

Sanctuary Care (UK) Limited

# High Peak Residential and Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

The inspection took place on the 25 and 31 October 2018 and was unannounced.

This was the first inspection of High Peak Residential and Nursing Home following a change of service provider.

High Peak Residential and Nursing Home is a 'care home' run by Sanctuary Care (UK Limited). People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home provides accommodation, personal and nursing care for up to 41 people in one adapted building. The majority of double rooms are used as single rooms with a maximum of 34 places provided. Most of the rooms have en-suite toilet facilities and communal bathing and toilet facilities are located throughout the care home. At the time of our inspection, the care home was accommodating 29 people.

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

The registered manager was present during the two days of our inspection and was supported by their regional manager and deputy manager. The management team were open and transparent throughout the inspection process and demonstrated a commitment to the ongoing development of the service.

The care home provided a warm and caring environment for people to live in. Overall, we observed that staff were responsive to the needs of people living in the care home and that people were treated with dignity and respect. We observed two occasions when the lounge area was not supervised by staff and saw people calling for help. We raised this feedback with the management team who arranged to review the staff deployment system and amend the staffing levels in the home to ensure the same number of staff were on duty throughout the day.

We found that information on people's assessed needs and the support they required from staff had been recorded within care plans. This included risk assessments and other supporting documentation. The care planning system was in the process of being updated at the time of our inspection to ensure the registered provider's current documentation was utilised. This work is due to be completed by December 2018. Nevertheless, care plans viewed had been kept under monthly review to ensure the information recorded was up-to-date and accurate.

Policies and procedures had been developed to ensure staff were aware of their roles and responsibilities

for ordering, storing and administering medication and to ensure safe systems and practice.

People were offered a choice of nutritious and wholesome meals. People were able to socialise and eat their meals at their preferred pace and support was available when required.

A programme of activities was in place. The activities coordinator was absent during the period of our inspection so alternative arrangements were put in place to ensure people continued to benefit from social and recreational stimulation.

Systems had been established to ensure that staff working in the care home had been appropriately recruited and to safeguard people from abuse or harm.

A complaints policy and procedure had been developed and people's views, concerns and complaints were listened to and acted upon.

People were supported to attend healthcare appointments and staff liaised with people's GPs and other healthcare professionals as necessary to maintain people's health or support them at the end of life. We observed that a GP visited the care home on a regular basis to ensure the healthcare needs of people were monitored and reviewed.

Staff had access to regular supervision and completed induction, mandatory and service specific training to help them understand their roles and responsibilities. Progress in completing training was kept under review and dates had been set for staff to attend outstanding training.

Staff had access to policies and procedures and had completed training in the Mental Capacity Act to help raise awareness of this protective legislation. We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Where people did not have capacity, and could not give consent, we saw documentary evidence that specific decisions had also been made in people's best interests and were the least restrictive option.

The registered provider had developed a range of management information and quality assurance systems to enable oversight and scrutiny of the service. This involved seeking the views of people who used the service and their representatives. Quality assurance systems were in the process of being updated at the time of our inspection to improve oversight, accountability and drive continuous improvement.

Some parts of the care home were in need of maintenance and refurbishment. We noted that capital expenditure plans had been developed and that work had commenced to improve the environment.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Safeguarding systems and processes were in place to help protect people from abuse and improper treatment.

Staffing levels were adequate and subject to ongoing review to ensure people received appropriate levels of care and support.

Recruitment procedures provided appropriate safeguards for people using the service.

Systems had been established to protect people from the risks associated with unsafe medicines management.

### Is the service effective?

Good ●

The service was effective.

Staff learning and development systems and processes had been developed to ensure staff were appropriately trained and supported for their roles and responsibilities.

Managers and staff acted in accordance with the Mental Capacity Act 2005 to ensure people received the right level of support with their decision making.

People had access to a choice of nutritious meals and systems were in place to liaise with GPs and other health and social care professionals when necessary.

### Is the service caring?

Good ●

The service was caring.

Staff engaged with people in a warm, friendly and caring manner and understood the principles of good care practice.

People were treated with dignity and respect and their privacy and human rights were safeguarded.

