Trinity Merchants Limited

Kara House Residential Care Home

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 18 and 19 April 2017 and was unannounced. The service was last inspected in February 2016 when it was rated as Requires Improvement.

Kara House is a care home registered to provide personal care and accommodation to 35 older people. At the time of our inspection there were 32 people living at the service. The home has two shared rooms, one of which two people shared.

One of the directors of the provider (Trinity Merchants Ltd) was managing the service after the registered manager had left in November 2016. They were in the process of being registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had previous experience of managing care homes registered with the CQC.

Since January 2017 a senior carer had been given additional responsibilities at the service. They were supernumerary to the shift and completed audits and updated care plans.

People received their tablets as prescribed and the medicines administration records were fully completed. However, we noted two people had been prescribed two creams, one to be applied twice per day and one three times a day, the cream charts indicated they had been both applied three times a day. Guidelines for creams that had been prescribed 'as required' were not in place. These were immediately changed and implemented following our inspection.

We found improvements had been made since our last inspection. An activities officer had been employed who organised regular group activities and worked with some people on a 1:1 basis. The home had been re-decorated and was now more homely, with new pictures on the walls and notice boards with reminiscence items in the hallway. Record keeping was more thorough, with the food and fluid charts now being fully completed.

A comprehensive range of audits and monitoring was in place, completed by the senior with extra responsibilities and reviewed by the manager. However these had not identified the issues we found with the cream charts and 'as required' guidelines. We saw issues that had been identified in the audits had been recorded and actions put in place.

All the people we spoke with said they felt safe living at Kara House and that the staff were kind, respectful and knew their needs well. We heard and saw positive interactions between people and staff members throughout the inspection.

There were sufficient staff on duty to meet people's needs, however some people said they had to wait longer for staff to support them at a weekend.

A safe system of recruitment was in place, although the gaps in employment for one new staff member had not been explained. After the inspection the manager told us they had obtained this information. An induction process was in place where new staff shadowed experienced staff so they could get to know people and their needs. Training was arranged and staff who were new to care were enrolled on the Care Certificate. Refresher training was up to date for existing staff. 90% of staff had obtained a recognised qualification in health and social care. The manager completed staff supervisions and regular staff meetings were held. This meant staff had the training and support to undertake their roles.

Care plans and risk assessments were in place for each person. These recorded their health and social care needs and provided staff with guidance on how to support people and mitigate any risks that had been identified. Care plans and risk assessments were evaluated each month by the senior care staff and updated for any changes in people's needs.

Handovers were held between each shift to update the staff on any changes in people's needs or health. This meant staff had the information to support people and meet their needs.

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards procedures. Capacity assessments and best interest decisions had been completed and applications for a DoLS made to the local authority where required. People confirmed the staff gave them choices over day to day decisions and supported them to complete the tasks they could do for themselves so that they maintained their independence.

Incidents and accidents were recorded and analysed to identify any patterns; for example falls. We saw referrals to the falls team or dementia crisis team were made where required.

Systems were in place to meet people's health and nutritional needs. People were regularly weighed in line with the assessed risk and referrals made to the Speech and Language Team (SALT), district nurses and other medical professionals as needed. Medical professionals told us the service made appropriate referrals and followed any advice they were given.

People's end of life wishes were currently sought as they became unwell, with the person's family being involved. Additional training in the 'Six Steps' for end of life care had been arranged for two staff. They would lead on developing care plans with people and their families before they became unwell so their wishes for their care at the end of their lives was known.

A medical professional told us the end of life care provided at Kara House was good, with some people's health improving so they were able to come off the end of life pathway.

All areas of the home were clean. Procedures were in place to prevent and control the spread of infection.

Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply. Regular checks were in place of the fire systems and equipment.

Regular resident meetings were held where people were asked for their feedback on the service. Relatives told us the staff and manager were approachable and they would raise any concerns they had directly with the staff. They said their concerns were acted upon by the staff team. Relatives also told us the service kept

them fully informed about any changes in their loved ones health or wellbeing.

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.

Oral medication was administered as prescribed. However guidelines for 'as required' medicines and creams were not always in place and the records showed some creams had been applied more frequently than prescribed. New guidelines and cream charts were written immediately after our inspection.

