Roche Healthcare Limited

Hartshead Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 May 2016 and was unannounced. The previous inspection, which had taken place on 7 and 9 April 2015, had found the service was in breach of the regulations relating to person centred care, nutrition and hydration and good governance.

The registered manager sent us an action plan to show how these breaches would be addressed. We found improvements in all these areas at this inspection.

Hartshead Manor is a nursing home registered to provide care for up to a maximum of 55 older people. There were 50 people living at the home when we visited to undertake our inspection. The home is a converted property providing bedroom and communal areas on both the ground and first floor. The home has a unit which is dedicated to supporting people who are living with dementia.

There was a registered manager in post and this person had been registered with the Care Quality Commission since March 2016. 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.

People told us they felt safe living at Hartshead Manor but not all relatives shared this view. Two relatives felt there were not enough staff.

Staff had a thorough understanding of safeguarding procedures and staff knew what to do if they thought anyone was at risk of harm or abuse. Risks to people had been assessed and measures were put into place to reduce risks. Staff were recruited safely and trained appropriately. Medicines were stored and administered in a safe way.

Records showed staff had received regular training and support, although one member of staff felt their induction was not adequate because, they told us, they had shadowed other staff for only three hours prior to commencing their duties. Staff received regular supervision. People received support to meet their nutrition and hydration needs. The home environment had improved and was more appropriate to meet people's needs.

Care and support was not always provided in line with the principles of the Mental Capacity Act 2005 because a person was administered medicines covertly without appropriate assessments being in place.

Staff interactions with people were caring and people appeared at ease in staff presence. There was a pleasant atmosphere in the home. Some staff occasionally used terms that could be perceived as derogatory, such as, "The assists," referring to people who required assistance.

Care plans were person centred and provided staff with information to provide personalised care and support. Care plans were regularly reviewed. People felt concerns were listened to and acted upon.

Some people who lived at the home, and their relatives, felt the registered manager did not know people well. Staff told us they felt supported by the registered manager. Regular meetings such as staff meetings and resident and relatives meetings were held. Regular audits and quality assurance checks took place, although these were not sufficiently robust. Up to date policies and procedures were in place.

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.

People told us they felt safe but some relatives felt there were not enough staff.

Safe staff recruitment procedures were in place.

Risks to people were assessed and measures put into place to minimise risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always act in accordance with the Mental Capacity Act 2005.

Staff had received training and regular supervision.

People were supported to have their nutrition and hydration needs met.

Is the service caring?

Good

The service was caring.

There was a pleasant atmosphere at the home and people appeared at ease with staff.

Staff were proactive in trying to ensure people were comfortable.

Staff understood how to protect people's privacy and respect dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised to the individual and reviewed regularly.

People told us they felt concerns were listened to and acted up. No formal complaints had been received.

People were given choices.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some people told us they did not know the registered manager.

Staff told us they felt supported by the registered manager.

Regular audits and quality checks took place, however, these required improvement to be fully effective in improving the service provision.

Hartshead Manor

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.

We inspected Hartshead Manor on 23 May 2016. The inspection was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor who was a registered nurse and an 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.

The registered provider had been asked to complete a Provider Information Return (PIR) and had submitted this to us prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we reviewed information we held about the home and contacted the local authority commissioning and safeguarding teams.

During the inspection we spoke with eight people who lived at the home, ten visitors who were friends or relatives of people who lived at the home, a kitchen assistant, a laundry assistant, three carers, a team leader, a registered nurse, an agency worker who was providing one to one care to a person and the registered manager. Following our inspection we spoke with a social worker from the local authority.

We looked at seven people's care records and daily communication logs, three staff files including recruitment, supervision and training data, as well as records relating to the management of the service and maintenance of the home.

Good

Is the service safe?

Our findings

There were some mixed views from people and relatives, regarding whether people were safe. A person who lived at Hartshead Manor told us, "I definitely feel safe here and well looked after." One relative told us, "It's absolutely brilliant. I have peace of mind now. I feel [Name] is safe here." Another family member we spoke with said they felt their relative was, "Very safe," and said, "[Name of person]'s okay here."

