Coveleaf Limited

Hope Manor Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of this service on 25 and 27 August 2015.

During this inspection we found six beaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in respect of person-centred care, safe care and treatment, meeting nutritional and hydration needs, premises and equipment, good governance and staffing. You can see what action we told the provider to take at the back of the full version of the report.

We last inspected this service on 27th September 2014 and found it to be compliant.

Hope Manor is a residential care home located in Salford, Greater Manchester and is owned by Coveleaf Limited. Hope Manor is registered with the Care Quality Commission to provide personal care and accommodation for up to 26 people.

The home is situated off a busy main road and close to local amenities. Parking facilities are available at the front

Summary of findings

of the home which also facilitates wheel chair access. Hope Manor is an older building with accommodation that is set over two floors. Interior décor is worn and traditional in presentation. At the time of our inspection there were 24 people living at the home, one person was in hospital and the home had two vacancies.

There was no registered manager in place at the time of our inspection. However, a new manager had recently been appointed and they were currently applying to register as the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found there to be insufficient numbers of staff to meet the needs of people who used the service. The service did not have an effective means of assessing staffing levels against the needs of people who used the service. Through our observations in communal areas of the service, we observed several instances where the care and support needs of people who used the service were not being met. During our inspection, we also observed unsafe practice when a drinks trolley carrying a hot tea pot was left unsupervised in the lounge.

We found the safeguarding policy to be out of date and no information was displayed around the service to provide guidance on how to raise a safeguarding concern. We asked the acting manager to rectify this and immediate action was taken to update the safeguarding policy. Additionally, the acting manager sourced the latest local authority safeguarding guidance, and displayed this in several prominent locations around the service.

We looked at a sample of recruitment files to make sure safe recruitment practices were being followed. We found the identity of people applying to work at the service had been checked and verified and that checks had been completed with the Disclosure and Barring Service (DBS). A DBS check helps to ensure that potential employees are suitable to work with vulnerable people. However, we found recruitment procedures were not being operated effectively. The recruitment and selection procedures in place did not include taking interview notes to demonstrate candidate's suitability for the role they had applied for.

During our inspection we identified several risks to the health and safety of people who used the service. We found that window restrictors on the first floor were unsafe and did not meet legal requirements. We asked the manager to rectify this and immediate action was taken. We also found a side door to the premises left open and unsupervised. This led out to an enclosed outside area with an uneven concrete surface and a significant step to negotiate. This meant that people who used the service were at risk of falling if they had attempted to go outside. We asked the manager to rectify this and immediate action was taken.

We found the service did not keep adequate records to demonstrate how risk was assessed in relation to buildings and premises. Risk assessments had not been completed in connection with the use of portable electrical devices, including those in people's bedrooms. The service was also unable to demonstrate how it had effectively assessed the risks associated with waterborne microorganisms. Furthermore, the service did not have a business continuity plan in case of fire, flood or loss of power.

Policies and procedures for the safe administration of medicines had recently been updated. We found medicines were administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records. We found unsafe practice in the way keys to the controlled drugs cupboard were managed and we asked the service to take immediate action to rectify this. We also found the storage of stock medicines to be disorganised.

Accidents and incidents involving people who used the service were not monitored and recorded effectively. The service failed to identify risks and failed to implement preventative measures to reduce the likelihood of such accidents and incidents occurring again. We found that personal emergency evacuation plan (PEEP) documentation was contained within some care plans but methods for individual evacuation were not included. The service did not maintain a PEEP 'grab file' in case of emergencies.

Summary of findings

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. We found the service was working with an external training provider to train and develop staff to nationally recognised standards. However, we found the vast majority of mandatory training was delivered via short online e-learning modules covering topics such as basic first aid, infection control, fire awareness, dementia, health and safety, mental capacity act and deprivation of liberty safeguards.

Prior to the current acting manager being in post, we found recording of staff supervision was inconsistent. However, we saw that a new supervision matrix had been introduced and that progress was being made in completing one to one supervisions sessions with staff.

During our inspection we looked at the meal time experience for people who used the service at Hope Manor. Overall we found the atmosphere within the dining room to be calm with some people who used the service happily chatting at their tables. Main meals were pre-ordered from a frozen foods' supplier and rotated over a four week period. No hot meals were freshly prepared on site. We found a choice of two main course options were offered on the day of our inspection, but these options did not correspond with the published menu.