People's personal information was stored securely to maintain

confidentiality.

### Is the service responsive?

Good 

The service was responsive.

Care plans and supporting documentation had been established that were in the process of being updated and subject to ongoing development and review.

There was a complaints procedure in place and any complaints were responded to appropriately.

People were encouraged to engage in a range of activities.

Systems were in place to ensure people were supported appropriately at the end of their life.

### Is the service well-led?

Good 

The service was well led.

The care home had a registered manager in place to provide leadership and direction.

Quality assurance systems and processes were in the process of being updated to ensure improved oversight and accountability within the service.

The service worked in partnership with other agencies and health and social professionals.

# High Peak Residential and Nursing 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.

The inspection was unannounced and the site visit activity started on 25 October 2018 and ended on the 31 October 2018.

The inspection was undertaken by two adult social care inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case of older people requiring residential or nursing care.

Prior to our inspection, we requested the registered provider to complete a 'Provider Information Return' (PIR). A PIR 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 looked at all the information which the Care Quality Commission already held on High Peak Nursing Home such as intelligence, statutory notifications and / or any information received from third parties. We also contacted the local authority and the clinical commissioning group to provide us with any information they held about the care home. We took any information provided to us into account.

During the inspection we used a number of different methods to help us understand the experiences of people living in the care home and to gather information.

We spoke with the regional manager, clinical development manager, registered manager, deputy manager, one registered nurse, a senior care assistant, two care assistants, the home's administrator and the

maintenance person.

We also spoke with seven people who lived in the care home, eight relatives and a visiting general practitioner.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records including three care records belonging to people who lived in the care home. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and well-being.

# Is the service safe?

## Our findings

We asked people who used the service or their representatives if they felt the service provided at High Peak Residential and Nursing Home was safe. All people spoken with told us that they felt safe and relatives told us that their loved ones were safe and this made them feel less anxious.

For example, one person living in the care home told us: "They [care staff] make me feel safe. They really do." Likewise, a relative told us "I know my father is safe because the property is secure."

We reviewed the care records for three people living in the care home. We found that each file contained information on people's assessed needs together with a range of risk assessments relevant to each person. This information helped staff to be aware of people's diverse needs, current risks for people using the service and the action they should take to minimise and control potential risks.

A fire risk assessment, fire evacuation policy, personal emergency evacuation plans and a business continuity plan were also in place to ensure an appropriate response in the event of a fire or major incident.

Systems had been established to log, record and maintain a monthly overview of any incidents, accidents, falls and other significant data. We noted that the care home's electronic records management system known as RADAR was also able to provide a detailed annual and monthly analysis of incidents such as the number of events, type of incident and level of risk. Other summary information reports could also be extracted from the system. For example, clinical information relating to infections, hospital admissions and pressure ulcers. The RADAR system was in the process of being updated at the time of our inspection to enhance the capability of the system.

We noted that an incident analysis form had recently been introduced which provided opportunities to identify any common causes, underlying factors and lessons learned. This helped to raise awareness and reduce the risk of future occurrences. Together these management information systems helped the registered manager and the senior management team to identify trends, maintain an overview of significant events and monitor the standard of care delivered to people using the service.

At the time of our inspection there were 29 people being accommodated in the care home who required different levels of nursing or residential care and support. The service employed a registered manager on a full-time basis who worked flexibly subject to the needs of the service. Additionally, a deputy manager was in post that worked alongside nursing staff and staff responsible for the delivery of care. Ancillary staff were also employed in administration, activity, housekeeping, domestic, laundry and maintenance roles.

We reviewed the dependency levels of people and looked at the staffing rotas with the registered manager. We noted that the dependency of people living in the care home was kept under regular review and saw that the home was staffed with two registered nurses and six care staff in the morning. During the afternoon, the staffing levels reduced to one registered nurse and four care assistants. At night there was one registered nurse and three care assistants on duty.

We discussed the allocation of staff with the registered manager and the regional manager during the inspection, as we noted two occasions during the afternoon when staff were not observed to be near a lounge area and two people were noted to call for assistance. Staff also raised concerns about the staffing levels during the afternoon.