However, a further family member said, "Staffing levels fall around tea time and you struggle to find anyone if you need them. I just feel there must be better homes than this." Another relative said, "There just aren't enough staff."

The registered manager and staff we spoke with had a clear understanding of what constituted abuse and the signs to look for which may indicate someone was at risk of harm or abuse. The registered manager was clear about the procedures they would follow if they suspected anyone was being abused or was at risk of harm. Staff had been trained in safeguarding and the staff we spoke with showed they understood the signs to look for and what action to take. A member of staff we spoke with told us they were aware of the whistleblowing policy and told us what action they would take if they felt the registered manager did not take appropriate action. This showed steps had been taken to prevent abuse and improper treatment.

There had been a recent safeguarding incident which had been reported to the police, local authority and to the CQC. This related to unexplained bruising of a person. An investigation took place and no conclusive cause for the bruising could be determined. Following our inspection visit, we discussed this with the local authority and were advised that, although there was no indication the bruising was malicious, a protection plan had been put into place, which involved the person's moving and handling plan being reassessed and information being disseminated to all staff. This demonstrated actions had been taken and appropriate reporting arrangements were in place to investigate safeguarding concerns.

The registered manager told us risks to people were managed through care planning. We saw risks had been assessed in relation to falls, bed rail use and medication for example. Measures had been considered and put into place in order to reduce risks, such as alert mats and crash mats to reduce the risks associated with falls. Risk assessments had been evaluated and updated monthly. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

A relative we spoke with told us they felt their family member would be better placed in a smaller home. This relative said, "[Name] walks about and falls but the staff don't have eyes in the back of their heads." We checked and risk reduction measures had been put into place and this person had been provided with one to one support. The family member confirmed one to one support was now in place. The registered manager confirmed a smaller, alternative home was being sought for the person but, in the meantime, additional support had been put into place.

The registered manager had subscribed to the principles of the Herbert Protocol. The Herbert Protocol is a national scheme which encourages carers to compile useful information which could be used in the event of

a vulnerable person going missing. The Herbert Protocol puts systems in place to allow for early intervention when vulnerable people go missing. This further demonstrated the registered manager had taken steps to reduce risks to people.

We looked at safety of the premises. The fire alarm system had been recently serviced and fire extinguishers had been recently inspected. Emergency lights had been tested during the month prior to the inspection and portable appliance testing (PAT) had taken place. Regular testing of fire points and fire doors took place and we saw action was taken when necessary. For example, records showed on 11 May 2016 that a fire door failed to release. This was logged as an action and rectified on the same day. The nurse call system was checked monthly and we saw evidence of faults being rectified in a timely manner. This showed steps were taken to help ensure premises and equipment were safe.

We looked at the emergency evacuation information. This was kept in a folder and was easily accessible in case of an emergency. Information included details of the layout of the home, people's individual evacuation needs and evacuation routes. This helped to ensure people's safety in the event of an emergency.

Accidents and incidents were logged and analysed regularly. This helped to identify any trends. We saw a falls diary was kept for a person who was at risk of falling. The date, time, circumstances and outcome of falls were recorded so this could be analysed and falls reduction measures put into place where necessary.

The registered manager explained staffing ratios were based on factors such as number of hours care people required and the number of staff required to assist each person. The registered manager had conducted some interviews during the week prior to the inspection, in order to recruit an extra nurse. In the meantime, agency nurses were being deployed.

We were told an additional member of domestic staff had recently been recruited but this member of staff was currently training. This meant domestic staff were covering extra duties. A member of staff we spoke with told us they felt there were enough staff and that numbers had recently increased. A further member of staff however said they felt staff were, "Stretched," particularly at meal times.