We looked at the care and support records of 10 people who used the service at Hope Manor. We could see improvements had been made in developing new care planning documentation but a number of old style care plans were still in use which were not fit for purpose. Information relating to the care and support needs of people who used the service was disorganised and significant gaps in recording were identified. Person-centred care was not provided in line with people's requirements. The service did not respond in an appropriate and timely manner to the changing care and support needs of people who used the service.

We also looked at the care and support records of people who used the service who had been assessed by a healthcare professional as a high risk of malnutrition. The service was unable to demonstrate how it was effectively meeting the nutritional and hydration needs of this group of people who used the service.

The service did not have a consistent approach to quality assurance and audit. However, we were able to see that improvements had been made in relation to medication audits and infection prevention and control.

The service had been working with Salford City Council Infection prevention and control team to improve standards of cleanliness and to raise awareness of infection prevention and control (IPC) amongst staff. On the day of inspection we found the home to be clean and tidy. However, we observed one instance of poor IPC practice going unchallenged.

We spoke with care staff to ascertain their understanding of the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS) legislation. We found care staff did not have sufficient working knowledge of this legislation or its practical application when providing care and support. However, we found the manager had an enhanced level of understanding of this legislation and fully recognised the knowledge gaps amongst some care staff.

Involvement of people who used the service and/or their representatives through the use of residents meetings was ineffective. At the time of inspection we found the last meeting had taken place in February 2015 and was poorly attended.

The service had a complaints policy and we found the manager had introduced a new complaints log. We saw evidence of one complaint had been made in the last year which appeared to have been dealt with and resolved appropriately.

Hope Manor had a policy of restricting visiting before 8am and after 8pm. This meant that family and friends of people who used the service were unable to visit during these restrictive hours.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

There were insufficient numbers of staff to meet the needs of people using the service and to consistently keep people safe.

Risks to individuals had not been fully assessed and therefore people could not be assured their safety and well-being was always fully considered.

Risks associated with buildings and premises were not fully assessed.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

The service was unable to demonstrate how it was meeting the nutritional and hydration needs of people at high risk of malnutrition.

The service did not have the design and signage features that would help to orientate people who were living with dementia.

Is the service caring?

Requires improvement

Not all aspects of the service were caring.

We observed one person who used the service ask three separate members of staff for support to go to the toilet. Each member of staff told the person to wait.

Staff did not have enough time to sit and talk with people who used the service in a meaningful and caring way.

People who used the service told us they thought the service was caring.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not provided to people who used the service in a person-centred way and did not fully meet their needs.

The service did not respond in an appropriate and timely manner to the changing care and support needs of people who used the service.

Daily recreational activities were limited and the service had no planned activities for the future.

Is the service well-led?

Requires improvement

Not all aspects of the service were well-led

At the time of our inspection there was no registered manager at the service.

Staff employed by the service told us they thought it was well-led.

Summary of findings

Systems for audit and quality assurance were not effective, including audit of accidents, incidents and care plans.

The service did not effectively demonstrate how the views of people who used the service and their relatives were sought.

Hope Manor Residential Home

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on 25 and 27 August 2015. The inspection team consisted of an adult social care inspector and an inspection manager from the Care Quality Commission.

Before the inspection we reviewed all the information we held about the service. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local adult safeguarding team and the local NHS infection prevention and control team.

During our inspection we spoke with three people who used the service, two visiting relatives and two healthcare professionals who were at the home on day of inspection. We spoke with five members of staff and the acting manager. We observed how care and support was being delivered in communal areas and we completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the personal care and support records of ten people who used the service, medication records, staff supervision and training records, as well as audits that were undertaken by the service. We also looked at four staff files including recruitment and selection records. Additionally, we looked at the kitchen area, laundry area, bathrooms and people's bedrooms.

Inadequate

Is the service safe?

Our findings

We spoke with three people who used the service and each person commented that they thought the service was safe. One person said "I feel safe. I've never had any worries". Another person commented "The staff are good. I don't feel unsafe". The third person commented "Yes I feel safe here". One visiting family member commented "I've never had any cause for concern".

During inspection we looked at staffing levels against the dependency levels of people who used the service. From 8am until 8pm the service employed one senior carer and two care assistants. They were supported by one domestic and one kitchen assistant. During night time hours, from 8pm until 8am, staffing levels reduced to one senior carer and one care assistant.

Staff told us they thought the service was short staffed. One member of staff commented "Today has been a quiet day. We do need more staff, definitely." Another member of staff told us "We haven't been full for a while but it gets harder when full. Staffing has always been at the same level."