A safe system of staff recruitment was in place. However, one of the three files we looked at did not contain details of a gap in the staff member's employment history. This information was obtained following our inspection.

Staff had received training in safeguarding vulnerable adults and knew the correct action to take if they witness or suspect abuse. We saw referrals to the local authority safeguarding team had been made appropriately

Care records included information about the risks people may face and guidelines for staff in how to minimise or eliminate the risks.

Is the service effective?

Good

The service was effective.

Staff received the training and support through supervisions to undertake their role.

The home worked within the principles of the Mental Capacity Act (MCA). Staff had a good understanding of the MCA and Deprivation of Liberty Safeguards so that people's right were protected when they lacked capacity to consent to their care and treatment.

People's nutrition and health needs were identified and referrals to other medical professionals were made when required. Food and fluid charts had been improved since the last inspection.

Improvements had been made to the environment to support people living with dementia.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives all said that the staff were kind and caring and knew their needs well.

End of life care plans were implemented when people were approaching the end of their lives. Additional staff training had been planned to improve the recording of people's wishes and their care at the end of their lives.

Is the service responsive?

Good

The service was responsive.

An activities organiser had been recruited and they provided regular activities for people to join in with if they wanted which would help maintain people's wellbeing.

Care plans were person centred and included details of people's support needs and guidelines for staff in how to support people to meet these needs.

Daily records, including details of any behaviours that challenged the service were detailed and fully completed. However we found the personal care charts were not always fully completed.

Is the service well-led?

Requires Improvement

The service was not always well led.

A director of the provider organisation was managing the service and was in the process of registering with the Care Quality Commission.

A senior with extra responsibilities had been introduced. They completed a comprehensive system of audits; however issues we found with the medicines had not been identified through the audits.

Regular staff meetings were held, which had noted an improvement in staff morale since the manager took over in November 2016.

Kara House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 19 April 2017 and the first day was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. One inspector returned for the second day of the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people, four relatives, the registered manager, the senior with extra responsibilities and six care staff. We observed the way people were supported in communal areas and looked at records

relating to the service. This included three care records, three staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

All the people who used the service and their relatives we spoke with said they thought Kara House was a safe place to live. People told us, "Staff keep us safe", "I had a number of falls in my previous flat; I feel I am safer here." A relative said, "[Name] is safe, warm, well fed and looked after here."

At the last inspection in February 2016 we found a breach in Regulations due to the discrepancies in a number of 'as required' medicines in stock and the recorded quantity. Cream charts were not clear as to the number of times the creams were to be applied, resulting in a variation in the frequency the creams were applied and the dates creams were opened not being recorded.

At this inspection we saw the medicine administration records (MARs) had been fully completed for people's prescribed medicines. The quantity of medicines held corresponded with the amount recorded on the MAR. This meant people received their medicines as prescribed.

At this inspection we found new topical cream charts had been introduced. These gave clear directions as to the frequency the creams needed to be applied. Information was also given as to where the creams were to be applied, for example to people's legs or lower back. However we saw one person's cream did not contain this detail. The body maps on the charts were not used. For some people the body maps would provide more detailed guidance as to where the creams were to be applied, for example which part of the person's legs the cream is required. The senior carer said they would indicate this on the body maps where this detail was needed.

We saw two people had two different topical creams prescribed, one to be applied twice a day and one to be applied three times a day. The cream charts had been signed three times a day for both creams. This meant one of the creams may have been applied more frequently than prescribed, which could place people's health and wellbeing at risk of harm. Immediately following our inspection the topical cream charts were re-designed making it clear which creams were to be applied and at what time. This should help ensure creams were applied as prescribed.

We noted that creams that had been prescribed to be used 'as required' (PRN) did not have guidelines in place as to when they should be used. This meant staff may not know when the creams were needed and when they did not need to be used.

We saw there were PRN guidelines in place for most prescribed tablets, however we saw one person did not have any guidelines for the two PRN medicines they were prescribed. One person's PRN guidelines stated they were able to say if they needed the PRN medicine, however their care plan stated they may tell staff they 'are ok' as they want to be left alone. At these times staff needed to monitor for any signs of discomfort. This meant the PRN guidelines did not reflect the assessed need as per the care plan.

Immediately following our inspection PRN guidelines were written for all medicines and creams. Information was also recorded how the person would inform staff they required a PRN medicine, either

verbally or non-verbally, including body language or facial expressions.