We spoke with staff and looked at staff rotas and found there to be a qualified nurse to cover each shift, as well as eight carers during the day and four carers during the night. On the day of the inspection there were nine care staff and one lead nurse, as well as the registered manager, an activities coordinator, a cook, four domestic staff and a maintenance person to provide care and support for 50 people. We saw people's needs were being met but we also observed staff to be very busy during peak periods. For example, we observed people waiting for long periods to be assisted at mealtime.

We looked at three staff files and found safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

People who required nursing care were administered medicines by a nurse and people who required residential care were administered medicines by a team leader who had been trained to administer medicines. We saw a notice was displayed, reminding staff not to interrupt the nurses or staff who were administering medicines. We found medicines were stored appropriately. Records showed regular temperature checks took place to ensure safe storage.

We looked at random samples of medicines remaining and found these reconciled with records, with the exception of one record where the stock was correct but the latest administration had not been deducted from the balance on the record. We highlighted this to the nurse at the time. Records showed whether people had been administered their medicines and if people had refused their medicines. The nurse explained to us they would advise the registered manager and the person's general practitioner if a person consistently refused their medicines. Two people were administered medicines covertly. In both instances we saw the person's general practitioner had been consulted regarding the safety of this. This helped to ensure people received their medicines safely and as required.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and we saw, whenever these were administered, two members of staff checked the remaining amounts and signed the controlled drugs register. The amount of medicines remaining reconciled correctly with the records. This showed that controlled medicines were being properly managed.

All of the people we asked told us they felt the home was kept clean and we observed the home to be clean. Anti-bacterial hand gel was placed at the entrance to the home. A notice was displayed reminding staff of good practice such as not wearing false nails or watches for example. We saw evidence that equipment, such as wheelchairs and pressures cushions, were cleaned regularly. This helped to prevent and control risk associated with infection.

Requires Improvement

Is the service effective?

Our findings

We asked a family member if they felt staff had the skills and knowledge to care for their relation. The family member told us, "They do very well indeed. It's a nice, clean home. I'm happy." Another family member said, "Staff are very good."

One relative had eaten meals with a person who lived at the home and they said the food was, "okay." The relative of another person who lived at the home said they had also eaten meals with their spouse and said, "The food is good."

However, a further relative told us, "It's got worse. It's too full down here. It's not big enough for the numbers they've got. I'd like to move [name of relative] but [name of relative] doesn't want to go."

We looked at training records and found staff had received induction and training in essential areas such as dementia and challenging behaviour, infection control, health and safety, fire safety, moving and handling, Mental Capacity Act and Deprivation of Liberty Safeguards, equality and diversity, nutrition and hydration and safeguarding. We noted, however, multiple courses had been completed on the same date. We therefore questioned the quality of training with the registered manager. We were told this had already been identified and we were shown an amended induction timetable to show the organisation of training had been considered and adapted to try and ensure staff had time to consolidate learning. This meant the registered provider and registered manager had taken steps to ensure staff had up to date skills to enable them to provide effective care and support to people.

Staff we spoke with demonstrated they had an understanding of how to care and support people who lived with dementia. A staff member explained they would speak slowly and not overload a person with information. Another member of staff explained they always offered choices by showing people the options if possible.

The staff we asked confirmed they received training to help them provide effective care and support. Staff confirmed they had the opportunity to shadow more experienced members of staff during induction. A staff member said, "The training here's good. It's interactive. Face to face." New staff completed the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. One member of staff we spoke with, however, felt their induction was insufficient. They told us they were left to feel, "Vulnerable and unsafe to work in the home after just three hours shadowing another member of staff."

The registered manager told us supervision was held with staff every three months and appraisals were held twice a year. We saw evidence of regular staff supervision taking place and this was well organised and planned using a calendar. Items discussed included policies and procedures, team work, audits and training. We also saw evidence of staff appraisals taking place. A staff member we spoke with told us they had regular supervision with the senior team leader or registered manager. This member of staff told us they

felt able to speak openly. This showed staff were receiving regular support and supervision to monitor their performance and address any development needs.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager told us they had not had specific training in relation to the MCA. However, the registered manager demonstrated understanding and knowledge of the MCA and related Deprivation of Liberty Safeguards. Staff had received training in relation to the MCA. A staff member we asked demonstrated an understanding of the need to assume people have capacity to make their own decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw evidence that, where people had been assessed as lacking capacity to consent to care and treatment and who were being deprived of their liberty, appropriate authorisation had been sought from the supervisory body. This demonstrated the registered manager was acting in accordance with the principles of the MCA in relation to DoLS.