The regional manager told us that changes were in the process of being introduced to vary the staffing levels within the care home so that the number of care staff on duty in the morning was the same for the afternoon. We were also informed that changes would be made to the allocations sheet to ensure they clearly identified which staff were responsible for covering each lounge area at all times each day. We received written confirmation from the regional manager that these changes had been implemented upon completion of our inspection.

Systems were in place for staff to handover key information relating to the needs and wellbeing of people using the service via daily handover sheets and other supporting records.

The registered provider had developed a policy on staff recruitment to provide guidance to people responsible for the recruitment of new staff.

We looked at four staff personnel files during our inspection for staff who were working in the care home. Records viewed confirmed that prospective employees had undergone an interview process and checks such as the Disclosure and Barring Service (DBS), references and proof of identity. In appropriate instances there was evidence that Nursing and Midwifery Council personal identification numbers had been checked to ensure valid nursing registration. All the staff files we reviewed provided evidence that the checks had been completed before people were employed to work at High Peak Residential and Nursing Home. This helped protect people against the risks of unsuitable staff gaining access to work with vulnerable adults.

The registered provider had developed a policy on safeguarding adults and whistleblowing to provide guidance to staff. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. A copy of the local authority's adult protection procedure was also available for staff to reference.

Discussion with the registered manager and staff together with a review of training records confirmed the majority of staff had completed safeguarding training. At the time of our inspection 14 staff were due to complete their annual refresher training. Staff spoken with demonstrated a satisfactory awareness of the different types of abuse and the action they should take in response to suspicion or evidence of abuse. Staff were also able to explain how they would whistleblow should the need arise

We asked the registered manager for information on any safeguarding incidents that had occurred in the service or that were known to the service in the last 12 months. We noted that tracking systems had been developed by the registered manager so that they could maintain oversight of any safeguarding incidents, action taken, outcomes and lessons learned. Records confirmed that there had been no safeguarding incidents since the new provider had taken over responsibility for the care home. This was in-line with records held by CQC.

Discussion with the registered manager confirmed they understood their legal obligation to notify the Care Quality Commission (CQC) and the local authority safeguarding team of any abuse or allegations of abuse. No whistleblower concerns had been received by the Care Quality Commission (CQC) in the past twelve months.

We checked that there were appropriate and up-to-date policies and procedures in place around the administration of medicines and found that the provider had developed a policy for the administration of medication. A copy of the policy was available in the medication storage room for staff to reference together with other relevant guidance and information such as patient information leaflets and PRN (as required) medication protocols.

Medication was dispensed by a local pharmacist and stored securely within trolleys and cupboards in a dedicated storage room. Separate storage was available for medication requiring cold storage and for controlled drugs.

We looked at how medicines were managed in the care home with the registered manager and deputy manager. We were informed that only the registered manager, deputy manager and registered nurses were designated with responsibility for managing medication.

Training records confirmed that all designated personnel had completed training developed and approved by the dispensing pharmacist. Systems were also in place to ensure an annual comprehensive assessment of competency was undertaken for designated staff. At the time of our inspection this was outstanding for only two night staff.

A list of staff responsible for administering medication and holding keys, together with sample signatures was available for reference. Resident identification charts had also been attached to medication administration records. This helped staff to correctly identify people who required medication and provided other key information such as known allergies and special instructions.

We checked the arrangements for the storage, recording and administration of medication for the home and found that this was satisfactory. We saw that a record of administration was completed following the administration of any medication. We also checked the arrangements for the storage, recording and administration of controlled drugs and found that this was satisfactory.

Systems were in place to record room and fridge temperature checks; medication returns and incidents concerning medication. Monthly medication audits were undertaken in addition to other routine stock checks and the dispensing pharmacist visited annually to undertake an external audit. The last audit in July 2018 provided overall positive feedback.

Areas viewed during the inspection appeared clean, hygienic and no malodorous smells were noted. Staff had access to personal protective equipment and policies and procedures and auditing systems for infection control were in place. The last infection control audit undertaken for the home achieved a score of 99%. Likewise, the last infection control audit completed by the infection control team in September 2018 achieved an overall score of 95%. We saw that an action plan had been developed to ensure any recommendations arising from the audit were completed.