We will check that the new cream charts and PRN guidelines have been embedded into the homes practice at our next inspection.

We saw a monthly medicines audit was completed using the local authority monitoring tool. The stock balance for ten medicines were checked as well as ensuring the MAR had been signed as required. The senior with extra responsibilities said they followed up any discrepancies with the relevant staff. However the audits had not identified the issues we found.

All the creams we checked had been dated when opened. Creams efficacy reduces if they are opened longer than the manufactured specifies. This meant that the creams could be disposed of as recommended by the manufacturer.

Medicines classed as controlled drugs were appropriately stored and recorded and a weekly stock check was completed. This minimised the risk of errors or misuse.

We saw all senior staff members had received training in the administration of medicines. Night care staff had also been trained so they could administer PRN medication people required during the night. We were told observations of staff administering medicines had been completed by the previous registered manager, however records of these were not available. The current manager said they were going to complete observations for all staff who administered medicines. This meant staff had the knowledge to safely administer medicines.

Staff were aware of what may constitute abuse and the procedures in place to protect people from harm. Staff were clear that they would report any concerns to the senior care staff or the manager and were confident they would act on their concerns. All staff had received training in safeguarding vulnerable adults. We saw that a safeguarding concern had recently been raised concerning some visitors to the home and had been reported appropriately. A protection plan had been implemented. This showed the service responded when safeguarding risks were identified and plans were put in place to protect people from harm.

We saw people's care records identified risks to their health and wellbeing, including the risk of falls, moving and handling, pressure ulcers and mal-nutrition using the Malnutrition Universal Screening Tool (MUST). We saw these were evaluated on a monthly basis and appropriate care plans were developed to mitigate the identified risks. We noted that where required a plan was in place to support people if they became anxious or agitated. Guidelines were in place for staff to follow to de-escalate the situation. All such incidents were recorded with details of any potential triggers to the behaviour and how the situation was resolved. One relative said, "Staff always have a way of distracting [name] when he becomes challenging."

We looked at three personnel files for staff who had been recently recruited. We found that they contained application forms detailing their previous employment histories, two references and showed appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. However we noted one person had a gap in their employment. The application form requested details of any gaps in people's employment record, but the reason for the gap had not been recorded. Another application form had recorded the reason for a gap in the employee's employment history. The manager told us they would establish the reason and record it on the employee's personnel file. Following the inspection the registered manager confirmed that this information had been obtained. This meant that the service had a system in place for recruiting staff who were suitable to work with vulnerable people, however for one staff member full details of their employment

history had not been obtained.

From the rotas we saw there were six staff members on duty in a morning which included two senior staff members. In the afternoon there were five care staff which included one senior staff member. There were three staff on duty at night. People, relatives and staff said they thought this was sufficient to meet people's needs. One relative said, "There's always staff about, they cope very well with everybody." We noted from the rota there were sometimes five staff on duty in the morning at weekends. One person we spoke with commented that they had to wait longer at weekends for staff to support them than during the week. We saw that a regular agency staff member was required to cover the night shift. The same agency staff were used to try to ensure continuity of care. During the day agency staff were only required to cover staff annual leave or sickness. During our inspection we noted that people's needs were addressed promptly and call bells answered in a timely manner. This meant there were enough staff on duty to meet people's needs, although at weekends people had to wait longer for support.

Incidents and accidents were recorded and 48 hour monitoring following an incident or fall was completed. All incidents and accidents were reviewed by the manager. We saw the incident forms contained full details of what had occurred and what action had been taken by the staff. The manger noted on the forms if the local authority safeguarding team and the Care Quality Commission had been notified of the incident. A monthly summary of all incidents was produced, including any actions taken, for example referrals to the falls team, so the manager could monitor any patterns or repeated issues. Risk assessments were reviewed following an incident or fall. This meant the staff had an overview of accidents and incidents and steps were put in place to reduce the likelihood of them re-occurring.

We saw that the home was clean and tidy throughout, with no mal-odour present. Our observations during the inspection showed that staff used personal protective equipment (PPE) such as gloves and aprons appropriately when carrying out tasks. An infection control audit had been completed by the local authority in February 2017 and the service had been rated as 'amber' (some risk) overall. We saw that an action plan had been agreed to address the issues raised by the audit which was in the process of being completed.