We saw a self-medication risk assessment tool in one of the care plans we sampled. The tool indicated, if the person was assessed as not being safe to self-medicate, a mental capacity assessment must be completed. We saw evidence this had been completed. The person's capacity had been assessed in line with the principles of the MCA and a decision had been made in the person's best interest, involving the person's family and health professionals. We saw other examples of decision specific mental capacity assessments such as in relation to being provided assistance with personal care. This showed some people's care and support was provided in line with the principles of the MCA.

Two people were given medicines in a covert manner. Each person's general practitioner had been consulted regarding the safety aspect of administering medicines in this way, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. However, in order to administer medicines covertly, it must be established the person lacks capacity to consent and the staff member administering the medicine must ensure a decision to do so has been made in the person's best interest. For one of the people who were administered medicine covertly, there was no record of the person lacking capacity in relation to medication administration. This meant the registered manager was not acting in accordance with the MCA. We raised this with the registered manager and, following the inspection, the registered manager provided evidence the person's capacity had been assessed and a decision made in their best interest.

We observed staff verbally seeking consent from people before providing care and support. We saw in some care plans, written consent to care and treatment had been sought, as well as consent to sharing information. However, in two of the care plans we sampled, we noted the consent to care and treatment section was not signed by the person or their representative. This meant, although consent was sought verbally, written consent was not consistently sought from people.

Staff were able to explain how they supported people who were sometimes resistive to the care and support offered or who displayed behaviour that could be challenging to others. A member of staff told us they were aware of individual triggers and, if a particular person became aggressive when being offered care, the staff

member was aware to leave the room and return again.

People were supported with their nutritional and hydration needs. Throughout the day we observed staff assisting people to drink fluids. We observed a mealtime experience at the home and found, on the dementia unit, this had improved since the last inspection. On the dementia unit we saw people were offered a choice of whether they wished to eat at the dining area or stay seated where they were and people were asked whether they would like to wear protection for their clothing. Staff respected the choices people made. Choices were given in relation to the food and drinks people wanted, whether hot or cold and people's preferences in terms of milk and sugar.

We heard staff discuss portion sizes and they were aware that particular people would prefer small portion sizes. We heard staff ask people how much gravy they would like and each plate was prepared to the person's liking.

Staff asked whether people had finished eating before taking food and plates away and people who had not eaten much food were respectfully encouraged and prompted to eat more. One person dropped some of their food and staff replaced this with fresh food. Some people, who were nutritionally at risk, were given supplements which helped to maintain their weight. We viewed the care plan of a person who required blood sugars to be monitored weekly. We saw this was up to date and signed by staff weekly.

We observed the organisation of the mealtime experience within the ground floor dining area to be not as effective as the dementia unit. For example, we observed some people waiting for more than 30 minutes for their meal, once they had been assisted to the dining area.

Some areas of the home environment had been improved since the last inspection and had been designed for people living with dementia. For example, memory boxes were in place outside people's bedrooms to help people to identify their rooms and to give the home a personalised feel. The layout of the dementia unit had improved since the last inspection and appeared more homely, with some chairs arranged in clusters to facilitate conversation. Menu boards were displayed on each unit within the home. There was a new hairdressing salon and a hairdresser visited the home twice weekly.

People had access to health care and we saw referrals were made to other agencies or professionals. For example, we saw in people's records they had been referred to general practitioners, district nurse and chiropodist. We saw a specific request had been made to review a person's medication and recent falls. This showed people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

Most people told us they felt staff were caring.