Through our discussions with the acting manager, we were able to identify the service was providing care and support for a number of people who were living with dementia, in addition to other physical health conditions. We established that three people who used the service required the support of two care assistants in order for personal care to be delivered effectively and safely. This meant that during the day, if two care assistants were deployed to support one person who used the service, only one other care assistant was available to meet the needs of all the other people. During the night, the ratio of staff-to-people who used the service was reduced even further. This could result in people not receiving the care required to keep them safe.

During the day people who used the service were left alone and unsupervised in the communal lounge for extended periods of time whilst the care staff were busy engaged elsewhere within the service. The consequence of this was that people who used the service were at greater risk during these unsupervised periods. By looking at the notifications the service had already submitted to the Care Quality Commission and comparing these against the services own accident and incident report file, we were able to establish that one person who used the service had recently fallen whilst unsupervised in the communal lounge area and sustained injuries that required hospital admission.

During the afternoon period we also observed hot drinks being served from a tea trolley. The member of staff giving out the hot drinks was called away to attend to other duties, leaving the tea trolley and a kettle of hot water unsupervised in the communal lounge. We observed two people who used the service make attempts to use the tea trolley as a walking aide and attempt to grab the hot tea pot. We intervened to make the situation safe and reported this incident directly to the manager.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to staffing.

During our inspection we found a side door to the premises left open and unsupervised. This led out to an enclosed outside area with an uneven concrete surface and a significant step to negotiate. This meant that people who used the service were at risk of falling if they had attempted to go outside. We asked the manager to rectify this and immediate action was taken to secure the door. We also found that window restrictors on the first floor did not meet legal requirements. We asked the acting manager to rectify this and immediate action was taken. Later during the inspection, a member of the inspection team was able to confirm the appropriate and legal window restrictors had been installed.

During our inspection we looked at health and safety and maintenance records to see how the service assessed risk in relation to buildings and premises. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, electrical systems and fire extinguishers. However, we found risk assessments had not been completed in connection with the use of portable electrical devices, including those in people's bedrooms, and the risks associated with waterborne microorganisms.

The service had not produced a business continuity plan to demonstrate the actions it would take in the event of an incident which may stop the service such a flood, fire or loss of power. This meant the service had not adequately assessed the risks to the health and safety of people who used the service.

Inadequate

Is the service safe?

This was a breach of Regulation 12 (1)(2)(d)(e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to ensuring the premises and equipment used by the service were safe.

We looked at the way the service protected people against abuse. Staff were able to confirm they had completed safeguarding training via online e-learning, which we verified by looking at training records. However, not all staff we spoke with were able to adequately explain the correct procedures to follow in the event of a safeguarding concern. We looked at the service safeguarding adult's policy and found this be out of date and contained contradictory and incorrect information. We asked the manager to rectify this and immediate action was taken by the service during our inspection.

We looked at the recruitment files of four members of staff. We found recruitment checks had been completed such as Disclosure and Barring Service (DBS) checks and identification checks. A DBS check helps to ensure that potential employees are suitable to work with vulnerable people. However, we found recruitment procedures were not being operated effectively. The recruitment and selection procedures in place did not include taking interview notes to demonstrate candidate's suitability for the role they had applied for.

We looked at how well people were protected by the prevention and control of infection. We saw evidence that the service had started to make improvements in how it managed infection prevention and control issues. The service had been working with Salford City Council Infection Prevention and Control Nurse Specialists in carrying out improvements as detailed in their infection control action plan. However, during our inspection we observed one member of staff display poor infection control practice that went unchallenged. Soiled linen was not placed in the appropriate linen bag and was freely carried through the corridor.

We found that personal emergency evacuation plan (PEEP) status of each person who used the service had not always been assessed and methods for individual evacuation were not included with care records. Additionally, the service did not maintain a PEEP 'grab file' which would provide a quick reference for staff in case of emergencies.

Policies and procedures for the safe administration of medicines had recently been updated. We found medicines were administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and relevant records were kept.

We observed a senior staff member whilst they administered medicines and saw that this was done competently and safely. Medicines Administration Records (MAR) all included a photograph of the person to help minimise the risk of errors.