We checked the systems that were in place to protect people in the event of an emergency. We found personal emergency evacuation plans (PEEPs) had been written for people who used the service. These contained details of the support a person would need to leave the building in the event of an emergency. Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak.

The service held records of weekly and monthly tests completed for the fire alarm, fire extinguishers and the water systems. Fire drills were held each month. A fire risk assessment had been completed by an external contractor following which the home had started checking the emergency lighting was fully operational each month. Records showed the equipment within the home had been serviced and maintained in accordance with the manufacturer's instructions. This should help to ensure that people were kept safe.

Good

Is the service effective?

Our findings

People we spoke with and their relatives were positive about the care and support at Kara House. Relatives said they were kept up to date with information regarding their loved one. One relative told us, "They ring me up all the time if something happens; [name] was in a lot of pain last week and they let me know."

Staff told us they completed an induction when they started working at the service. This included shadowing experienced staff as a supernumerary member of staff and completing mandatory training in moving and handling, safeguarding, fire awareness and food hygiene. Staff who were new to working in care were also enrolled on the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

We looked at the training provided for existing staff and saw that refresher training was kept up to date. On-line training courses were used which included a set of questions at the end of the course to check staff understanding. Staff confirmed they were reminded by the manager when their training was due for renewal. Practical training for manual handling was provided by in house staff who had been trained to train their colleagues. We noted that 90% of the staff team had achieved a nationally recognised qualification in health and social care. New staff were enrolled onto the nationally recognised qualification when they had completed the Care Certificate.

Staff told us they had regular supervisions with the manager and felt well supported. They said they were able to speak with the senior with extra responsibilities, senior staff or manager whenever they needed to. Records showed the manager had held supervisions with staff since they had started to manage the service. There had been a six month gap in supervisions prior to this. The manager told us they planned to complete supervisions with staff every three months.

This meant the staff received the training and support to undertake their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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 manager and staff we spoke with had a good understanding of the MCA and DoLS and were able to

explain why DoLS were in place for some people. A list of all people who had an authorised DoLS in place and people where an application for DoLS had been made and was waiting for authorisation by the local authority was available in the staff office.

The service used the local authority capacity assessment form to assess people's capacity. Where required the local authority best interest forms were used to make decisions on people's behalf, for example for the use of bed rails to reduce the risk of a person falling out of bed. These showed that families and professionals were consulted about the decision being made.

The manager kept a tracker matrix of when DoLS applications had been made, when a best interest assessor had visited the home and when an authorised DoLS was due to expire. The Care Quality Commission was notified of all DoLS when they had been authorised.

Some care plans referred to a relative having a Lasting Power of Attorney (LPA). An LPA is a legal document which allows a named person to make decisions in a person's best interest if they lack the capacity to make the decision in question themselves. The manager was requesting copies of the LPA's so the home had proof of who was able to make which decisions on a person's behalf.

We noted that consent forms, including for the care plans, staff administration of medicines, use of photographs had been signed by people's relatives if they were unable to sign the form themselves. Unless a relative has a LPA in place they are not able to sign consent on behalf of their loved one. However it is important that relatives are involved in developing people's care plans and in their care. We discussed this with the manager who said they will change the form to state people are signing their consent if they have capacity or are the LPA or are signing their agreement otherwise.

We observed staff seeking people's agreement before providing support during our inspection. Staff also explained how they provided people with choices about their day to day lives, for example what clothes to wear, what they wanted to eat and what time they wanted to get up. This meant the service was meeting the requirements of the MCA.

We observed the handover for the incoming afternoon staff. The senior carer gave an update on each person. This information was also written on a handover sheet for reference. This provided the staff starting their shift with brief details of each person's wellbeing and if they needed additional observations or support due to being unwell or there being a change in their needs. Any appointments in the diary for the home were also discussed during the handover so all staff were aware if there were any planned visits, for example by the GP or district nurse. One person had a hospital appointment to attend; a member of staff was allocated to support them to this appointment during the handover. Staff told us that when they returned from an extended period off work, for example following annual leave, they asked the senior with extra responsibilities or senior carer and their colleagues about any changes in people's support needs.

This meant staff were provided with up to date information about each person's wellbeing so they were able to provide the appropriate support.

