HC-One Limited

Appleton Manor

Inspection report

Lingard Lane
Bredbury, Stockport
Manchester
Lancashire
SK6 2QT

Tel: 01614067261
Website: www.hc-one.co.uk/homes/appleton-manor/

Date of inspection visit:
07 January 2016
08 January 2016
14 January 2016

Date of publication:
24 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7, 8 and 14 January 2016. Our visit on the 7 January was unannounced.

The service was last inspected on 5 August 2014 when no breaches of regulations were found.

Appleton Manor Nursing Home is a nursing home managed by HC-One. It provides 24 hour nursing care and support for up to 58 older people including people with dementia. It is situated on the borders of Brinnington and Bredbury near Stockport. It is close to local amenities and there is convenient access to public transport and motorway networks. The home is a modern two storey building; people with nursing needs are accommodated on the ground floor, with a residential unit upstairs accommodating up to 33 people. On the day of our inspection there were 54 people accommodated.

When we visited the service a registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 manager of the home had recently been appointed, but not yet registered with CQC, and was present throughout. The previous registered manager, who had moved to become a peripatetic manager for HC-One homes was also present during our inspection. The appointment of the new manager had been well received. One visitor told us "We are seeing lots of improvements. She's got the passion for it
We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Not all care plans were written in a person centred way and this could place people at risk of receiving unsafe or inappropriate care.

There was a strong offensive odour that permeated throughout the first floor of the home originating from a person's bedroom. Although there was an appropriate cleaning schedule this had not helped to remove these odours.
People who used the service had risk assessments relating to their health and safety on their care files, but these had not always been fully completed and reviewed regularly to make sure the identified risks were mitigated.

Care plans contained out of date information and rooms did not display people's names which increased the risk being of people being given the wrong care and treatment.

Care plan reviews did not take into account specific issues which could result in poor outcomes for people, such as skin integrity needs, continence support needs and dementia needs.

Staff we spoke with were confident about their duties and responsibilities in relation to the Mental Capacity

Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had received training in this topic.

People who used the service, who we asked, told us that Appleton Manor was a safe place to live and felt they were well looked after. People we saw looked well cared for and comfortable in their surroundings. We had brought our inspection forward following concerns raised with us about recruitment and retention of staff and safeguarding issues. When we inspected we saw that where allegations of abuse and issues of concern had been brought to the attention of the provider action had been taken to minimise the effect on people who used the service. Staff shortages led to an over reliance on agency staff, and the home had halted new admissions into the home until staff could be recruited and given appropriate training. When we spoke to the home manager about this, she informed us that nine new starters had been recruited to commence training the week following our visit.

Staff understood their role in making sure they safeguarded vulnerable people from harm and had undertaken training in adult safeguarding.

The staff training records showed staff had access to a range of appropriate training such as dementia awareness, pressure care awareness and end of life care and the staff we spoke with confirmed this. They also told us that they felt well supported by the new manager and found the management team very approachable.

Staff had all received a thorough induction, training and support when they started work at Appleton Manor and understood their roles and responsibilities in relation to the care and support people required.

People were supported by sufficient numbers of suitably trained staff, who had been appropriately and safely recruited to support and meet people's individual needs.

People were provided with personalised care by staff who supported them to live as independently as possible. People were also supported by staff to eat and drink enough to maintain a balanced diet. We found that people's care was delivered consistently by staff who knew how to support people and meet their assessed care needs.

We saw good relationships between individual staff and people who used the service. We saw that care was provided with kindness; staff were respectful when speaking with people and responded promptly when people required assistance.

People told us they knew who to speak to if they wanted to raise a concern or complaint and a copy of the complaints process was displayed in prominent areas throughout the home.

Systems had been put in place to monitor the quality of service being provided. These systems included regular checks on all aspects of the management of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A cleaning schedule in place had not helped to remove offensive odours particularly for the bedroom where the odour originated.

Staff understood their role in making sure they safeguarded vulnerable people from harm and had undertaken training in adult safeguarding.

People were supported by sufficient numbers of suitably trained staff, who had been safely recruited and were available at all times to support and meet people's individual needs.

Medicines were managed safely and people received their medicines as prescribed; this included controlled drugs.

Is the service effective?

Good

The service was effective.

Care staff had all received induction training and support when they started work at the service and understood their roles and responsibilities.

People were supported and encouraged to make their own choices and decisions about their daily lifestyle routines.

