HC-One Limited

Appleton Manor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 20 and 22 June 2017 and was unannounced on the first day.

We last inspected the service in January 2016 when we rated the service as requires improvement. At that time we found the service was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, these related to safe care and treatment, person centred care, premises and equipment and governance.

This inspection was to check improvements had been made following the last inspection and to review the ratings.

Appleton Manor Nursing Home is run by HC-One. The home is situated on the borders of Brinnington and Bredbury near Stockport. It is a purpose built two storey building which provides nursing and residential care for up to 58 older people. The home is split into two areas nursing care is provided on the ground floor for up to 25 people. Residential care and support for people living with dementia is provided for up to 33 people on the first floor. Appleton Manor Nursing Home is close to local amenities and there is convenient access to public transport and motorway networks. Car parking is available at the front of the home.

At the time of our inspection there was no registered manager in place as the previous registered manager had left the service in May 2017. However a temporary manager from another HC-One home located on the same site as Appleton Manor was in place pending the recruitment of a new manager. The provider advised us that steps were being taken to recruit a suitable manager within a reasonable timescale.

Systems to make sure the safekeeping and administration of medicines were followed and monitored were in place and reviewed regularly. Medicines were stored safely and administered by designated trained care workers and nurses. Any specific requirements or risks in relation to people taking particular medicines were clearly documented in people's care records.

We saw people were supported by sufficient numbers of care workers and nurses. Care workers and nurses told us they had undergone a thorough recruitment process and had undertaken employee induction and training appropriate to their job role. This helped to make sure the care provided was safe and responsive to meet people's identified needs.

During both days of the inspection we saw positive and caring interactions between care workers, nurses and people who used the service which helped to make sure people's wellbeing was promoted and their dignity was respected.

People lived in a clean and well maintained environment. We saw that the home was decorated to a high standard; there was a warm and relaxed atmosphere throughout the home. Appropriate equipment and health and safety checks were carried out to help maintain a safe environment for people to live in.

People who used the service and their relatives were complimentary and positive about the care and support provided and the attitude of the care team and management. They felt that the overall care provided was very good and the environment was furnished and maintained to a high standard.

Complaints were addressed and recorded appropriately by the management team. People who used the service and their relatives told us they knew how to make a complaint and felt confident to approach any member of the staff team if they had any concerns.

Accurate and complete records in respect of the care and treatment provided to people were being maintained. Systems were in place to monitor the quality and safety of the service provided to people living in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding policies and procedures were in place and care workers knew how to protect people from the risk of harm.

Systems were in place to make sure medicines were stored, recorded and administered safely by suitably trained nurses and care workers.

Written information showed how to mitigate any risks to people which were identified and detailed in their care plans.

Is the service effective?

Good

The service was effective.

Care workers received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

People had access to external healthcare professionals, such as specialist nurses and General Practitioner's.

Food options and refreshments were available throughout the day.
People's nutrition and hydration was monitored to ensure their nutritional and hydration needs were being met.

Is the service caring?

Good

The service was caring.

We observed positive interactions between care workers/nurses and people who used the service.

People received care and support from nurses and care workers who knew them well.

People's care records were stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them moving into the home. Care records identified risks to people's physical health, mental health and well-being.

People's health care reviews were held monthly or more frequently if necessary. Specialist guidance was included in people's care records to address any changes in their health.

People told us they felt confident in raising concerns or complaints, if they had any, with the management team, nurses or care workers.

Is the service well-led?

Requires Improvement

The service was well-led

A registered manager was not in place at the service. People who used the service and staff spoke positively about the temporary manager.

The provider promoted a person centred approach to help make sure people's needs and preferences were met.

Systems in place in order to monitor the quality of the service were being fully utilised.

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 the 20 and 22 June 2017 and was unannounced on the first day. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information that we held about the service and the service provider. This included safeguarding and incident notifications which the provider had told us about. Prior to this inspection we received information from the local authority adult social care team and the National Health Service (NHS) Clinical Commissioning Group (CCG) who confirmed they had no concerns about the services that were being provided at Appleton Manor.

During our inspection we spoke with six people living at Appleton Manor, two visiting relatives, the temporary manager, a visiting GP, a registered nurse, the wellbeing coordinator, a cook, a housekeeper and three care workers.

We used the Short Observational Framework for Inspection (SOFI). This is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other impairment.