Management information systems had been developed to ensure effective monitoring of clinical information relating to infections. Monthly infection control surveillance reports were also sent to the local clinical commissioning group to ensure oversight and scrutiny of infection control data.

The home had a series of internal and external checks for the safety of the premises and equipment. We checked a number of test and service maintenance records with the care home's maintenance person relating to: gas safety; electrical wiring; fire extinguishers; fire alarm system; passenger lift; hoists and slings and portable appliances and found all to be in order.

## Is the service effective?

### Our findings

We asked people who used the service or their representatives if they felt the service provided at High Peak Residential and Nursing Home was effective. People spoken with confirmed the service was effective.

For example, comments received from three people living in the care home included: "The staff always ask for my permission"; "Night staff are very good" and "Food it's nice."

Likewise, a relative told us "It's a good home. They don't come much better. It's nice and so is the food. I'm happy with it".

One relative raised concern regarding the way a person was supported during meal times. We shared this feedback with the registered manager so that the issues raised could be acted upon.

High Peak Nursing Home is a three-storey building with resident accommodation on the ground first and second floor. The home is equipped with a passenger and stair lift and has 34 bedrooms, the majority of which have ensuite toilet facilities. All rooms have an emergency nurse call system. There are lounge areas, a dining room, hairdressing salon and assisted / communal bathroom and toilet facilities located within the building. There is a large patio where people can sit and enjoy the outdoors and a car park at the front of the building.

We undertook a tour of the building and noted that some parts remained in need of maintenance, redecoration and refurbishment. We spoke with the regional manager and the registered manager regarding the condition of the care home and noted that an improvement plan had been developed. The improvement plan highlighted that a schedule of work had been prepared to ensure the care home benefitted from ongoing investment to key areas. For example, the redecoration of corridors, lounge areas, communal bathrooms and toilets; provision of new furniture and the installation of new flooring in the lounge and dining areas and the conversion of a bathroom to a wet room. We observed that this work had commenced and painters and decorators were on-site and in the process of redecorating one of the lounge areas during our inspection.

We saw that people were encouraged to personalise their rooms with their individual belongings such as pictures, ornaments and personal possessions to make them homely and comfortable. We also noted that people had access to aids and equipment to help people mobilise and maintain their independence.

We spoke with the regional manager and the registered manager regarding staff training and development. We noted that the registered provider purchased e-learning training from an external training provider for staff to complete and that a change in training provider had occurred earlier in the year. Consequently, staff were in the process of transitioning over to the new system. Progress had been delayed due to issues with the care home's Wi-Fi network.

We looked at the training resources available for staff and saw that comprehensive induction booklets had

been produced by the registered provider for staff to complete. The workbooks were designed for the specific roles of staff such as a care assistant or nurse and were linked to organisational policies and procedures.

Discussion with staff and examination of training records confirmed staff had completed a range of induction, mandatory, service specific and qualification level training that was relevant to their roles and responsibilities. Nursing staff were supported with their revalidation for the nursing and midwifery council (NMC) to ensure that they met the necessary requirements through training. We noted that systems were also in place to ensure agency staff were inducted into their roles.

Overall, completion rates for mandatory training were good with the exception of moving and handling training (46%), safeguarding adults (65%) and fire prevention and awareness (74%). We saw evidence that 16 staff had been booked on moving and handling training during November 2018 and systems were in place to ensure the outstanding training needs of staff were met. Although some staff were in need of refresher training, we observed good transfer processes undertaken by staff when using hoisting equipment. Records indicated that six staff had also completed a recognised qualification in health and social care at level 2 or 3.

Staff spoken with also confirmed they had attended periodic team meetings relevant to their roles and responsibilities and formal supervision and annual appraisals throughout the year.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

The registered provider had developed policies on the MCA and DoLS. Staff spoken with told us that they had completed training in this protective legislation to help them understand their duty of care and this was verified by reviewing training records. Although completion rates for this training were good, some staff spoken with lacked awareness of this legislation. We shared this feedback with the registered manager so that they could review this aspect of staff learning and development.