During the inspection we identified two people had their medicines given covertly, that is given in food or drink. We spoke with staff who were able to explain that this was only done at certain times when the person was not compliant with their medicines and was dependant on their mood. We saw documentation that demonstrated that staff made every effort to offer the medicine to the person prior to administering it covertly. We saw documentation that evidenced this was done in the person's best interests. Medicines audits were undertaken daily and a more detailed audit carried out on a monthly basis. Medicine fridge temperatures were regularly checked and records were up to date and fully completed.

However, we found the key to the controlled drugs (CD) cupboard was held with a master set of keys. We were told only senior carers had access to the CD cupboard, but we established that the master keys were routinely handed over to various members of staff when access to other parts of the building was required. This meant that any member of staff could potentially have access to the CD cupboard. We raised this with the acting manager who told us they would take immediate action to rectify this so that the CD key was separated from the master keys and to ensure that only one designated senior member of staff had access to the CD cupboard during any given shift. We checked to ensure all CD drugs were accounted for, that the running total was correct and that each administration was witnessed and countersigned.

Requires improvement

Is the service effective?

Our findings

During our inspection we looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. People who used the service and their relatives told us they thought staff were trained to be able to meet their or their family member's needs. One person who used the service commented "When I need help they seem to know what they're doing." A visiting relative told us "[My relative] has recently moved here. [My relative] has improved since being here so I think the staff know what they are doing."

Prior to the current acting manager being in post, we were able to see that formal supervision of staff was inconsistent. However, we saw the acting manager had recently introduced a new supervision matrix and that progress had been made in completing one to one supervisions sessions. A new training matrix had also been introduced which enabled us to see the current level of staff training and where training gaps had been identified.

During our inspection we looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. We found the service was working with an external training provider to train and develop staff to nationally recognised standards. However, we found the vast majority of mandatory training was delivered via short online e-learning modules covering topics such as basic first aid, infection control, fire awareness, dementia, health and safety, mental capacity act and deprivation of liberty safeguards. When we spoke with staff about this, they told us they did not feel standalone e-learning was the best method for this time of key training to be delivered.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Care home providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

At the time of inspection, the service had 16 active DoLS in place and two DoLS applications had been submitted to the relevant authorities. The service had a DoLS policy in place but this was out of date and required updating.

However, we found that due processes had been followed by the service and each DoLS we looked at contained all the relevant documentation and we could see decisions were made in people's best interests. We spoke with care staff to ascertain their understanding of the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS) legislation. We found care staff did not have sufficient working knowledge of this legislation or its practical application when providing care and support.

This was a breach of Regulation 18(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to staffing.

During our inspection we looked at the meal time experience for people who used the service at Hope Manor. Overall we found the atmosphere within the dining room to be calm with some people who used the service happily chatting at their tables. One person who used the service told us "The food is good. I try to eat what I can." Another commented "We get asked each day what we want to eat. There's not much choice though." Main meals at Hope Manor were pre-ordered from a frozen foods' supplier and rotated over a four week period. No hot meals were freshly prepared on site. We found a choice of two main course options were offered on the day of our inspection, but these options did not correspond with the published menu.

During lunch time service, we observed one person who used the service showing a lack of interest in their meal who made no attempt to eat. For a period of 20 minutes we directly observed that no support was offered by staff. Eventually a care assistant noticed that the person was not eating and support was provided. We spoke with the care assistant to ensure an alternative meal was offered.

We looked at the 'daily charts' file which contained weight charts. We found monthly weight records spanning a 12 month period. However, we identified a number of recording gaps, which indicated people had not been weighed for several months. However, where the service had identified individuals were losing weight, appropriate referrals to the NHS community dietetics service were made. We identified two people who used the service who had been assessed as high risk of malnutrition. We case tracked these people to look in more detail how the service was meeting their additional nutritional needs.

Requires improvement

Is the service effective?

Due to a waiting list of patients requiring dietetic assessments, and whilst awaiting a more comprehensive dietetic assessment, an initial screening was completed by the dietetics service. Following screening, an initial nutritional care plan was provided. The nutritional care plan clearly outlined the actions the service must take in order to start meeting individual's additional nutritional needs. The care plan included instructions to weigh people on a regular basis and to ensure additional nutritional support by means of providing supplements and fortified food.

A short time after the initial nutritional care plan had been provided, we saw both people who used the service then had a comprehensive dietetic assessment completed by a qualified dietician. A full and detailed written nutritional action plan was provided by the dietician and placed within the respective care records. Six nutritional actions were recorded and instructions were given to weigh the individuals on a weekly basis.