We looked at how people were protected from poor nutrition and supported with eating and drinking. The care records we looked at all contained a risk assessment regarding people's nutritional intake. Where people were at risk they had been referred to a dietician or the Speech and Language Team (SALT). Appropriate food supplements were prescribed and offered. Regular checks were made on people's weight. At the last inspection we found the food and fluid charts were not always accurately completed. At this inspection we saw new food and fluid charts had been introduced and they had been fully completed.

These were checked each week by senior with extra responsibilities to look if there was a pattern of reduced intake and that referrals to the SALT had been made where required.

We observed the lunchtime experience in the dining room and also for those people who ate in the lounge areas of the home. We saw the meal time was well organised and people were offered a choice of food. People were supported to eat their food where required. We saw one person did not eat much of their meal and were offered an alternative meal which they accepted. We noted there were sufficient staff in the dining area and lounge area to support people during the meal. People were complimentary about the food at Kara House. We were told, "I like my food, I can always ask for more and staff will give it to me" and "We are well fed; I've put on weight since I came to live here." A relative told us, "The food's definitely right; it's old fashioned food with plenty of veg and potatoes."

The chef was knowledgeable about individual people's needs for a soft, pureed or fortified diet and had a list of people's requirements in the kitchen. The care staff informed them if a person's dietary requirements changed. We saw a separate pudding had been prepared for one person who was diagnosed as being diabetic. The most recent inspection from the environmental health department in January 2017 had awarded the service a 4 (Good) rating. The issues highlighted during this environmental health department inspection had already been addressed by the home.

This meant people's nutritional needs were being met by the service.

Each person was registered with a GP. We saw referrals had been made to district nurses, the dementia crisis team and other medical professionals when required. This meant that people's health needs were being met. One health care professional told us that the home made appropriate referrals to them, followed the advice provided and the staff had all the information they required ready for them when they visited. They said, "We have advised the staff about good hygiene and applying cream so they can now do this to protect a skin tear until we make our regular visit to Kara."

We saw that people at risk of developing pressure sores had the appropriate pressure relief mattresses in place and records were kept of when people were supported to re-position. A medical professional told us, "People's pressure area care needs are met; if specialist equipment is needed they involve us." This meant the people's health needs were being met by the service.

Kara House supports people who are living with dementia. At the last inspection we made a recommendation about planning the environment for people living with dementia. We saw improvements had been made. The home had been re-decorated and new pictures purchased for the lounge. Each person had their picture on their door which may assist them to orientate themselves within the home. New calendars had been purchased for the lounge which displayed the day and date as well as the time. Notice boards with reminiscence items were located in the hall area. Bathroom doors were painted bright yellow so they stood out and people could locate them. The dining tables were set with tablecloths and condiments were available. The rear garden of the home was well maintained and was accessible for people to sit out in when the weather was nice. One relative said, "It's much more homely now."

Good

Is the service caring?

Our findings

All the people we spoke with said the staff were respectful, kind and caring. We were told, "Staff are very nice people; very respectful" and "Staff seem to be doing their job alright, you know they are caring and respectful." Relatives said, "The staff are all pleasant, welcoming and approachable" and, "Staff are so helpful all the time."

The staff we spoke with all knew the people who used the service and their needs. They were able to describe the support people needed and their likes and dislikes. Staff were able to explain the support needs of one person who had recently moved to the service. One relative told us, "All the staff know [name's] needs. Their personal care needs has increased recently and they are being met." However two people told us that when agency staff worked, especially at a weekend, they did not know people as well. As previously noted in this report agency staff were not regularly used during the day.

Each person had a 'This is Me' document in their care files. The service asked people and their families, where appropriate, to provide details of their lives, for example their family, the jobs they had and any hobbies they had enjoyed. This meant staff had the information about people and their lives to be able to form meaningful relationships with them.

We saw and heard good interactions between people who used the service and staff members throughout our inspection. We also observed staff members supporting people with hoist transfers. This was completed calmly and they made the person feel reassured as they explained each step of the transfer.

Staff members addressed people by their preferred names. Staff discreetly prompted people with their personal care needs. Everyone we saw was well dressed. At the time of our inspection there was one shared room at the home. Staff explained how they maintained people's privacy and dignity by using a dividing curtain in the room.