We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Applications were submitted to the local social services department who were responsible for agreeing to any DoLS imposed and for ensuring they were kept under review. Where people did not have capacity, and could not give consent, we saw documentary evidence that specific decisions had been made in people's best interests and were the least restrictive option.

The registered manager maintained a record of DoLS applications submitted to the local authority. At the time of our inspection, 15 applications had been submitted and all were awaiting a decision.

The registered provider operated a four-week rolling menu that was reviewed periodically to reflect seasonal produce, availability and the preferences of people living in the care home. The menus were available in book format in the dining rooms and also displayed on notice boards for people using the service to view. People were supported to make their daily meal choices the day before each meal was prepared to ensure individual preferences were accommodated.

We looked at the most recent food standard agency inspection score for the home following an inspection in October 2018. We noted that the care home had been awarded a rating of 5. This is the highest rating that can be given and means that the hygiene standards in the care home were very good.

We spoke with the cook on duty during the inspection and looked at the kitchen. The cook told us that all meals were home made using fresh produce. The kitchen appeared clean, well organised and appropriately stocked. We noted that catering staff had access to information on people's dietary needs such as people's likes, dislikes, allergies, type of diet and portion sizes etc. which had been stored in a file for reference.

The menus offered an alternative choice of meal at each sitting. We observed the breakfast and lunchtime meals being served and saw that food looked and smelled appetising and was attractively presented. People had a drink of their choice and additional refreshments and snacks were provided throughout the day or upon request.

The care home had two dining rooms. At the time of our inspection one of the dining room areas was being used to store furniture as the adjacent lounge was being refurbished. The one dining area in use offered a clean and comfortable environment for people to socialise and eat their meals. Tables were appropriately laid with tablecloths, condiments, dried flowers, menus and paper napkins.

We observed a lunchtime meal and saw that people had a choice of refreshments and meals. Food was attractively presented in the dining room and looked and smelt appetising. People were also supported to eat their meals in their rooms if they wished. The registered manager told us that care home operated a protected mealtime policy and that arrangements had been made to phase mealtimes, to enable people sufficient time to eat their meals whilst the refurbishment work was undertaken. We noted that one relative was regularly invited to have lunch with a loved one to enable their relationship to be maintained.

Staff spoken with demonstrated a good understanding of each person's dietary needs and food preferences. Staff confirmed they would complete relevant monitoring charts for food and fluid intake for people at increased risk of malnutrition or dehydration.

The registered manager told us that they endeavoured to work in partnership with other teams and services to ensure the delivery of effective care and support for people using the service. For example, whilst undertaking the inspection we observed that a local GP was undertaking a visit to the care home to review the wellbeing of people using the service.

One visiting healthcare professional told us "Without doubt, this is the best home I've been involved with. The care is second to none."

We noted that staff had developed working relationships with a range of social care and health professionals to help ensure positive outcomes for people's health and wellbeing. For example, GP's, chiropodists, opticians and a local dentist. Staff also made referrals to appropriate health professionals such as speech and language therapists and dieticians when they had concerns about someone's health.

Discussion with people using the service or their representatives and examination of records provided evidence that people using the service had accessed a range of health care professionals such as their GP's chiropodists and opticians subject to individual need.

# Is the service caring?

## Our findings

We asked people who used the service or their representatives if they found the service provided at High Peak Residential and Nursing Home was caring. Overall, people spoken with confirmed the service was caring and that people were treated with dignity and respect by kind and compassionate staff.

During our inspection of High Peak Nursing Home we spent time talking with people living in the care home, their relatives and a visiting health care professional. Overall, feedback received from people regarding the standard of care and treatment was positive.

Throughout the inspection we undertook observations within the care home. We observed the environment to offer a warm and friendly place to live. We saw that people using the service appeared comfortable in their home environment and appeared well groomed, clean and generally happy in their appearance.

Staff spoken with demonstrated a commitment to providing personalised care and support, maintaining independence and safeguarding people's dignity, individuality and human rights. Staff were seen to respond promptly to people's needs and were observed to engage with people in a kind, respectful and compassionate manner. We saw that relatives were also made to feel welcome and encouraged to visit their family members at different times each day.