After reviewing all the available information, we found no evidence to support how the service had implemented the nutritional action plans. Recording of weight was inconsistent and significant gaps were present in records. Additionally, It was evident from speaking with staff they lacked insight into the existence of the nutritional action plans and did not fully understand how they should be implemented. We raised our concerns with the acting manager who acknowledged the fact there were significant gaps in recording of information and accepted we could not be satisfied the nutritional care plans had been followed. We referred our concerns to the local authority safeguarding team.

This was a breach of Regulation 14 (1)(2)(d)(e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to meeting people's nutritional and hydration needs.

Most of the people who used the service at Hope Manor suffered from varying degrees of dementia and were at times confused and disoriented. We found the service did not have the design and signage that would help to orientate people with this type of need. Hope Manor is an older building with accommodation organised over two floors with lift access. We saw that several people who used the service were able to wonder about the corridors from time to time. Improvements were required to ensure the environment was better suited to deal with the needs of people suffering from dementia.

We recommend that the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'.

Requires improvement

Is the service caring?

Our findings

People who used the service and their visiting relatives told us they thought the staff at Hope Manor were caring. One person who used the service commented "The girls are caring. They do what they can." Another person commented "Yes, on the whole the staff are caring." A visiting relative told us "[my relative] has been here for a number of years. Never had any problems. The staff are caring."

During breakfast service in the dining room, we observed one person who used the service ask three separate members of staff for help to go to the toilet. We observed each member of staff telling the person to wait as they were busy. Once the persons request for help was ignored for the third time, we intervened and directly requested that staff provide help and support.

On another occasion, whilst cups of tea were being served, we observed staff interacting with a person who used the service who was asleep in a chair. The member of staff entered the room and placed the cup of tea down next to the person. They then shouted the person's name loudly but were unsuccessful in waking the person up. The staff member then turned the television up very loud and again started shouting the person's name. When both of these approaches failed to wake the person up, they simply left the room leaving the person asleep in the chair, the cup of tea was left on the side and the television volume was left unbearably loud. We asked the staff member to turn the television down which they then did.

Some people who used the service at Hope Manor present with behaviours that may challenge. This was because the person might be living with a mental health condition or living with dementia. We looked at written records which were made in the 'daily record' file and viewed entries that had been written by care staff that were inappropriate. Some care staff had written entries describing people's care and support needs in derogatory terms. One example of this was a person who used the service being described as "really dirty". Another person who used the service was described as being "nasty".

This was a breach of Regulation 10(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to treating people with dignity and respect.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed our SOFI for 30 minutes during the afternoon of our inspection in the communal lounge. During this time we observed one member of staff support 14 people. The member of staff was interacting with some people who used the service by chatting to them. However, the majority of people sat in the lounge were not engaged and spent the period of time sat in silence with a television on in the background.

During this period of formal observation, the member of staff who was in lounge left to attend to other duties leaving all the residents unsupervised in the lounge area and no activities taking place. This demonstrated to us that staff did not always have enough time to dedicate to sit and talk with people who used the service in a meaningful and caring way. However, during our inspection, we did observe a number of other occasions when staff interacted well with people who used the service and demonstrated care and compassion.

At the time of our inspection, Hope Manor was not an accredited provider of end of life care. However, we could see that where people who used the service had a medical condition that was likely to deteriorate, appropriate referrals had been made to relevant agencies. In four care records, we found evidence of advance care planning discussions with either the person who used the service or their representative to determine the way they would like to be cared for at the end of their lives.

Inadequate

Is the service responsive?

Our findings

During our inspection, we saw that the acting manager had started to update the care and support records of each person who used the service. In total, we looked at a sample of 10 care and support records, five of which had been updated and transferred into a new style of care record, and five which had not.

Of the five new care records we looked at, we could see improvements had been made. The care records had been reorganised into dedicated sections such as admission, social history, recreational activity, personal care and nursing related assessments. However, the basis for the new care records was too task oriented and lacked sufficient person-centred information.

We found the new care records included a section entitled 'working and playing' which provided a brief summary of what the person who used the service enjoyed doing. However, this information was not sufficient enough to demonstrate how the person's individual likes, dislikes, personal preferences and life history had been considered. Where information had been included under 'working and playing', we could find no evidence of how this element of the individuals care plan had been implemented. Furthermore, the new care plans did not demonstrate, to what extent, people who used the service and/or their representatives wished to be involved in planning and agreeing their own care, support and treatment.