There was a staff supervision plan in place which was being followed regularly. Future supervision dates had been planned to make sure staff were continually supported in their work.

People were supported by competent staff to eat and drink enough and maintain a balanced diet, good health, have access to healthcare services and receive ongoing healthcare□

Is the service caring?

Good

The service was caring.

People's privacy, dignity and individuality were respected and people looked well cared for and they wore clean and

appropriate clothing.

Staff spoken with were knowledgeable about people's individual needs and preferences and understood how to respect and promote people's privacy and dignity.

We found the atmosphere in the home to be homely and relaxed and we observed positive interaction between the people who lived there and the staff supporting them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans and daily records had not been reviewed or checked regularly to make sure they include up to date information about people's health care needs.

People told us they were aware of how to make a complaint or raise a concern and were confident that anything they raised would be taken seriously and treated confidentially

Is the service well-led?

Requires Improvement

The service was not always well-led

A manager registered with the Care Quality Commission was not in place at the home and it is a condition of the provider's registration that a registered manager is in place.

Systems were in place to monitor the quality of the service people received and drive improvement. However, these systems had not been effective.

People using the service and their families were provided with opportunities to express an opinion about how the service was managed and the quality of service being delivered.

Appleton 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.

This inspection took place on 7, 8 and 14 January 2016. Our visit on the 7 January was unannounced.

The inspection was carried out over two days by two adult social care inspectors.

We had been informed by the local authority safeguarding and commissioning teams of concerns around changes in management, staffing levels and some safeguarding concerns so we brought our inspection forward. Before we visited the home we reviewed the previous inspection reports and notifications held on our records that we had received from the service.
As we had brought forward our inspection we had not requested the service to complete a provider information return (PIR). A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During the inspection we saw how the staff interacted with people using the service. We spoke with three people who used the service, one domestic, three visitors, two senior health care assistants, the home manager, the previous registered manager, and three care workers. We also spoke to the agency cook and an agency care worker

We walked around the home and looked in some of the bedrooms. We looked in the communal lounge, dining room, the kitchen, the shared toilets, the shower and bathroom. We reviewed a range of records detailing people's care and support which included the care plans and medicine records of six people, the staff training and supervision records for four staff employed at the home, and quality monitoring records such as auditing records about how the home was being managed.

Requires Improvement

Is the service safe?

Our findings

There was a strong offensive odour that permeated throughout all areas of the first floor including the dining room and communal lounge. The malodour originated from a person's bedroom and it was clear the person had been living in the current malodorous environment for some time. We asked the home manager if a cleaning system was in place to remove the odour and make sure the odour did not impact on the lives of other people living at Appleton Manor. The home manager told us all rooms were cleaned daily and whilst they had noticed the odour, they thought it was coming from another room which had since been re carpeted. They told us that the room had become malodorous due to the person's incontinence. Following this discussion the home manager immediately contacted the organisations estates manager, who after assessing the person's room, instructed that the floor covering and skirting boards be removed and replaced with new ones. This work began during the inspection.

This was in breach of regulation 15 (1) (a) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 All premises and equipment must be clean and suitable for the intended purpose for which they are being used.

People told us they felt safe. One person who used the service said "They know how to look after me and make sure I am safe. I have no worries here".

There was a safeguarding procedure in place which was in line with the local authority 'safeguarding adults at risk multi agency policy' and staff spoken with knew how to access a copy of the policy. Staff spoken with had a good understanding of safeguarding issues and staff learning and development records showed that staff had received training in this topic. Information we held about the service indicated any safeguarding matters were effectively managed and reported to the appropriate safeguarding agencies.

Staff spoken with advised us of the process they would follow when reporting any concerns about people's safety to the home manager. They were clear about how to report safeguarding concerns in a timely way to external authorities such as the local authority and the Care Quality Commission.

Staff also knew to be vigilant about the possibility of poor practice by their colleagues and knew how to use the homes whistleblowing policy. Whistle blowing is when a person raises a concern about a wrongdoing that may place a person at risk of harm in the workplace. They told us they would feel confident if they needed to report any concerns about poor practice taking place within the home.

We examined records of accidents and incidents in relation to people using the service and saw that where necessary appropriate authorities such as the local authority adult safeguarding team and the Care Quality Commission (CQC) had been notified in a timely way of such events. Accidents and incidents were well documented and up to date.