Staff told us that they had access to policies and procedures and important information on people's needs and support requirements. Through discussion and observation, it was clear that staff were aware of matters that were important and unique to people. For example, known risks, required personal aids and preferred routines and preferences.

We undertook a short observational framework for inspection (SOFI) during the morning in one of the lounges. We noted that most people were sleeping and there was therefore little interaction between people living in the care home. However, we saw some positive interactions between people using the service and staff.

For example, one person started to complain about a chest pain. We observed one of the nurses respond quickly by offering the person some medication. The nurse was also seen to remain with the person offering them reassurance and support until they felt better. In another instance, we observed a staff member asking a person if they wanted to watch the television. The staff member responded to the person's request by turning the television on.

The registered provider had developed a policy on data protection and information on the organisation's privacy notice was published on the Sanctuary Care website. Personal information about people receiving care at High Peak Residential and Nursing home was kept securely to ensure confidentiality.

Information on the High Peak Nursing Home had been produced in the form of a statement of purpose and a resident information guide. The resident information guide had also been produced in an easy read

format using signs, symbols and photographs to help people understand the information more easily.

This documentation provided people using the service and their representatives with key information on the service such as: information on the registered provider; details about the care home; safeguarding, advocacy and equality and diversity; feedback and involvement; fees; inspections and useful contact details.

The manager was aware of how to access advocacy services in the event a person required support to make decisions and did not have family and friends to assist them. An advocate is a person that helps an individual to express their wishes and views and help them stand up for their rights.

## Is the service responsive?

### Our findings

We asked people who used the service or their representatives if they found the service provided at High Peak Residential and Nursing Home was responsive. People spoken with confirmed the service was responsive to their individual needs.

For example, feedback received from three people living in the care home included: "They [care staff] come quickly to me"; "They respect you"; "Activities keep my mind active" and "GPs called straight away."

Likewise, feedback received from two relatives included: "The care isn't rushed" and "They [staff] have the right temperament."

We reviewed the care records for three people living in the care home. Files viewed contained a range of information such as: pre-admission assessments of need; care plans; risk assessments and relevant supporting documentation.

We noted that some documentation in use had been developed by the previous owner and some files contained blank forms that were not required. We received assurance from the regional manager and the registered manager that plans were in place to cleanse and transfer all documentation to the registered provider's current systems, processes and documentation to ensure best practice. This transitional work had been recorded on the home's action plan and was work in progress at the time of our inspection. Tracking systems had also been established to enable the registered manager to monitor progress against the target completion date of December 2018.

We observed that a clinical development manager from within the organisation had been allocated time to work with staff in the care home to ensure effective support and oversight with this work. We noted that progress was routinely monitored and that reports produced were produced to identify outstanding tasks. Action had also been taken to address record keeping issues in response to recent feedback from the local authority and a representative from the clinical commissioning group.

We saw that care plans had been produced in response to people's identified needs and outlined important information such as: planned outcomes for each person; individual abilities and skills; the details of any support needed from staff and any perceived risks to each individual. Monthly evaluation records had also been completed to ensure care plans were routinely monitored and to confirm that records were up-to-date and accurate.

Supporting documentation including: admission information; personal profiles; visiting professional records; daily notes; consent forms; terms and conditions and other miscellaneous records were also available for reference.

The registered provider had developed a policy on end of life care to provide guidance to staff. At the time of our inspection, none of the people living in the care home were receiving end of life care.

We noted that the care home provided both palliative and end of life care and had attained the Gold Standards Framework (GSF) quality hallmark award at 'platinum status' - in recognition of sustained excellent practice. The GSF is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best.

We discussed the home's arrangements for end of life care planning with the registered manager and noted that records were in place to record people's wellbeing, wishes and preferences. For example, the care home utilised a booklet produced in collaboration with the local NHS trust, Clinical Commissioning Group and hospice to record important information. Likewise, the provider had produced a dedicated end of life assessment and care plan. This took into consideration important factors such as where a person would prefer to be cared for when nearing the end of life; their religious, cultural, emotional and spiritual needs; preferred undertaker and special wishes.

The registered manager and staff spoken with demonstrated a strong commitment to providing responsive and personalised care and support to people approaching the end of their life.