We reviewed seven care worker personnel files, agency staff profiles, the registration details of three nurses, records of staff recruitment checks, records of staff training and supervision and the care records of six people living in the home.

We also reviewed a sample of people's medicine records, records relating to how the service was being managed such as records for servicing and maintenance of premises and equipment, safety audits, and a sample of the services operational policies and procedures.

Good

Is the service safe?

Our findings

At our last inspection in January 2016 we found that the provider did not assess the risk to the health and safety of people using the service and did not take practical steps to mitigate risks identified. This was a breach of 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. At this inspection we found that improvements had been made in this area and the provider had put appropriate arrangements in place to help identify, manage and mitigate risk to people.

We saw records to show that risk assessments were in place where risks to people had been identified. For example we saw that in relation to people's skin integrity where necessary the provider had introduced body maps in order to highlight pressure sores, bruising or skin tears.
Additional moving and handling risk assessments were in place for people who required support with their mobility or were at risk of falls. Dietary risk assessments were also in place for people with specific dietary requirements such as softened or pureed meals. The risk assessments we examined contained enough detail to fully identify the risk and strategies for care workers and nurses to manage and minimise those risks to ensure people's safety.

Environmental risk assessments had been undertaken using a system for documenting and recording any maintenance work required. Health and safety audits had been carried out on a regular basis by the homes maintenance person. Checks on windows and window restrictors, doors, lighting and heating had also been carried out, recorded and were up to date. We saw records and audits for Legionella water checks, fire equipment checks and fire drills were carried out regularly by external contractors. Additional records that showed regular checks had been undertaken on electrical appliances and portable appliance testing were in place. This helped to make sure that any environmental risks to people were minimised.

Records to show all of the people living at Appleton Manor had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency situation such as a fire evacuation. Records showed that all nurses and care workers had undertaken fire safety training at regular intervals.

Systems to help protect people from the risk of abuse were in place. The service had a safeguarding policy and procedure which was in line with the local authority's 'safeguarding adults at risk multi-agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records which showed the provider had suitable procedures to help make sure any concerns about people's safety were appropriately reported. Care workers and a nurse we spoke with were knowledgeable and confident about the services safeguarding procedures. They were able to give a good account of the risks associated to vulnerable adults, the safeguards in place to minimise those risks and explain how they would be vigilant about poor practice in order to recognise and report suspected abuse. They confirmed they had received safeguarding and whistleblowing training and understood the service's whistleblowing policy (the reporting of unsafe and/ or poor practice).

People we spoke with told us they felt safe living at Appleton Manor and made positive comments about the

care being provided to them. They said, "I feel safe living here" and "I'm very safe". A visiting relative we spoke with said, "[Person's name] is really safe here; yes really safe and I have no worries about [Person's name] at all".

An accident and incident policy and procedure was in place. Records of any accidents and incidents were recorded and analysed to check if there were any themes. Appropriate notifications had been made to the Care Quality Commission (CQC) and the local authority adult social care safeguarding team where necessary.

We saw that medicines were administered safely, on time and as prescribed by people's General Practitioner (GP). All medicines including medicines to be given as and when required (PRN), such as paracetamol were provided in their original packaging by a supplying pharmacy following the HC-One medicines policy and procedure. We saw that medicines were stored in medicines trolleys that were located in designated locked rooms. Any excess medicines were stored in locked cupboards in the medicines rooms.

We saw records that showed medicines delivered to the home had been checked in by two designated care workers or nurses who were trained in this topic. We examined a sample of medication administration records (MAR) which showed they had been completed accurately, there were no missing signatures and they were up to date. An up to date care worker/ nurse verification signature sheet containing the names of authorised medicine handlers was in place and had been signed by designated care workers.

We saw there was a photograph of each person, on their individual MAR to assist care workers and nurses in identifying them. Any special instructions about how particular medicines should be taken were followed to ensure people received the correct dose, at the right time via the correct route. For example we observed a senior care worker carrying out the lunch time medicines round. Where people had been prescribed paracetamol to be taken when required (PRN) for pain, we observed the senior care worker checking the MAR's, and approaching those people to ask them if they had any pain and whether they required any medication prior to administering their medicine to them.