Monthly accident and incident audits were carried out and submitted to the local authority and analysed for any obvious patterns developing, for example, any falls which did not require hospital admission or minor

medicine errors, such as delays or missed tablets. This ensures that any errors can be identified and responded to in a timely manner.

There was a recruitment and selection procedure in place that was in line with the current regulations for recruiting staff to work in a care setting. We looked at four staff recruitment files and found that they contained appropriate documentation to demonstrate that staff had been recruited in line with the policy's instructions. This included the completion of a disclosure and barring service (DBS) pre-employment check and receipt of two appropriate references. The DBS is a service that identifies people who may be barred from working with children and vulnerable adults and informs the service provider of any criminal convictions recorded against the applicant. These checks help the manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people.

We asked staff about the staffing levels on each duty shift and one member of staff told us, "Every day is different although a nurse isn't required on the first floor. But a nurse is on duty this afternoon to do the medicines round. We really need two nurses. The medication round takes a long time and would be better if there were two of us, one on each floor". We examined the staff rota and saw that the staffing levels on both days of our inspection confirmed the staffing numbers, skill mix and staff qualifications were sufficient as described by the staff and the manager. We observed the medication round, which was given in a timely manner, and whilst medication was being dispensed other staff were able to support the people who used the service.

We asked the manager what systems were in place in the event of an emergency occurring that could affect the running of the home and the provision of care. We were shown a 'business continuity plan' that provided staff with relevant information should an emergency arise, such as electricity failure or gas leaks. We examined the homes fire risk assessment and noted that regular safety checks had been carried out to make sure the fire alarm, emergency lighting and fire extinguishers remained in good working order and that all fire exits were kept clear. We saw that these systems and checks were complete and in place when we walked around the home. The home also kept an evacuation pack in the entrance area. This is a bag which contained equipment which might be required in the event of an emergency, such as first aid kit, torches, wipes and tabards. There was also a fire drill record and a copy of each person's Personal emergency evacuation plan (PEEP) this is a short document which describes how best to assist someone out of the building in the case of an emergency.

The home had an up to date medicines policy and procedure and we checked the procedure and systems for the receipt, storage, administration and disposal of medicines. The supplying pharmacy provided people's medicines to be administered in its original packaging and all medicines including medication to be given 'as and when required' such as paracetamol, were administered from their original packaging following the HC-One medicines policy.

We saw that medicines were stored safely in a locked medicine trolleys within a locked clinic used specifically to store medicines. Records were kept for medicines received and disposed of; this included controlled drugs (CD's). We observed part of the afternoon medicines round and saw that medicines were administered following the homes procedure by an authorised staff member who had received appropriate training to carry out this role.

We looked at the medicine administration records (MAR) for five people who lived at the Appleton Manor and found that the records had been completed accurately and were up to date. The MAR sheets showed that people were receiving their medicines as prescribed by their General Practitioner.

We asked three people if their medicines were administered on time and they confirmed they were. We saw that medicines were given by staff trained to administer medicines and in accordance with safe procedures.

We checked the kitchen and saw that it was clean and that the fridge temperatures were being monitored regularly and food stored safely to prevent any risks of cross contamination or food wastage. A Food Standards Agency 'Food Hygiene' rating had been given in August 2014. This showed the service had been awarded the highest rating of 5.

The premises were found to be tidy and hazard free and suitable for the intended purpose. We saw that toilets had posters detailing safe hand washing techniques, and that liquid soap; paper towels, disposable aprons and hand gel were available, further helping to reduce the risk of cross contamination.

Staff we spoke with understood the importance of infection control measures, such as the use of the national colour coding scheme for cleaning materials to minimise risk of cross contamination. For example, mops and buckets were colour coded so different ones were used in the kitchen areas, bathrooms and laundry areas, and the use of personal protective equipment such as tabards, disposable vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

The building was secure, and hazardous items such as cleaning materials were stored safely when not in use. We checked the service had systems in place to protect people and staff from infection and cross infection. In the laundry we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

We saw that armchairs, walking frames, and pressure relieving equipment were clean, well maintained and safe. The home completed regular checks to ensure the safe use of hoists, profiling beds, and bathing equipment.

Staff kept entrances and exits to the home clear. The front door of the home was secured using a secure door entry system so that staff could monitor who came in and left the building. This did not restrict people's movements and records showed people could leave the home with appropriate supervision and safeguards in place if they wanted to.

Good

Is the service effective?