The care home had a hospitality room that was available for relatives to use when required. We saw examples of 'cultural awareness' information and prompts that had been produced by the registered provider to guide staff on common practices relating to different religions and death and dying. Likewise, we viewed support leaflets offering support and guidance to relatives after the death of a loved one. We noted that feedback was also sought at an appropriate time from relatives, to ensure learning and continuous improvement in the quality of end of life care provided.

The registered manager told us that the care home had established links with GP's, Macmillan specialist nurses and other palliative care specialists. This helped to ensure that people received appropriate support towards the end of their life if they expressed a wish to stay at High Peak Residential and Nursing home.

The registered provider had developed a procedure for communications on translation, interpretation services and accessibility. Likewise, an accessible information standard user guide had been produced to help staff identify how to record and meet service user's need to ensure compliance with the Accessible Information Standard 2015.

The Accessible Information Standard (AIS) requires that all publicly funded adult social care and care provided by social care services must identify and meet the information and communication needs of those who use their services.

At the time of our inspection, the care home was supporting people with a diverse range of needs. We noted that the registered provider had produced information in alternative formats to help people understand information. A poster offering to produce information in alternative formats such as braille, audio or different languages was also displayed on a notice board in the reception area for people to view.

The registered provider had developed a complaints procedure to provide guidance to people using the service and / or their representatives on how to make a complaint. An easy read version had also been developed for people to read. The care home's complaints procedure was displayed on noticeboards so that people had access to this information.

A complaints log had been established to record any concerns or complaints. This outlined the log number for each complaint; date complaint received; verbal or written; complaint code; details of the complaint; feedback given; outcomes and date closed.

We looked at the complaint records for the care home which highlighted that there had been four complaints regarding the service in the last 12 months. We noted that appropriate action had been taken to investigate and respond to any concerns raised.

The registered provider employed one part-time activity coordinator who was responsible for the development and provision of a range of activities for people using the service five days per week.

On the day of our inspection the activity coordinator was not on duty in this role and had been absent from work for a period of three weeks prior to our inspection.

We saw that a weekly programme of activities had been produced however examples viewed were not dated. Records of individual and group activities had also been completed however the records had not been updated following the absence of the activity coordinator.

On the first day of our inspection, we observed no activities in the morning but there was a resident and relatives meeting in the afternoon which a member of the inspection team attended. We also observed a member of staff coordinating a music and chair exercise session for a group of people in another lounge. On the second day of our inspection, we observed a bingo session taking place in one of the lounge areas.

The registered manager told us that they were looking to generate interest from local volunteers to assist in the provision of activities and to befriend people using the service. We noted that there was also an expectation from the registered provider that care staff should assist in meeting the social and recreational needs of people living in the care home during the absence of the activity coordinator to ensure people's social, recreational and leisure needs were met.

Activity programmes viewed highlighted that people had participated in a range of activities such as board games, quizzes, art and craft work, sing-a-long sessions, poetry and reminiscence activities.

A feedback score of 100% satisfaction was recorded by 22 respondents for activities following the last annual satisfaction survey in August 2018. No concerns were received from people using the service regarding the activities however one person told us that they would like to go fishing. One relative and some staff spoken with told also us that people would benefit from more activity coordinator hours.

The local authority recommended that the registered manager explore the viability of employing an additional activity coordinator following their last monitoring visit. We shared this feedback with the registered manager who assured us that they would undertake a review of the activity programme and evaluate options. Upon completion of our inspection we received a dated programme of activities to cover the absence of the activity coordinator. We also were provided with a copy of a new daily staff deployment schedule which identified specific staff to assist in the provision of daily activities.

The care home utilised a range of assistive technology to help keep people safe and to maintain their independence. For example, a hearing loop system, wireless nurse call system, mobile pendants and motion sensors were available subject to individual needs.

# Is the service well-led?

## Our findings

We asked people who used the service or their representatives if they felt the service provided at High Peak Residential and Nursing Home was well led.

Feedback received from people using the service and their representatives was positive. Staff spoken with also told us that the registered manager was approachable and that they felt supported by the management team.