Following this we observed the senior care worker reconciled any medicines administered with the remaining amount recorded. This meant that the systems in place in relation to the recording of medicines were being used and followed correctly to ensure risks associated with medicines were minimised. We saw records to show that the provider carried out medicine administration competency assessments. This meant that care workers and nurses designated to administer medicines were supported and monitored to ensure people received their medicines safely.

A recruitment and selection procedure was in place and was also used to recruit agency and bank workers. We looked at seven care worker recruitment details and found that these care workers had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references. These checks help the registered provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults.

We examined the registration details of three registered nurses and found each nurses personal identification number (PIN) to be in date and expiry dates were recorded. This showed the provider had ensured nurses employed at the service were continuing to meet the professional standards that are a condition of their ability to practise.

All staff members were issued with an employee handbook which contained information about HC-One policies and procedures and management expectations of staff.

When we spoke with care workers about the staffing levels at the home they told us that they were usually fully staffed and there were enough care workers and nurses to meet the needs of people using the service. One care worker said, "We rarely use agency workers. Some staff will cover a shift in a colleague's absence". When we examined the staff duty rota we saw this confirmed that the staffing numbers and skill mix were appropriate and sufficient as described by the care worker we spoke with. People we spoke with told us they felt there were usually sufficient care workers and nurses on duty at the home.

Care workers we spoke with told us they had access to personal protective equipment (PPE) to help reduce the risk of cross infection and was always used when providing personal care to people. They were aware of the need to make sure they used the protective equipment such as disposable aprons and gloves available and confirmed to us there was always plenty of PPE available for them to use This helped to protect them and people using the service from the risk of cross infection whilst delivering care.

Systems to manage infection control and prevention at the home were in place and we examined records to show that the home was compliant with infection prevention and control requirements. When we visited the laundry room we saw there was a dirty to clean work flow system in operation where clean and dirty items were physically separated throughout the laundry process. The temporary manager, care workers and nurses were aware of their responsibilities in relation to managing infection control and prevention at the home.

We saw that a recent infection/prevention and control audit had been carried out by the local authority infection prevention nurse in April 2017. The home was scored an overall 100%. This meant that people were protected from the risk of infection because appropriate guidance had been followed.

When we visited the kitchen we found the home had been inspected by the Food Standards Agency in February 2016 and had scored a five star rating which indicated that the kitchen safety and hygiene standard at the home was very good.

Good

Is the service effective?

Our findings

At the last inspection in January 2016 we found that the provider had not made sure that the premises were clean and suitable for the purpose for which they were being used. At that inspection we found that despite there being an appropriate cleaning schedule in place there was a strong offensive odour that permeated throughout the first floor of the home and this was a breach of Regulation 15 Health and Social Care Act 2008 Regulations 2014 Premises and equipment. Following a discussion about this with the temporary manager the provider immediately began work to address our findings and instructed that the floor covering and skirting boards be removed and replaced with new ones.

At this inspection we found that improvements had been made in this area. When we visited the first floor of the home we found that there was no malodour apparent. We saw that this area of the home was clean, well maintained and smelled fresh. We saw that the flooring and skirting boards of the malodorous area had been replaced and a cleaning schedule was being used to maintain a fresh environment.

Additional work had been carried out to replace the flooring and furnishings in the first floor corridors and communal areas and flooring contractors were completing this stage of the refurbishment during this inspection. During both inspection days we found that both floors of the home, and people's bedrooms, smelled fresh and looked clean and tidy. This showed people were being cared for in a clean and hygienic environment.

We saw that furnishings had been replaced with good quality washable sofas and armchair covers and consideration had been given to the décor which had been designed for people with living with dementia on the first floor of the home. For example we saw memory boxes contained items that each person could associate to their work and home life before they moved into the home. Toilets and bathrooms could be easily identified because good clear signage was in place to help signpost people around the home.

When we looked at seven care worker training records we saw that some care workers had obtained a National Vocational qualification in Health and Social Care and new care workers had received training via the Care Certificate. This is a national recognised qualification that aims to equip health and social care workers with the knowledge and skills they need to provide safe and compassionate care. We saw that care workers had undertaken mandatory induction training in topics such as fire evacuation, safeguarding, food hygiene and infection control.

This induction was followed by a two week period of shadowing (working under the supervision of an experienced care worker) within the home. This gave the new care worker/nurse the opportunity to get to know the people who used the service. A probationary period of six months could be extended if the care workers/nurses performance did not meet expectations or the care worker/ nurse felt they required additional time to develop their skills.