One person said, "The staff are very pleasant and helpful, my bed's comfy and I've no complaints." Another person who lived at the home told us, "The girls [carers] can't do too much for you. I like the way they speak to you. They're there if you need anything."

Another person told us, "I'm very happy here. We are well looked after and very fortunate in that respect."

A relative said, "It's very good here and caring. If I ask for, or suggest, anything then it's carried out." Another relative said, "the care here is as good as it gets." A further relative told us, "The carers are really good, but there needs to be more of them." Another family member told us they were happy with the care their relative received and staff made them feel welcome at the home when they visited.

Although the majority of comments regarding staff were positive, one relative said, "There just aren't aren't enough staff. Some are very pleasant, the rest just don't seem interested or bothered. I'm not overly impressed."

A member of staff explained to us how they would protect a person's privacy and dignity. The staff member said they would close doors and curtains and use towels to cover people to make people more comfortable. Another member of staff we spoke with said, "I love it. If you haven't got compassion you shouldn't be doing this job."

We observed carers and people spontaneously burst into song and laugh and joke together and try to answer questions together when a quiz was taking place. There was a happy atmosphere and people appeared to be at ease and relaxed in the company of staff. We observed appropriate assurance and touch towards people from staff.

Staff demonstrated they understood how to protect people's dignity and respect their privacy. For example, a district nurse visited the home during the inspection, to treat a person's leg. Staff ensured the person was assisted to their room, so this could be done in private.

One care plan we sampled stated, '[Name] can, at times, forget how to wear clothing and put jumpers on inside out and back to front. Staff to assist with clothing as [Name] is a very proud person.' This demonstrated people's dignity and choices were taken into account when care planning.

We observed staff assisting people to move with the use of equipment, such as a hoist. We heard staff saying to a person, "You're going up [Name]," and, "down we go." This helped to put the person at ease at what could otherwise be a distressing time. Whilst one person was being assisted to move, with the use of equipment, they began to show signs they were becoming anxious. A member of staff ensured the person was safe throughout the manoeuvre and then encouraged the person sing. This was effective and had the

result of reducing the person's anxiety level as they sang a song.

Although most of the interactions we observed were positive in nature, we also observed some staff use terms that could be deemed derogatory. For example in the ground floor dining room we heard a member of staff say to a person, "We have to help the assisted first," referring to people who required assistance. On the dementia unit, we heard people being referred to as, "The assists." We shared this information with the registered manager.

We saw a member of staff observed a person looked to be uncomfortable because of the way the person was sitting. The staff member brought a cushion and asked the person if they could place it behind them to make the person more comfortable. This showed the member of staff was caring in their approach.

We observed a carer assisting a person to drink. The carer sat next to the person and was patient, assisting the person at their own pace. When the person became agitated, the carer stopped but continued to check the person's welfare and asked if the person had had enough to drink. We saw a person became upset during the inspection because they had torn a tablecloth. A member of staff sat next to the person reassured them, chatting quietly. These were further examples of a caring approach.

We observed at lunchtime on the dementia unit a person had food on their face. A carer discreetly asked the person's permission if they could wipe their face and this was done in a caring manner. The staff member used a wipe to clean the person's face and their clothing.

The registered manager told us some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders in place. This information was recorded, along with information relating to people's end of life wishes. We saw DNACPR orders in the front of people's care plans and this information was also recorded on handover sheets. This helped to ensure staff were aware of people's wishes in relation to end of life.

Good

Is the service responsive?

Our findings

One person told us, "We are well looked after. We get to go on day trips. They take us places on a coach. I wouldn't stop here if I wasn't happy." Another person said, "I have nothing to complain about. I love it."

A visiting relative said, "[Name]'s treated as a person and not as an invalid. They play dominoes, the staff talk to [name] and they're made to feel a part of things."

A family member we spoke with told us they, or one of their relatives, visited the home every day and felt welcome. This family member told us they had been involved in the care planning for their relative living at the home. We were told the registered manager kept the family member well informed.