Our findings

All the people on the first floor were living with dementia. Two staff members who worked on this floor within Appleton Manor told us about the training they had received at the home, and one said, "I feel like I'm in at the deep end because we've had no training specific in dementia or challenging behaviour". This person went on to say that they would like a better understanding of the stages of dementia, and recognised that the people who used the service were all at different levels. When we asked the manager about this she informed us that training is available, and staff had begun to complete modules of the 'Open Hearts and Minds' dementia training, an on line training course which provided staff with the skills and knowledge to deliver kind, individualised care for people living with dementia and for people whose behaviour at times could challenge the service. When we observed staff interactions with people living with dementia we saw that they responded in a person centred way and showed an understanding of the individuals and how to support them.
Another staff member confirmed they had all undertaken core training in topics such as, safeguarding, food hygiene, infection control and basic first aid but was unsure as to whether they had received dementia training. Training such as this helps to make sure that staff's knowledge, skills and understanding is up to date and that staff are able to meet people's needs effectively.

We asked one care worker about their induction to the home. They told us that they had a week working alongside a more experienced member of staff, to get to know the people who used the service and the ways the home operated. As part of their induction staff were given training in topics such as moving and handling, first aid, fire safety, infection control and moving and handling.

On-going training was completed through an on line system and information held on the staff training and development record and within staff files showed that staff had all received further training in topics such as safeguarding, fire safety, equality and diversity, end of life care and whistleblowing. The manager provided documentary evidence to demonstrate that all of the staff team had undertaken appropriate training which was updated regularly and had been enrolled on courses such as the National Vocational Qualification (NVQ) level two in health and social care.

We saw records that showed staff had undertaken training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and through discussion with the staff we noted that all staff were clear about their responsibilities when these restrictions were in place for any person using the service.

We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The 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. At the time of our inspection there were 13 applications for DoLS authorisations in place.

The manager had a clear understanding about this legislation and provided us with details about the arrangements in place for people who used the service to give consent to their care and treatment. We were told that any care and treatment provided was always discussed and agreed with people who were able to consent. For example, one person who used the service told us that when they retired to bed they were always asked if the door should be left open or closed or if they would like the light leaving on.

From our observations and from examining people's care records we saw that people were being provided with enough fluids during the day to keep them hydrated. Water and soft drinks were offered throughout the day and tea and coffee was served in the morning and afternoon. People who required help were offered support to have drinks regularly and we saw that people were supported by competent staff to eat and drink enough and maintain a balanced diet and good health.

We asked one person who used the service about the food. They told us it was "Always very good. There is a lot of variety but there is always something I like". They told us for breakfast they had a choice of porridge, cereals toast and jam, or a cooked breakfast. Lunch was the main meal of the day and there was a choice of main meals followed by a dessert. Food was prepared in the main kitchen and sent on trolleys to the two units which had their own dining areas. However, at the time of our inspection the regular cook was away and an agency chef had been brought in to prepare the food, and this had led to some confusion. For example, the cook was not informed that many of the people who used the service preferred porridge, and none had been made. At lunchtime, the trolleys were sent to the wrong units, and had to be returned. This meant a delay in serving meals and by the time people received their meal it was served at the wrong temperature. Moreover, the confusion heightened the risk of the wrong meals being served, for example, staff were unsure that people had received the correct desserts and had to double check. This increased the risk that people were given food that was unsuited to their diet, for example, if they were diabetic and required a sugar free dessert. We were assured that this error was due to the unfamiliarity of the agency chef with the separate trolleys.

We observed lunch being served in both dining rooms, where the tables were attractively laid with tablecloths, mats and condiments. We saw that the portion sizes were good and that the food looked appetising. People were given a choice of where to sit; one person decided that they did not wish to sit at a table, and chose to eat in their armchair. They were supported to do this with an adjustable over chair trolley to eat their meal comfortably. We observed a warm interaction between staff and people during the meal. Staff stayed in close proximity to offer assistance to people if required and engaged pleasantly with them as they helped.

Staff told us, and we saw that they knew how to fortify meals to increase their calorific content for those people identified as being underweight. Staff also knew when to refer to specialist support such as dieticians through the General Practitioner (GP) for further help with weight management.

People told us, and we saw documentation in care files to confirm that people were supported to see other health professionals when required. The name and address of the person's GP was recorded in their care files and we saw evidence in the files of referrals to health professionals such as Speech and Language Therapists.