The temporary manager told us that care workers and nurses had received additional training in appropriate topics to meet people's specific health and wellbeing needs and this was confirmed when we

examined the staff learning and development plan. We saw that care workers/nurses had undertaken training in dementia awareness, falls awareness, care planning and person centred care. This helped ensure that people were supported by suitably qualified, skilled and experienced care workers/nurses.

Care workers and nurses we spoke with said about the staff training provided, "There's quite a lot of online training which is a very transparent system because the manager can check up on the training we [care workers] have done and the training we need to do" and "The training I have had at Appleton Manor has helped me deal with situations that I have had to report to senior staff, like safeguarding" and "The training tells us about the paperwork that needs to be completed, how to report immediately and follow through on an incident. If it wasn't for that training, I wouldn't have known what to do" and "I'm learning lots and I love it".

There was an ongoing annual staff appraisal and a system of regular staff supervision in place. The system was used at regular intervals to discuss and evaluate the quality of care workers and nurses individual performance and where best practice was in place. Care workers and a nurse we spoke with confirmed they received an annual appraisal and supervision at least every three months. We examined seven care worker supervision and appraisal records which showed that care workers and nurses had received regular supervision and an annual appraisal. Staff supervision provides the worker with the opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

Nurses and care workers we spoke with said, "Paperwork and record keeping is thorough at Appleton Manor and the training provided ties in with what we do", and "The annual appraisal helps to identify if any learning or personal support is needed".

When we spoke with a visiting relative they were complementary about the care workers and nurses' ability to provide people with the care and support required. They said, "I cannot fault them, they are wonderful and they are trained to do their job well".

A visiting general practitioner (GP) made positive comments about the care workers and nurses ability to carry out their job role and said, "They [nurses and care workers] work very hard and I'd say they are all well trained".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The temporary manager told us that DoLS applications were required for some people living at the home and had been submitted to the supervisory body (the local authority). We saw a tracker was in place to monitor when applications had been made to the supervisory body, when any applications had been authorised and the DoLS expiry date. The temporary manager, nurses and care workers we spoke with were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them. The manager was aware of the needs to notify the Care Quality Commission once the application had been approved.

Care workers and nurses had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. A care worker we spoke with confirmed their approach was to always seek a person's consent before providing care to a person. They said, "We always explain to people what we are doing and get their agreement where we can. If they are unable to agree then we talk to them and explain as we carry out the task". and "Like when we're supporting somebody to eat, we always speak to people during the meal to gauge when they have had enough or if they are enjoying the meal". A visiting relative said, "[Persons name] has dementia, sometimes they can tell the staff what they want, other times they can't. Staff always consult me about [Person's name] and how I'd like them to care for [Person's name] when they can't say so themselves". Our observations confirmed this.

We saw the meals served were well presented, looked appetising and were nutritionally balanced. We examined the menu and saw that a variety of meal options were available at different times of the day. We saw people had choices about what they wanted to eat and where required they were assisted or supported to eat their meals or with prompts from care workers. Dining tables were set for each meal time and where people preferred to eat in their rooms they were supported to do so. We saw people were frequently offered a variety of drinks to maintain their hydration and snacks were available throughout the day.

Care records and daily records we examined showed attention was paid to people's dietary requirements and what they ate and drank. We examined people's daily observation and weight records which indicated the type and amount of food people had eaten. This meant people's nutrition and hydration was monitored to ensure their nutritional needs were being met. Care workers, nurses and the cook were aware of the need to follow the speech and language therapist (SALT) instructions. For example making sure that people at risk of choking received a soft or pureed diet. SALT provides treatment support and care for people who have difficulties with communication or with eating, drinking and swallowing.

Care records we examined showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses and general practitioners (GP's). Notes of such visits were included in people's care plans. Other care records showed attention was paid to people's general physical and mental well-being, including risk assessments. For example where people were at risk of developing pressure sores this had been identified and recorded and appropriate health care support, such as a district nurse, was requested. Care records that recorded people's weight, dental and optical checks were also in place and reflected the care being provided to people.

We saw there was sufficient and suitable equipment in place to promote people's mobility such as handrails, hoists and wheelchairs. Appropriate raised seating was provided and pressure relieving equipment were well maintained and in good condition. Corridors were wide enough for wheelchairs and other mobility aids to manoeuvre adequately.