We reviewed seven care plans. These were person centred and included important information to enable staff to provide care and support to people. At the front of each care plan we viewed we saw a photograph of the person and crucial information such as whether a DNACPR was in place. Care plans contained a personal history profile of the person. In some of the care plans we viewed this information had been thoroughly completed but in one care plan we sampled, some information was lacking, such as in relation to the person's life history. This information is useful to enable staff to build positive relationships with people and for people to receive personalised care and support. We shared our findings with the registered manager who agreed to address this.

Care plans contained information relating to the level of support people required in different areas such as medication, communication, optical care, eating and drinking, pressure care and personal cleansing and dressing. Personalised information was included in plans and this helped staff to understand the care and support a person required. The level of detail in some care plans we sampled gave staff a good understanding of actions to take in specific circumstances. For example, one care plan identified the risk of a person not comprehending that other residents were not their family and may not want to speak with the person, causing the person to become anxious. The plan identified that distraction techniques should be used and provided detail of what staff should say to the person, in order to reduce their anxiety. This helped staff to be able to provide personalised, appropriate support.

We found one care plan contained conflicting information, such as stating the person's preferred gender of carer would be female but then in another section of the same care plan the preferred gender of carer was identified as male. We shared this information with the registered manager.

The registered manager told us care plans were reviewed monthly and updated whenever needs changed and we saw evidence of this in the care files we sampled. This showed people's care needs were regularly reviewed.

Care plans reflected the importance of people being given choice and control. One plan we viewed stated, 'Likes bath or shower. Give [Name] the choice.' We saw people being offered choices throughout the day of the inspection.

We observed care to be provided in line with people's care plans. For example, one person's care plan stated the person liked to have the radio on when they were in their room. This person was assisted to their room after lunch in order to have some bed rest, and we heard staff ask the person if they would like their music turning on. Another care plan we viewed identified the person must be seated on a pressure cushion in order to provide pressure care. We saw staff ensured the person was seated on a pressure cushion and the cushion was moved from the person's wheelchair to chair when the person moved. This showed care and support was provided in line with the person's identified care needs and preferences.

We found that, whilst some rooms were personalised to individuals, some on the dementia unit were not. For example, one bedroom had only one picture in the room and no other personal effects. We found, on the dementia unit, some bedroom doors were constantly left open, even if the person was not in their room. Other people who lived on the dementia unit were seen walking in and out of people's bedrooms. People should have a choice whether they wish to have their doors open or closed and, if they lack capacity and are unable to choose, then a decision may be made in their best interest. We raised this with the registered manager who agreed to look into this.

Activities included crossword, foot spa, coffee morning, bingo, entertainer, trips out and raffles. We saw a notice advertising morning tea on the last Wednesday of every month. The notice stated, 'Everybody welcome.' We observed activities taking place on the day of the inspection. A quiz took place and we saw ball throwing and a game of skittles taking place. We observed the activities coordinator who interacted well with people and people were at ease in their presence. Activities were delivered in a very friendly and engaging way. Some people and their relatives commented favourably regarding activities and, in particular, how engaging the activities coordinator was. However, the activities were generic and we questioned whether the activities were linked to care plans and people's own interests. We felt additional training and support for the coordinator could result in a wider range of personalised activities being facilitated. Having a dedicated activities coordinator meant that staff at the home were able to continue to deliver care whilst people participated in activities.

The registered manager told us they had received, "Lots of compliments," and had received no formal complaints. We saw the complaints procedure was displayed for people and visitors to see, should they wish to complain. A family member said, "If I have a concern I tell them. I feel they listen and act when issues are raised."

We looked at the staff communication book and this contained evidence of actions such as the ordering of medicines, care plan review dates, people's hospital appointments, messages for general practitioners and other health professionals, dressings required and catheter change dates for example. This helped to ensure people's health needs were met in an organised way.