This meant staff maintained people's dignity and privacy and supported them with respect. One person said, "Staff are very nice people; very respectful."

We saw staff members encouraged people to complete tasks themselves to maintain their independence. For example encouraging people to eat themselves. Staff also described how they encouraged people to complete any personal care task they are able to do for themselves and don't do everything for them. One relative told us, "[Name] likes to do most things for himself."

People's care plans contained information about people's cultural beliefs. We saw that one person had been visited by the local priest and had had communion. This meant people's cultural needs were being met by the service.

We saw people's care plans were stored in the staff office and staff records were stored in the manager's office. This meant people's confidential information was securely stored. However we saw the medicines

administration records (MARs) were kept with the medicines trolleys in the dining area of the home. This meant it was possible for people or their relatives to access the MARs. We recommend the MARs are stored in a secure location when not being used to maintain people's confidentiality.

We saw that people's end of life care plans were not completed until they became unwell. The manager would then discuss their wishes with the person if they were able to, however more often with their relatives. This meant people's wishes for their care at the end of their lives was not established when they were well and were potentially more able to inform the home what their wishes were.

We saw one person had an end of life care plan in place at the time of our inspection. This detailed the personal care, pressure area care and food and fluids support the person needed. It also indicated the signs that the person may be in pain, for example facial expressions. Anticipatory drugs had been prescribed so they were available if required. The person's family had been involved in the care plan and had stated they would prefer for their loved one to remain at Kara House rather than going to hospital. Details of the person's funeral wishes were noted. This meant information about people's wishes for their care at the end of their lives was obtained when it was required.

A medical professional we spoke with said the home supported people well with palliative care at the end of their lives. They said, "People are looked after safely in bed and some people's health has improved so they have come off the end of life pathway."

We saw a third of the staff team had completed on line training in end of life care. The manager had enrolled two staff to complete the 'Six Steps' end of life programme. The Six Steps is a recognised programme to improve end of life care within care homes. Part of the Six Steps is discussing with people their wishes for their care and support at the end of their lives and completing an advanced care plan to record these wishes. The same staff had also been enrolled on courses for nutrition, spirituality and managing breathlessness for palliative care. This meant the manager had plans in place to improve the training in end of life care and then to discuss people's wishes with them and their relatives. This should enable the home to provide the appropriate support that people want at the end of their lives.

Good

Is the service responsive?

Our findings

At the last inspection we found there were limited activities organised at the home. At this inspection we found improvements had been made. An activities officer had been recruited who worked five days each week. They told us they did not have a weekly plan of activities as they had found that often people, on the day, did not want to do what the planned activity had been. They therefore asked people what they wanted to do each day. They visited people in their own rooms on a 1:1 basis as required and went out locally with people if they wanted to. We saw the activities officer arranged games, quizzes, music sessions and parties for people's birthdays. An arm chair exercise session was also arranged every fortnight. People told us, "[Activity Officer] is good for us, he keeps us busy", and "Oh we love a bit of bingo!"

We also saw staff interacting socially with people throughout our inspection, especially in the afternoon. This meant the service provided regular activities for people to join in with if they wanted which would help maintain people's wellbeing.

We looked at three care plans in detail and saw they were written in a person centred way. They contained details about people's health and social care needs and gave guidance to staff in how to meet these needs, for example mobility, communication, sleeping and relationships.

The manager said they completed an initial assessment of need for people who were moving to the home. Staff confirmed this was made available to them before the person moved in so they were aware of their needs. Detailed care plans were then developed as the staff got to know the person. The manager wrote the care plans with input from the staff team. One staff member told us, "[Manager] will ask for staff input as we get to know them well."

Relatives we spoke with said they had been involved in developing their loved ones care plans when they had first moved to the home. One said, "I went through the care plans; they are on the ball with that."

The care plans were evaluated each month by the senior care staff members and any changes in people's needs noted. One staff member said, "We let [senior with extra responsibilities] know if anyone's needs change and they will update the care plans."

At the last inspection we found the daily records for one person whose behaviour challenged the service were not fully completed. At this inspection we found the daily notes were detailed and record keeping for any behaviour the service found challenging had improved. This meant the service was able to review the care plans with all the relevant information being available. However we found the personal care charts were not always fully completed. All the staff we spoke with knew people's personal care needs well, but were not evidencing the support they provided. The senior with extra responsibilities told us they would address this with the staff team.