The service maintained a homely environment to enable people's planned activities, routines and lifestyles to be supported effectively by care workers and nurses.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at Appleton Manor and felt they were receiving good care and support from the care workers and nurses. People made positive comments about the care workers team, their approach and their attitude towards them. They said, "They [staff] are like family to me" and "They are very kind" and "They let you get up when you want".

Visiting relatives said, "They [staff] are great, overall they are excellent; they know [Person's name] personally; they know [Person's name] really well" and "Staff are kind considerate and compassionate, they know [Person's name] inside out".

The atmosphere at the home was welcoming and relaxed. We observed good interpersonal relationships between care workers/nurses and people who used the service. Care workers interacted with people well, engaged them in conversations that were interesting and meaningful to them. For example we saw care workers showing warmth and empathy towards people at meal times, when serving meals, asking if they were enjoying their meal and if they had eaten enough at that particular mealtime. Care workers shared friendly conversation with people and we observed them laughing and joking with people whilst supporting them to mobilise around the home within the person's capabilities.

We saw care workers had developed a good rapport and understanding of the people who used the service and treated them and their belongings with respect. For example, we observed a care worker gently reminding a person where they had left their handbag and brought it to them, placing it gently on the persons lap. We could see from the person's facial expression that their belongings were important to them because they expressed relief once they had been given their handbag.

Care workers and nurses had a good knowledge about how to provide care to people and we observed people being given choices for example in relation to meals, drinks, activities, daily living and where they wanted to sit in communal areas. We saw that people were supported and involved in making decisions about their care and we observed care workers gently asking people if they required a 'nice cup of tea' as people sat down to watch a morning television programme.

Care workers were aware of people's personal preferences and this information was contained in people's care records, such as their likes, dislikes, whether people preferred to have a bath or a shower or the time they preferred to get up in the morning. This showed that care workers had a good understanding of the person when providing care and support to them.

When we spoke with two care workers and a nurse about people's individual needs they were able to demonstrate their knowledge about people very well and gave good examples of how people preferred their care and support to be given. We saw these details had been accurately reflected in people's care records.

The temporary manager, nurse and care workers were aware of how to access a local advocacy service to ensure that people were could request independent advice and support when needed. An advocate is a

person who represents people independently of any government body. They are able to assist people in ways such as, acting on their behalf at meetings and/or accessing information for them.

We looked at the home's EoL care policy and procedure which was person centred and geared towards helping the person, and their relatives to have full control about decisions relating to the person's future care and end of life needs. We saw records that confirmed care workers and nurses had undertaken training in this topic. A care worker we spoke with said, "The EoL care training was so good; it brought things into perspective about the care that should be given when people are nearing the end of life".

We were told by the temporary manager that where people living at Appleton Manor were receiving end of life (EoL) care the provider had introduced a document to record any important matters concerns or worries the person or their relatives might have at that time. The provider used a six steps EoL system based around the person's advanced care plan (ACP) and at this stage a discussion would take place to make sure the persons wishes such as room ambiance, medication, hydration/nutrition, personal care needs, pressure area and comfort would be considered and planned. Any additional issues raised would be discussed at a monthly EoL meeting attended by the temporary manager and the home nurses where appropriate.

The meeting would also discuss triggers to highlight areas of decline such as weight loss and pain. We saw that a traffic light system of green, amber and red was in place to identify advancing disease, increasing decline and the last days.

We saw that people's records and any confidential documents were kept securely in secured rooms that could only be accessed by designated staff and no personal information was on display. This ensured that confidentiality of information was maintained.

Good

Is the service responsive?

Our findings

At the last inspection in January 2016 we found that the provider did not ensure that people's care records contained individual personalised information about continence issues. We also found that assessments in relation to people's needs and preferences had not been carried out collaboratively with people and there were breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. At this inspection we found that improvements had been made to meet the requirements of this regulation.

People's needs had been assessed before they moved into Appleton Manor. Needs assessments showed people and their relatives had been included and involved in the assessment process wherever possible. Care records showed that care workers and nurses used information from the initial needs assessment to develop detailed care plans and any support records that would identify people's abilities and the support required to maintain their independence. This meant these records enabled care workers to provide care to people in a person centred way. For example one needs assessment identified a person had a history of falls and records clearly detailed the risks to the person. Written information for care workers and nurses to follow showed that a falls awareness chart was in place which identified the equipment to use to reduce the risk of the person falling, environmental considerations and how to help the person recognise when they were at risk of falling.