When we walked around the home we saw shared lounges and dining rooms were warm and homely. We found communal bathrooms, toilets and shower rooms were spacious enough to manoeuvre a bath chair and bath hoist. Raised toilets and hand rails were in place to maintain people's independence. However, the home décor was not dementia friendly and lacked basic appropriate resources such as door signage to aid people maintaining their independence and to reflect a person centred approach to dementia care

Good

Is the service caring?

Our findings

We found the atmosphere at Appleton Manor to be homely and relaxed. People spoken with told us they were happy with the care and support they received at the home and made positive comments such as, "There is nothing they wouldn't do for me, they see to my every need." One person who was nursed in bed said: "They are always popping in to make sure I am alright. They stop and chat to me, even though I know how busy they are".
One visiting relative told us "[My relative] is treated well; they all look after her, even though she can be difficult". We saw a compliment which asked that the manager pass on a message to a care worker: "Please let her know what a wonderfully kind manner she had…with all the residents. It meant a lot and I admired her skills".

When we arrived at the care home at 7.15 a.m. on the first day of our inspection, people were still in their rooms and the night staff were starting to support those people who wanted to get up. There were no set rising times, and people were being assisted to get up in their own time. We observed breakfast and saw that cups of tea were taken to some people in their rooms.

Appleton Manor had a comfortable and calm atmosphere and we observed respectful and caring interactions between care staff and people who used the service. For example we saw one person being assisted to transfer from a chair to his room. Two staff supported the person to rise and hold the walking frame, but after a few steps they realised he was struggling. They pulled up another chair and allowed him time to catch his breath before assisting to carry on with the journey, supporting him to maintain balance. One care worker offered an arm for assistance, and walked at an unhurried pace, chatting pleasantly to the person and pointing out any hazards.

A member of staff told us "I love it here. I get to know all the people and their ways, and become attached to them. I look forward to coming in to work." We saw staff treated people with patience and kindness, and spoke to them in a respectful way. For example when one person was showing some signs of agitation a member of staff approached them gently, established eye contact and touched the person gently on the arm. They enquired if the person was worried and helped provide reassurance in a calm manner. The care staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. Staff responded to requests for assistance and we saw they had one to one personal conversations with people.
People told us that staff supported them in the way they had agreed and that they asked for the person's consent before carrying out care and support tasks. We observed this in practice, for example, we saw that when entering occupied rooms staff would first knock and wait for a response. People were taken to their own rooms or bathrooms for personal care, and doors were closed when staff supported people with their personal care needs.

Two members of staff told us how they each respected people's privacy and promoted their wellbeing. One told us, "We have to know them as individuals; they are all different, so we sense their mood and when they want time alone or want to talk, or need help." We observed some interactions between staff and a person

living with dementia who sometimes engaged in inappropriate behaviour. The care workers helped him to understand the boundaries of his behaviour and responded in a person centred way by explaining in a way the person could understand what appropriate behaviour was without causing any offence to the person. We asked a care worker about this and they told us that they recognised that this was a part of the person's dementia.

During the inspection we saw people move freely around the home using their mobility aids. We saw that people who were unable to mobilise independently received care and support which was delivered sensitively and in a caring manner by staff. We saw staff asking people their preferences and offering snacks and drinks throughout the day. We saw staff checking on particular people who could not verbally communicate. In these cases other communication methods were used such as hand gestures and direct eye contact. In each situation we saw staff were responsive to people's individual characteristics to make sure their needs would be met.

We saw evidence in the care plans we examined that people were supported to express their views and be actively involved in making decisions about their care, treatment and support through the care plan review process wherever possible. Where people were unable to make decisions about the way their care and wellbeing was being delivered we were advised by a relative that they had been included in contributing information to their relatives care plan. They said, "I have seen [my relative's] care plan and it's all what they would want." We saw in the care plan that they had signed their agreement.

Throughout the inspection, we saw staff respecting people's privacy and dignity when they were supporting people around the home. We saw staff involving people by asking them where they preferred to sit in the shared lounge and assisting them to their chosen seat.

The provider had introduced the Six Step programme in end of life care and staff had received appropriate training in this topic. This is a programme which guides care staff in supporting people nearing the end of life. The care plans we looked at set out people's preferences so that staff could support them to remain in the home and be comfortable at the end of their life where appropriate.
If an agreement had been reached to advise medical teams not to attempt cardiopulmonary resuscitation (CPR) a form signed by the General Practitioner (GP) was included in the care files.

People were supported to maintain relationships with family and friends. Feedback from visitors was positive, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visit.

