the records and charts on a daily basis, to ensure that accurate records were maintained.

The home employed two activities coordinators. We spoke with one of the coordinators who told us that an activity programme was in place and they also supported people to go out to do activities in the community. The home had access to a mini bus, which was regularly used to take people out and about. One person said that they had been out recently with two other people living at the home, to a local gig. However, they also commented that they would like to go out more often and another person said that they would like to attend the gym more frequently but staff didn't always have enough time to support this.

The activities programme demonstrated that there were a range of activities on offer, which included arts and crafts, swimming, baking, exercises and pamper sessions. We saw that the activities coordinators also carried out individual sessions with people who remained in their rooms, to try to reduce any social isolation. The activity co-ordinator told us that they tried to arrange activities around people's preferences and talked to people and their relatives to find out about what they enjoyed. We saw that there was a "Getting to know you form" at the front of people's files and staff used this to try and get to know and understand people's preferences. The manager told us that a music therapy student had been visiting the home on a weekly basis and some people had found this to be very positive.

We saw there was a complaints procedure in place, which was on display in the main entrance and within different areas of the home. We saw that people were given information when they moved to the home about how they could complain or raise any concerns. People told us that they would feel able to raise concerns with the manager or staff should the need arise. We saw that there were signs in the home which encouraged people to provide their feedback.

The manager held a file which contained information about any complaints that had been received, however not all complaints received had been filed, although they had been dealt with. We saw that there had been one complaint since the manager had taken up post in September 2015; however the manager told us that she had also dealt with a further complaint and would be including the outcome of this complaint in the complaints file. The manager had acted on the concerns that had been raised and had responded appropriately to these. We also saw that the outcome of one complaint had been to change part of the medication procedures and demonstrated that the complaint had been seen as an opportunity to improve the service.

Requires Improvement

Is the service well-led?

Our findings

People told us that the management team were very supportive. One relative described the home manager as "lovely" and told us that her approach was "very good". Another person told us that she was very "approachable".

There was a clear leadership structure in place and staff felt supported by management. The home manager had been in post since October 2015. When we visited, the manager was not yet registered with The Care Quality Commission (CQC) but had applied and the process was near completion. The manager explained that she had worked hard since coming into post and after an initial settling in period, had focused upon making improvements to the quality of the care. We saw that the management team had worked with the local authority quality assurance and contracts team to take some actions to address particular aspects of the care provision. The manager understood her responsibilities and was supported by a wider team of staff. She was available throughout the inspection and engaged very positively with the inspection process. We saw that a number of changes been made and new systems had started to be implemented. The manager was able to tell us about the areas that needed further improvement and was clear about the actions that were needed to achieve this.

The manager told us that she had focused upon the recruitment of new staff and although the home was now fully staffed they were continuing to recruit, which would ensure that there were sufficient staff to cover for sickness and annual leave. We saw that the staff had been organised and a system had been implemented whereby staff were given responsibility for providing support to certain people within the home, this ensured that staff were clear about their roles and were more clearly accountable for the provision of care to those people. We were told that staff morale had improved in recent months and that people were "working as a team". The manager was aware that further management organisation was required and she planned to implement systems in certain areas.

The staff spoke positively about the manager, who they said she was approachable and committed to managing the home well. Staff told us that they worked as a team and that they were able to raise any concerns with the manager. One staff member told us "I love it here" and said that they could go to the manager with any problems. We saw that the manager was visible around the home and had a friendly approach towards people living at the home and their visitors.

The manager worked closely with the deputy and other senior staff and held a daily meeting with them. The manager and staff said this was a useful way to communicate with each other about relevant matters. During the inspection we observed one of these meetings and saw that this enabled staff to communicate well, ensuring that staff were aware of information such as changes to people's health needs. We also saw that regular meetings took place with staff and the minutes of these meetings demonstrated that the manager had clearly set out her expectations of staff and included discussions around the quality of the care provision.

People living at the home told us that they knew the manager and found that she was approachable. The

manager had arranged regular meetings with people and their relatives to discuss the quality of the care, we saw that four meetings had taken place since the manager came into post in October 2015. We saw that plans had been put in place to make improvements as a result of these meetings. For example, changes were planned for the food provision as a result of feedback received. Staff had used magazines to discuss meal options with people and taster sessions were being organised. The manager had identified that people would like to get more involved with the cooking and plans were in place to enable people to do this.

There were other processes in place which sought people's views about the home. The manager told us that an I-pad was available for people to use to provide feedback, but had found that people tended not to use this. The manager was planning more focused meetings with people and their relatives to enable them to provide feedback and help with continuous improvement. We saw that residents' surveys were also carried out, the latest one having been carried out in November 2015. The manager was awaiting the results of these and advised that an action plan would be developed dependent upon the results.

The provider had also implemented a "conversation into action" plan. The manager told us that she had held a conversations/meeting with staff to get their input and ideas . Through these conversations an action plan is being developed to put some of these ideas into place.

The home had a system to regularly assess and monitor the quality of service that people received. The manager showed us a plan of the audits which are completed on a weekly, monthly and three monthly basis. We saw evidence that a monthly manager's report was completed, which reported on areas including health and safety, safeguarding, pressure damage, reporting incidents, internal audits. The manager told us that they had started to implement care plans audits and had identified some actions to improve these. The manager acknowledged that there was further work which was required on implementing some if these audits, such as a regular audit of all accidents and incidents to analyse any overall themes or trends.

We asked the manager for information regarding any quality assurance visits carried out by the provider to support the manager and to highlight any areas for further improvement, however there were none available. We therefore found that the provider had not carried out regular visits to support and monitor the management and service provision. This was particularly important as the home manager was relatively new in post.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not operate effective systems and processes to make sure they assess and monitor their service.

CQC's records demonstrated that we had been notified by the manager about the majority of significant events as legally required to do this. However we found that CQC had not been notified about the two most recent DoLS authorisations. The manager confirmed that this had been an oversight and told us that the new system that had been put in place should prevent this in the future.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Arrangements for eating and drinking did not always meet people's individual preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (2)(c)People's confidentiality was not maintained as records and personal information was not always kept securely. 17 (1) The provider did not operate effective systems to make sure they assess and monitor their service.