People's care records were reviewed, actioned and evaluated monthly or more frequently if the person experienced any health changes. Care reviews help to monitor whether care records were up to date and reflect people's current needs so that any necessary changes could be identified and addressed at an early stage. We saw that care records contained a detailed personal history and gave clear guidance for care workers and nurses to follow in order to support the needs of people who use the service. We looked at records that showed attention was given to people who were at risk of weight loss and instructions for care workers/nurses to follow were clearly documented. A monthly weight management meeting was held to ensure care workers and nurses were aware of any observations that were required in relation to people's weight management.

Care workers and nurses we spoke with were able to demonstrate their understanding about person centred care. They told us that it was important to make sure people's care was delivered to them to help maintain or increase their independence and people should always be included in decisions about their care.

One care worker gave an example of how a person's health had improved since moving into Appleton Manor. They said, "When [Person's name] moved into the home risks were identified in relation to their nutrition and hydration, they were socially isolated and fearful. We [care workers] have worked with [Person's name] their family and their general practitioner to improve their health and wellbeing. We had regular care reviews with their GP and [Person's name] because [Person's name] was resistant to change in relation to their medication which had previously made them drowsy. We also addressed their night continence needs and gradually introduced continence support which has greatly improved the situation

for [Person's name] and has reduced the risk of them developing pressure sores. We also support the person's family by giving them reassurance, and in turn they have helped to develop a really good personal history for [Person's name]. We regularly monitor and record [Person's name's] skin condition and weight and complete a body map when necessary. [Person's name] began to gradually trust us and we can see a great improvement in their interactions with other people, they now join in activities without being prompted by staff".

When we looked at the persons care records we saw that information in relation to the persons care was consistent with what the care worker had told us. This showed that people using the service received additional appropriate support when required to ensure their care and treatment needs were being met.

Activities were organised by an activities coordinator who consulted people individually about their preferences before completing the activities programme. Most activities took place on the first floor of the home where people were living with dementia. The activities coordinator told us that people were supported to take part in hobbies and interests and individual or group daily leisure activities were always provided. We looked at risk assessment that highlighted where there were potential risks when people were involved in particular activities such as leaving the home and involvement in outside activities.

The activities coordinator said, "We are proactive with activities offered. There is always something for everybody because we researched people's interests and hobbies before providing activities. For example, we know that quite a few people enjoy 50's and 60's music so we have booked a visiting singer to attend on a regular basis. I also provide small group activities and meet regularly with other HC-One activity coordinators to share ideas about what activities work and what doesn't work especially with people living with dementia".

On the second inspection day we observed a small group of people taking part in an activity to improve/maintain their hand and eye coordination. After lunch we saw that a large group of people assembled in the lounge to watch the visiting singer. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

The temporary manager told us that whilst some people living on the ground floor of the home were unable to take part in some of the activities provided, because of their health condition, they were provided with additional therapies such as hand and feet massage if they required. This meant people were supported to take part in or receive therapeutic activities combined with the health care already being provided.

People and visiting relatives we spoke with told us they knew how to make a complaint if they had any concerns and guidance telling people how to make a complaint was displayed on notice boards around the home. A complaints policy which allowed for a full investigation into the complaint and for all complaints to be taken seriously was in place. The policy allowed complaints to be escalated to the Local Government Ombudsman if the complainant remained dissatisfied with the outcome. We saw actions to complaints had been recorded and the complaint resolved to the person's satisfaction.

During the inspection we observed the temporary manager speaking with a visiting relative about their relatives lost item. The temporary manager remained patient, showed good listening skills, allayed any concerns the visiting relative had and sought to resolve the concern immediately. Following this we saw that the temporary manager recorded the concern appropriately. We saw that the concern was resolved and concluded to the satisfaction of the visiting relative on the same day.

Another visiting relative we spoke with said, "I don't have any reason to complain, [Person's name] is well

looked after and we can talk to the staff or manager about anything".

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in January 2016 we found that the provider did not have full oversight of people's care plans which contained insufficient detail to provide personalised care and treatment to people and there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection we found that improvements had been made in this area and the provider was now meeting the requirements of the regulation as discussed in the responsive section of this report.