Relatives we spoke with told us the staff team kept them informed of any changes in their loved ones health or needs. One relative said, "Staff are very approachable, very attentive. They do give you a lot of feedback."

A medical professional we spoke with told us the home were quick to respond to any issues and had measures in place to manage people's behaviours where appropriate. They said they had held an education session for the staff team about managing people's behaviour and had found the staff already had a good baseline knowledge. They said the home provided them with all the relevant information when they visited.

At the last inspection we saw the care files were stored in the then registered manager's office in the basement of the building, which meant they were not accessible to the staff team. At this inspection we saw a staff office had been created on the ground floor and all care files were kept in this office. This meant the staff team could access the files when they needed to.

Kara House is a residential service; therefore if people's needs changed they may require a service that provides nursing care. If people's needs increase when they are living at the home referrals are made to the relevant health professionals; for example the dementia crisis team. If Kara House is not able to meet the changing needs of the person the person's social worker, family and medical professionals, for example district nurses, are involved in a re-assessment of the person's needs. Where applicable the home supports the person to move to another service by providing access to the person's care files. This should help people transition to a service that is able to meet their increased needs.

We saw regular residents meetings were held and people were asked about the food at the home, activities they would like to do, the décor of the home, staff support and if they had any concerns. People also said they would talk to the staff or manager directly if they needed to. Relatives also told us they would speak with staff directly if they had a concern. One relative said, "I talk to the staff and they will sort anything out for me." We saw there had been no formal complaints made since our last inspection. This meant the service responded to concerns when they were made which prevented issues escalating to a formal complaint.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had left Kara House in November 2016. The director of Trinity Merchants (the provider) was managing the service and was in the process of registering with the Care Quality Commission (CQC). They had prior experience of managing residential homes registered with the CQC.

The manager told us they planned to introduce a deputy manager role to the home. Since January 2017 one of the senior carers had been undertaking the role as the senior with extra responsibilities and had been made supernumerary to the rota. The senior with extra responsibilities completed the audits and updated people's care plans as required.

At the last inspection in February 2016 we found the quality assurance systems in place were not sufficiently robust and issues identified in the audits had not been actioned. At this inspection we found improvements had been made.

The senior with extra responsibilities had developed the auditing and monitoring systems in place at the home. These included weekly checks of personal care sheets, food and fluid charts, pressure mattress checks, senior carers' end of shift checks, daily logs, handover sheets, medication and cream charts. All audits were recorded and the information scanned and stored electronically. We saw the senior with extra responsibilities ensured the relevant information had been completed and monitored for any changes in people's needs; for example a pattern of people not eating as much as they used to. Actions to be completed, for example contacting the GP or dietician, were noted and checked that they had been completed.

The senior with extra responsibilities checked that care plans had been evaluated by the senior carers and updated where required. They also checked that all recording sheets had been completed, for example when a GP had visited a person that this was recorded in their care file. They also completed a health and safety walkthrough of the home each day they worked to check corridors were kept clear, the home was clean and there were no odours present and observing that the staff were working safely. Comments were made and any action taken recorded.

The results of the audits were sent to the manager for their information and review. This meant the home had developed a comprehensive set of audits and monitoring systems. However the audits had not highlighted the issues we mentioned previously in this report about the lack of 'as required' medicines guidelines for some people and cream charts and personal care charts not being completed correctly. These issues had immediately been remedied by the home. We will check the audits have bedded into the service and are robust at our next inspection.

Staff members told us that the new manager was approachable and staff morale had improved. They said communication within the staff team had improved and they felt more involved in organising and planning people's care and support. We were told, "I feel a lot more involved now, we support each other as a team and the seniors and manager back us up", "Information sharing and communication is good now; the

manager will listen and discuss things with us" and "Things are more organised and thorough now."

Two staff meetings had been held when the registered manager had left the service to discuss the roles of the staff team and how the manager wanted to move the service forward. The second meeting noted that staff morale had improved. Separate meetings were held for night staff, seniors and the domestic staff so topics relevant to each group could be discussed. Staff meetings were now held every three months. Staff told us they were able to raise any ideas or concerns at these meetings and felt that these were listened to and openly discussed within the team.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.