High Peak Nursing Home had a manager in place that was registered with the Care Quality Commission. The registered manager was present throughout the two days of our inspection and was supported by their regional manager and deputy manager.

The management team engaged positively in the inspection process and were helpful, transparent and keen to share and receive information regarding the operation of the care home. They also demonstrated a strong commitment to ensure the continuous improvement of the service.

We noted that the registered manager operated an open-door policy and it was clear that they remained passionate about their role and responsibilities. Throughout the inspection, the registered manager took time to communicate and engage with people living in the care home, staff and visitors and was warm and friendly in their approach.

High Peak Residential and Nursing Home is operated by Sanctuary Care (UK) Limited (the registered provider) and is governed by a board of directors that have overall responsibility for the management and operation of the service.

The registered provider had developed an annual business plan for the care home. Furthermore, a corporate mission statement was in place which focussed on 'keeping kindness at the heart of our care'. This was underpinned by a set of values which included: the 'delivery of personalised care', 'treating people with respect and dignity', 'delivering the highest quality of service', 'building rewarding careers' and 'supporting people to live happy and contented lives'. The registered provider had also published a range of information on its website for people to view.

A quality assurance procedure had been developed which outlined the registered provider's systems and processes for assuring quality in its registered services. The framework was based upon seeking the views of people who use the service or their representatives and included a number of routine checks and audits.

We noted that the provider's quality assurance team had undertaken an inspection of the care home during July 2018. At that time an overall score of 86% was achieved. We saw that the regional manager had also completed monthly compliance visits. The most recent score following the regional manager's visit was 88% (within the good category). Any areas requiring action were recorded and kept under review via service improvement, home action plans and the organisation's electronic records management system known as

RADAR. This helped to ensure continued oversight and scrutiny of the operation and performance of the service.

An audit calendar was also in place which outlined a series of audits that were to be completed at different intervals throughout the year. The audits covered a range of areas such as care plans, medication, laundry, kitchen, infection control, health and safety and mattress audits. All audits viewed (except for care plans which were not scored) highlighted that the compliance scores were in either the good range (80-95%) or excellent range of (95-100%).

At the time of our inspection the care home was still using audit documentation relating to the previous registered provider. We noted that plans were in place to transfer to the new documentation as a matter of priority and that this was work in progress.

An annual satisfaction survey was also distributed to people using the service or their representatives during August 2018 using an easy read format. We viewed the summary report for the survey which indicated that 22 out of 30 survey forms had been completed and returned. The questions focussed on the living environment; meals; staff; care services and activities; privacy and dignity; communication and information and overall feedback. Feedback scores for each category were consistently high and ranged from 92% (staff) to 100% (care services and activities). Upon completion of the survey a 'Your opinion matters – action plan' was produced which highlighted how the service aimed to make further improvements regarding the choice of meals, living environment and feedback re staff.

Relative and resident meetings were coordinated throughout the year during which people were encouraged to share and receive information. Notices were placed on the communication notice board informing residents and their relatives of forthcoming meetings and events.

Staff had access to a suite of policies and procedures that had been developed by the registered provider. Copies were available to staff within the care home or could be accessed remotely via on-line passwords.

The care home had not received an enter and view visit from Healthwatch Warrington since Sanctuary Healthcare(UK) Limited have been responsible for the care home. Healthwatch England was established as an effective independent consumer champion for health and social care. It also provides a leadership and support role for the local healthwatch network. A report is produced following any visits. The last report provided positive feedback and was published in December 2016.

Periodic monitoring of the standard of care provided to residents funded via the local authority was also undertaken by Warrington Borough Council's Contracts and Commissioning Team. This is an external monitoring process to ensure the service meets its contractual obligations.

The last monitoring visit was undertaken in September 2018 in partnership with a representative from the clinical commissioning group. A number of areas for development were identified during the visit relating to the distribution of new policies; establishment of management information systems; review of care plans and associated records and staff training. We found that the home had made progress in responding to the feedback contained within the report.

The registered manager is required to notify the CQC of certain significant events that may occur in the care home. The registered manager had kept a record of these notifications and had notified the Commission of reportable incidents as required under the Health and Social Care Act 2008.