Staff we spoke with had a good understanding of equality and diversity and respecting people's individual beliefs, culture and background. We saw that the home manager had contacted a local church and plans had been made to introduce a chaplain who would visit to provide communion.
Staff had access to diversity training and we saw from the records that 88% of staff had completed this. We asked one member of staff about this and they were able to give examples of how they would respect practices which might be different from their own.

Requires Improvement

Is the service responsive?

Our findings

The names of people who used the service were not displayed on their bedroom doors, which could lead to confusion. On the first morning of our inspection we observed a member of staff who was unfamiliar with the layout of the ground floor taking a breakfast tray to someone who used the service. They were initially unable to find the room and when they did they, although they knocked and entered after receiving a reply they did not check that they had found the right person to give breakfast to. This could mean people are given the wrong treatment.

Before people moved into Appleton Manor we were told that assessments were carried out to gather information about the person and whether their needs could be met at the home. We looked at care records that belonged to two people who lived in the dementia unit. Whilst we saw individual assessments had been completed one care plan contained out of date information, for example; the wrong bedroom door number was found to be noted on several documents within the person's care plan. This meant that staff who were new to the home might provide people with inappropriate care or treatment because they could not be sure who the room belonged to.

This was in breach of regulation 12(2) (b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 doing all that is reasonably practicable to mitigate such risks.

In the same person's care plan we saw that a skin integrity risk assessment completed on the 21 November 2014 identified there was a significant hazard because the person was at high risk of developing pressure ulcers. The record stated that appropriate preventative measures were in place such as, checking the persons skin frequently, completing a body map record to highlight vulnerable skin areas, applying cream on a daily basis and providing the person with pressure relief every two hours when they were in bed. However on the risk assessment continuation record the last written entry had been made on 27 September 2015, where it was written 'staff to continue to monitor service user's skin integrity'. We found there were no other entries made in the continuation sheet and no written indication that staff had continued to monitor the person's skin integrity as instructed. This meant that the person was at risk of developing pressure sores because the risk assessment relating to their health and safety had not been completed and reviewed regularly to make sure the identified risks were mitigated.

Where pressure care had been identified as a need, we saw turning charts were in place. However, these had not always been completed. Just before lunchtime on the second afternoon of our inspection we noticed that one person who was nursed in bed had a positional change chart on which to record when their posture in bed was changed. We noted that there was no record of any change since 06.30 that morning. When we raised this with the nurse on duty they made enquiries and informed us that the person had been turned at 9.30am and that this was a recording error rather than an omission of care. We checked with the individual who told us "they do come in regularly to help me shift, but I can't recall when or how often."

This was in breach of regulation 12 (2) (a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 assessing the risk to the health and safety of service users receiving care and treatment.

We found that a local authority care plan written on 11 June 2014 showed a person had previously been treated for incontinence and urinary problems. However we saw from the person's care plan records there was no written assessment or information highlighting their incontinence. This meant the person was at risk of developing urinary problems because their incontinence needs were not being properly addressed.

This was in breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 the care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

We found there was a significant lack of detail in one person's care plan for the person to receive personalised care and treatment and informed the manager of this. On the second inspection day the manager told us they had reviewed and updated this person's care plan. However when we examined the care plan we found the person's room number was still the wrong number, the care plan had been reviewed without the involvement of the person or their relative and without carrying out a new needs assessment. There were still some gaps in information, for example; whilst the person's risk assessment identified they were at high risk of developing pressure ulcers the care plan was not specific in detailing the action staff should take to prevent the risk of pressure ulcers occurring. This meant that the care plan review did not take into account specific issues which could result in poor outcomes for the person if not addressed, such as skin integrity needs, continence support needs and dementia needs.

This was a breach of regulation 17(1) (2) (c) of the health and Social Care Act 2008 (Regulated Activities). Systems must be established to maintain an accurate complete and contemporaneous record in respect of each service user.
We found inconsistencies in another person's care plan. We noted that this person had not been weighed as a note showed that they were 'frightened of using the hoist'. Her care plan stated that she needed to be weighed each month but gave no indication of how this was to be done. It also stated that she would require an 'Oxford Hoist' to mobilise but did not mention that she did not like to use this. This person received all care in bed. A further entry indicated that the person was able to 'get up and sit in a chair but refuses'. There was no evidence that the staff had considered other ways of either monitoring her weight or considering why she did not wish to get out of bed. This meant the care plan did not take into account how best to support this person which increased the risks of skin breakdown, loss of mobility and dexterity and lack of stimulation.