We found that dementia care planning and person centred planning for people's emotional needs was limited. Where people had emotional needs or behaviours that challenged, we found no evidence to demonstrate that care and support needs had been effectively reviewed and that appropriate support was planned or implemented. There were no behavioural charts in place to monitor people's unwanted behaviours and care plans held no information about the frequency, intensity or triggers to these behaviours in order to assist with their management. There was also no guidance to staff on how best to support the person when these behaviours were displayed.

An example of this was demonstrated after looking at the care and support records of one person who used the service who frequently presented with challenging behaviour. We found a written entry had been made by staff, which demonstrated a serious incident had occurred during a period of challenging behaviour. Although we could see evidence the service had made contact with a relevant health care professional, we found the service had failed to recognise the seriousness of the incident, had failed to carry out an appropriate risk assessment and failed to ensure a review the person's on-going care and support needs was completed. Furthermore, we found the service had failed to make a referral to the local safeguarding team. We discussed our concerns around this this with the acting manager and later referred our concerns to the local authority safeguarding team.

During our inspection we found limited evidence of meaningful person-centred activities taking place. During the first day of our inspection we found well intentioned attempts being made by some staff to engage with people who used the service by means of a general knowledge quiz but the methods to engage with people were not person-centred and demonstrated a lack of training and understanding, particularly around involving people living with dementia.

This was a breach of Regulation 9(1)(a)(b)(c) 9(3)(a)(b)(d)(e)(f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to person-centred care.

In the five old style care records we looked at, we found these were not fit for purpose. Information relating to the care and support needs of people who used the service were disorganised and significant gaps in recording were identified. Some documentation was not securely fixed into the care plans, for example, GP and hospital letters, leaving them at risk of being misplaced. The old style care plans did not provide sufficient information in order to fully understand what the care and support needs of the individual who used the service were. This was of particular concern as these care files were still actively in use.

We found the service used a variety of recording systems in connection with the care and support needs of people who used the service. Information was stored across three separate filing systems entitled care plans, daily charts and daily records. Information was not consistently recorded, was often inaccurate and contradictory and was not easy to read. Records relating to the personal care needs of people who used the service did not demonstrate how frequently

Inadequate

Is the service responsive?

people were receiving a bath or shower. We found a number of records indicating that people who used the service were independent with personal care tasks, when in fact they were fully dependant on support being provided.

This was a breach of Regulation 17 (1) (2)(c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to good governance.

The service had a complaints policy and we found the manager had introduced a new complaints log. We saw evidence of one complaint had been made in the last year which had been dealt with and resolved appropriately**.**

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. A new manager had recently been appointed and they were currently applying to register as the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run

People who used the service and their relatives spoke favourably of the new acting manager. One person who used the service commented "I know they haven't been here very long but [the manager] seems nice." Another person who used the service commented "[the manager] always says 'good morning' to me each day and seems very pleasant." One relative said "I haven't had chance to speak to [the manager] yet but there has been some big improvements since they arrived." When asked if the service was well-led, a community healthcare professional who was visiting at the time of our inspection commented "Things have definitely improved over the last few months since [the manager] has been in post. Staff appear more motivated and communication is getting better."

We asked staff what they thought of the leadership and management of Hope Manor since the new acting manager had been in post. One member of staff commented "Things seem a lot better with [the new manager] here." Another member of staff commented "[the new manager] is the most organised manager we have had."

During our inspection we found the service did not have effective systems in place for audit and quality assurance. We identified failings in recognising and responding to concerns around falls and failures to recognise omissions and poor recording in care plans. We found that accidents and incidents involving people who used the service were not monitored and recorded effectively. The service failed to identify risks and failed to implement preventative measures to reduce the likelihood of such accidents and incidents occurring again.

We found that involvement of people who used the service and/or their representatives, through the use of residents or relatives' meetings was ineffective. Records indicated the last meeting had taken place in February 2015 and was poorly attended. We saw limited examples of resident and relatives' surveys having been completed.

This was a breach of Regulation 17(1) (2)(a)(b)(e)(f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to good governance.

During our inspection, we looked at Hope Manor's website. We found that information contained on the website was outdated and misleading, particularly in relation to the claim that the service provided specialist care for dementia and Alzheimer's. Furthermore, in an online video, a statement is made that the service does not restrict visiting. This contradicted our findings during inspection as Hope Manor had a policy of restricting visiting before 8am and after 8pm. This meant that family and friends of people who used the service were unable to visit during these restricted hours.