At the last inspection in January 2016 a registered manager was not in place, however a temporary manager had been appointed and had submitted their application to register with the Care Quality Commission (CQC). At this inspection we found that this manager had registered with the CQC but had left the service in May 2017. However we found that a registered manager from another HC-One home located on the same site as Appleton Manor was in place pending the recruitment of a new manager. The provider advised us that steps were being taken to recruit a suitable manager within a reasonable timescale.

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Appleton Manor is registered with the Care Quality Commission (CQC).

A management structure was in place and the provider was committed to providing continuing management support at the home in the absence of a registered manager. The area director visited the service on a monthly basis and reports from these visits were shared with a senior operational management team.

The provider promoted a person centred approach to help make sure people's needs and preferences were met. Discussions with care workers, nurses and people who used the service confirmed management were always present in the home. All of the people we spoke with made positive comments about the temporary management structure and felt their needs were being met by a sufficient number of competent care workers and nurses.

Nurses and care workers we spoke with understood their role and responsibility to the people living in the home. They felt management were supportive and responded well to their needs and those of the people living at Appleton Manor. Care workers spoke very positively about the temporary manager and the culture at Appleton Manor and said, "We've coped well with the recent staff changes and we have good support from [temporary manager's name] It has been really positive" and "[temporary managers name] is very organised, they're on the ball" and "The home has got a good vibe and we are well supported by the manager" and "We [staff] don't mind coming into work, we are doing everything we are supposed to be doing for the people who live here".

People we spoke with made positive comments about the quality of the service and said, "The staff are well trained" and "The staff care about me and support me" and "So far it's been very good care here". Two

visiting relatives said, "The quality of care is very good" and "The staff are lovely people and the overall quality of care is excellent".

We saw records to show that meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about Appleton Manor but also what, if any, improvements could be made. We saw that notes of the meetings were kept to ensure an accurate account of people's verbal contribution was maintained.

The temporary manager of the home completed clinical indicators audits which provides comparative information for the National Health Service (NHS) Clinical Commissioning Group (CCG) about the quality of the service at Appleton Manor. We examined the two most recent clinical indicator summary reports from May and April 2017. The reports highlighted the number of hospital admissions, people's weight loss, the number of people who require bed rails, the number of modified diets, infections, deaths, falls and pressure sores. The clinical indicators report indicated any patterns that emerged were reported, analysed and actions taken were recorded. The results of the reports were shared with an internal HC-One clinical indicators team in order to identify the action required to address any issues prior to the next monthly audit.

In addition to this the temporary manager completed a National Health Service (NHS) continuing health care (CHC) records which also informed the clinical indicators report. CHC is a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals who have significant ongoing health care needs. We saw records to show that the temporary manager had already addressed and actioned any identified issues to make sure there was no delay in maintaining or improving the health, safety and welfare of people using the service.

We examined records from the most recent quality inspection undertaken by an internal quality inspector. These inspections identified good practice and where improvements were required. The temporary manager undertook twice daily walk arounds in the home to check and record on people's health and safety and the safety of the environment. This showed that the provider carried out checks to ensure oversight of service delivery and the quality of the service. This ensured appropriate remedial action would be taken to address any identified issues in a timely way to ensure people received a safe and good quality service. Daily flash (handover) meetings were operating to ensure staff had the relevant information they needed to support people safely and effectively.

A business contingency plan was in place which identified potential risks and threats to service provision and the provider's actions should they occur in order to ensure continuity of the service for people.

The temporary manager shared with us copies of the various organisational policies and procedures such as, complaints and suggestions, safeguarding, accidents and incidents, medicines management and staff recruitment. Policies and procedures help the provider to guide the actions of all individuals involved in the service. They provide consistency in all practices carried out in the home. Policies we looked at had been reviewed regularly and a future policy review date had been planned.

We checked our records before the inspection and saw that accidents and incidents that the Care Quality Commission needed to be informed about had been notified to us by the registered provider. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

In June 2017 HC-One People Development Programmes was awarded the Skills for Care 'Centre of Excellence' status. This was in recognition for HC-One's commitment to staff development and delivering

best practice in-house staff learning and development programmes and opportunities.

The registered provider recognised staffs caring attributes through observations of staff practices and behaviours and operated an employee reward scheme to acknowledge staff loyalty. This helped the staff team to feel valued and maintain a good standard of care.