This was in breach of regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

However, there was documentation in care plans we looked at that considered the person's care, treatment and support, how their needs would be met and how their rights would be protected. Care plans included information in relation to the person's level of dependency and where they might require further intervention from medical professionals such as district nurses, dietician or General Practitioner (GP). Care plans also included a falls risk assessment, choking risk assessment, and malnutrition universal screening tool (MUST) to identify adults who are malnourished or at risk of malnutrition, a body map to identify any changes to the person's skin and where there might be a risk to the person's skin integrity, communication needs and personal care needs were also included.

Formal systems were in place for daily exchanges between staff of information about people's care and support needs. Staff told us that staff handovers were held at every shift change when a new team or staff member came on duty to help make sure risks to people using the service were identified, escalated and

monitored where necessary. This was confirmed when we observed a staff handover and information was shared appropriately and in a timely way the home had a complaints and compliments policy on display and comments slips were available for people to jot down any concerns. In addition visitors were encouraged to give feedback on their visit, and a touch screen computer situated adjacent to the front door allowed visitors to rate the home. This was linked the organisation's 'datix' system. This allowed the home to conduct trend analysis and take any required actions.

We looked at the complaints file and saw that all complaints were logged and investigated. The manager informed us that she kept an 'open door' policy which meant that she was often able to respond immediately to issues of concern and deal with complaints at an informal stage. We asked people who use the service if they knew how to make a complaint. One person told us "Yes, of course. I would speak to the care staff and if they didn't do anything I would ask to speak to the manager." This person told us that they had complained about their bed when they first came in to the service, and the staff dealt with the complaint immediately, providing her with a bigger bed.

We saw that there was a variety of activities on offer to people who used the service. One full time and one part time activities co-ordinator were employed to support activities such as card games, crafts, and bingo. We observed a general knowledge quiz during our inspection, which a number of the people who used the service appeared to enjoy. We saw one person being taken out to buy a morning newspaper, and they informed us that the activity co-ordinator will take her out each day to buy a paper. The home also had a minibus for use on occasional trips and days out, and we were informed that there had been a recent trip out for a meal which was well attended. The activities co-ordinators also arranged for visiting performers and we were told that a school choir had recently been in to entertain the people who used the service.

The home manager informed us that she was keen to involve people in their day to day care, and promoted bi-monthly relatives meetings by sending out personal invitations by post. We saw that the typed minutes of the last meeting showed a good interest with over thirty people attending and issues discussed had led to appropriate action being taken where required. She had formed a residents committee, which met regularly to discuss topics such as meals, staff approach, home environment and activities. For example, people had asked for toast and Horlicks at supper time, which was now provided.

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Appleton Manor is registered with the Care Quality Commission. A manager had been registered in July 2014, and was still working for the provider in a different role. A new manager had been appointed, but had not yet been registered. We asked that the new manager seek to register with the Care Quality Commission (CQC). She informed us that she had begun the process of applying and provided some evidence to show this. Both the previous manager and the new manager were both present throughout our inspection.

At the time of our inspection the manager was supported by the previous manager, who had recently been appointed as a peripatetic Manager for HC-One homes, and a deputy, who also worked on the nursing unit. In addition the provider offered support and managerial supervision through an Operational Director.

The appointment of the new manager had been well received. One visitor said: "We are seeing lots of improvements. She's got the passion for it". Staff also expressed confidence; one person told us "She listens to what we have to say and she will take action. She's not afraid to deal with some difficult issues". Another said: "She's on the ball. She's got a lot of experience and knows what she is doing and what needs to be done". We saw that the manager maintained a visible presence and did not confine herself to the office. She conducted a daily 'walkabout' to ensure that the service was running efficiently. Any actions required were noted and documented, and we saw that this informed a management audit to allow for greater accountability for actions.