Shifts were planned in such a way that there was a crossover of 15 minutes between shift changes, so that appropriate information could be shared between staff. Handovers between shifts were verbal and written. A staff member told us, "We pass information to each other, such as if someone has a UTI [Urinary Tract Infection] we tell each other and ensure fluids." This demonstrated appropriate information was shared between staff to provide continuity of care and support.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been managing the service since April 2015 and had been registered with the CQC since March 2016 to manage the service.

One person said, "There's not an overabundance of staff and I've not met or spoken with the manager."

Some relatives and people we spoke with told us they did not know who the manager was and they were unsure whether they had met the registered manager. A relative told us, "You don't see the manager. They don't get around and talk with residents or visitors." A registered manager needs to know people and visitors in order to develop an effective oversight of the home.

A family member said, "They have meetings. They listen and act when issues are raised."

Some staff commented favourably regarding how they felt supported by the registered manager. A member of staff told us the registered manager was supportive and had made improvements across the home. Another member of staff told us, "Things have improved and the staff work hard." A further staff member said they felt confident the registered manager would listen and act if needed. A member of agency staff we spoke with, who was providing one to one care to a person, told us they felt supported by the staff team and the registered manager.

The registered manager told us they were able to access peer support from the registered provider and from other home managers and they felt supported in their role.

One member of staff commented they felt the registered manager was constrained and commented, "The owners hold the purse strings."

The previous inspection report was displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

The registered manager told us resident and relative meetings were held every quarter and that the registered manager had an open door policy. We saw a notice displayed which stated, 'Relatives' meetings will now be held every three months.' We looked at records from a recent meeting during January 2016, which was attended by a resident, three relatives and three members of staff. Issues such as staffing, activities and maintenance were discussed. Relatives told us suggestions were acted upon. This showed the registered manager listened to people's views and took actions to improve the home.

The registered manager told us they encouraged staff to be open and honest. Staff meetings were held every three months. We looked at the minutes from the staff meeting held during February 2016. Staff were reminded to store equipment, such as the hoist, safely and also reminded to assist gentlemen to shave if requested. This showed the registered manager shared relevant information with staff to make staff aware

of their responsibilities.

We saw evidence that some maintenance works were completed. Staff logged maintenance requests in a book, such a replacing bulbs and repairing leaks and these were actioned. However, we also found the toilet roll holder was missing from the wall in one person's en-suite. In another room we saw the wardrobe handle was broken and hanging off from one of the doors. We could not see this had been reported or actioned.

Quality and safety audits took place regularly, for example in relation to care planning, the safety of bed rails, wheelchairs and mattresses. Records showed a new mattress was ordered and fitted in a timely manner when this was deemed necessary. This showed actions were taken to improve the quality and safety of service provision.

The registered manager told us they completed a daily walk around the home in order to undertake quality checks. We saw evidence of these and the manager addressed areas such as cleanliness, quality of care plans and weight records. We saw evidence of action being taken as a result of issues identified. This demonstrated that systems and processes were in place, such as regular audits and quality checks, to assess, monitor and improve the quality of service.

It was clear improvements had been made since the last inspection and, although the manager was completing regular audits, these were not yet sufficiently robust to identify some of the issues we identified during the inspection, such as conflicting information in care plans, maintenance works and mental capacity assessments and consent.

In two of the bedrooms on the dementia unit, we found there was no toilet roll available in the person's en-suite bathroom. We raised this with a member of domestic staff, who told us these were replaced as they progressed through the cleaning schedule. However, this was undignified for the people involved and this issue had not been identified through auditing.

A relative told us that a person, who had profound hearing loss, had been without their hearing aid for over two weeks because the battery required replacing. A member of the inspection team raised this with a staff member and the person's aid was fitted with a new battery on the day of the inspection. However, this person had not been able to hear properly and was therefore potentially excluded from their peers and care staff for a prolonged period of time. This had not been identified through any management oversight.

We found policies and procedures were in place and up to date, for example in relation to complaints and safeguarding and staff were aware of these. Policies were displayed for people and visitors to see.

The registered manager told us their vision was to promote a, 'Fairness for all.' The registered manager engaged with others, for example by attending good practice meetings with peers and the local authority.