Before our inspection we checked our records to see if any accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant that we were able to see if appropriate action had been taken by management to ensure that people were kept safe. We saw that the manager had reported all incidents to us. In addition we spoke to the local authority and reviewed other information sent to us since our last inspection. There had been a number of issues and concerns reported to the local authority which had been investigated. Where issues of concern had been addressed there was evidence that lessons had been learnt. For example following a coroner inquest (which found that a person who used the service had died of natural causes) the service reviewed its policy on nutrition and hydration and introduced a choking risk assessment to ensure that people were receiving food and drink appropriate to their needs.
We saw that there had been nine safeguarding alerts investigated by the local authority. Some of these had been raised by the service whilst others had been forwarded by health and social care professionals or concerned whistle blowers. Where these allegations had been substantiated we saw that appropriate action had been taken to minimise the consequence to people who use the service and to put protective measures in place. These included some disciplinary action which had led to staff dismissals, and this in turn had led to a staff shortage and an over reliance on agency staff. In order to address the issue the home had agreed with the local authority to halt any new admissions into the home until staff could be recruited and given appropriate training. When we spoke to the home manager about this, she informed us that nine new starters had been recruited to commence training the week following our visit. In the meantime, however,

the home had been reliant on agency workers to maintain an appropriate level of staff, and although the new manager had made arrangements to minimise the number of agency and bank workers on shift by requesting some continuity, the use of such staff was a cause of some frustration to permanent care workers. We were told by two staff that they "Have never not worked with agency". They explained that there had been gaps on each shift they had worked which were covered by staff who may be unfamiliar with the routines and needs of people who used the service, and meant that they required oversight and guidance, which permanent staff felt took them away from spending time with people who used the service.

The staff we spoke with had a clear understanding of the role and responsibilities of the manager, and were aware of their responsibility to pass on any concerns about the care being provided. They told us that there was a whistleblowing policy and felt supported to use this if necessary. One person told us about an incident where they got upset about poor care and reported this to the manager. They informed us that the manager provided full support and investigated the concerns thoroughly and without prejudice. The care worker told us "The way it was handled would encourage me to report again. I am here to make sure people get the right care, not to make friends".

There was a system in place to monitor the quality of the service. The manager completed a monthly audit and reported on falls; pressure sores; weight management; accidents; hospital admissions and infections; and any other incidents which occurred during the month. Incidents were monitored for trends so that methods for reducing reoccurring incidents could be identified. In addition the provider completed a six monthly assessment of care provision. We looked at the most recent assessment carried out in November 2015. This showed recommended improvements, issues learnt and areas for development which had been formulated into an action plan to improve the quality of the service, and we saw that actions had begun to meet identified goals, particularly around staff recruitment and training. There was also a formal Operations Director site visit; the latest was in December 2015 during which they reviewed safeguarding protection plans and action taken to minimise the risk of harm. However, we found that this had not always effective; as audits had not picked up on some of the issues we found on our inspection, for example, inconsistencies in care plans.

The new manager had introduced a daily meeting which she chaired and included the cook, head of housekeeping and senior staff for both units. At this meeting issues were discussed and appropriate action identified, including any events likely to occur on the day. This established a good system of communication allowing all staff to be informed of any events. They had also introduced a "Resident of the day": This system allowed a co-ordinated approach to reviewing needs, so for the named person, the kitchen staff would review dietary and nutritional needs; housekeeping would complete a deep clean of the person's room and check equipment was in working order, and there would be a thorough review of care plans and risk assessments completed by the care staff. This included, for example, weight, medicine checks, and review of visitors and other forms of stimulation. This system allowed for a person from each unit to have a converging review of their needs on a monthly basis, and meant that there was a co-ordinated approach across the service to improving the quality of care provision.

There were current and up to date corporate policies and procedures in place to support the daily management of the home and help to make sure that staff were clear about their duties when they were involved with all aspects of people's healthcare and wellbeing. Current and up to date policies and procedures are critical to the health and safety, legislation and regulatory requirements at the home and may place people at risk of receiving unsafe and inappropriate care if they are not used or followed in accordance with the regulations.

The staff we spoke with reflected the values and philosophy of the service to provide a safe, comfortable and

caring environment. We saw evidence that the new manager had implemented methods to help staff work together to improve the quality of the service and create an open and honest culture with transparent and open communication, promoting teamwork and integrated care. Staff told us they were optimistic about the new manager and believed she would help to improve the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans did not ensure that care and treatment was personalised specifically for service users, particularly around continence issues. Regulation 9 (1) The service did not carry out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user Regulation 9 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service did not assess the risk to the health and safety of service users receiving care and treatment. Regulation 12(2)(a) The provider was not taking practical steps to mitigate the risk to the health of service users Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	Premises must be clean, suitable for the

	purpose for which they are being used and properly maintained Regulation 15 (1)(a)(c)(e)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance there was insignificant detail in care plans to provide personalised care and treatment