Amore Elderly Care Limited

Charles Court Care Home

Inspection report

The Ploughman
Hereford
Herefordshire
HR2 6GG

Tel: 01432374330
Website: www.priorygroup.com

Date of inspection visit:
13 July 2017
18 July 2017

Date of publication:
08 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 13 July 2017, with a further announced visit on the 18 July 2017.

Charles Court Care Home provides accommodation, nursing and personal care to a maximum of 76 people, divided over two floors. At the time of our inspection there were 60 people living at the home.

There was no registered manager in post at the time of our inspection. A new manager had been appointed by the provider, who confirmed to us their intention to register 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.

We previously carried out an unannounced comprehensive inspection of this service on 4 and 10 January 2017. During that inspection we identified two breaches of legal requirements in relation to staffing and governance. The provider was judged as requiring to make improvements in safe, effective, caring, responsive and well-led domains. After the inspection, the provider wrote to us to say what action they would take to meet legal requirements in relation to the breaches of regulation. We undertook this comprehensive inspection to check that the provider was now meeting their legal requirements and to respond to concerns we had received regarding the quality of care being provided at the home. During this inspection, the provider also confirmed to us that their voluntary embargo on new admissions would continue until further improvements had been made.

During this inspection we identified one breach under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). You can see what action we told the provider to take at the back of the full version of the report.

In January 2017, we identified a breach of regulation in relation to how the provider had failed to effectively assess, monitor and improve the quality and safety of services provided. Though we saw improvements had been made, the provider had still failed in some areas to address poor practice and ensure accurate record keeping as part of their governance overview.

We found care plans did not always address people's medical needs. End of life care plans were not always updated to reflect people's wishes. Pre-admission assessments had not always been fully completed. Charts monitoring the application of prescribed creams, re-positioning, mattress and bedrail checks were either not completed or completed inconsistently. Life stories had not always been completed for people and some care plans did not reflect people or their families wishes following a review.

Risks associated with people's care and support had not always been appropriately assessed and recorded.

People were supported by staff who knew how to keep them safe. Staff knew what abuse was and how to respond if they suspected abuse.

There was enough staff available to meet the needs of people and keep them safe. Most people felt there were enough staff to meet their individual needs.

The management and administration of medicines was safe.

Staff were trained and provided with support so they could deliver care that met people's needs.

Most staff understood the Deprivation of Liberty Safeguards and followed legal requirements in relation to the MCA.

People were provided with food and drink, which supported them to maintain a healthy diet.

People were treated with kindness and respect. Staff respected people's own decisions and encouraged them to make choices in their care.

People were supported to take part in daily activities.

People knew how to make a complaint.

People and staff told us that improvements had been made by the provider.

People and staff felt that the home manager was approachable and supportive.

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.

Risks associated with people's care and support had not always been appropriately assessed and recorded.

People were supported by staff who knew how to keep them safe. Staff knew what abuse was and how to respond if they suspected abuse.

There was enough staff available to meet the needs of people and keep them safe. Most people felt there were enough staff to meet their individual needs.

The management and administration of medicines was safe.

Is the service effective?

Requires Improvement

The service was effective.

Staff were trained and provided with support so they could deliver care that met people's needs.

Most staff understood the Deprivation of Liberty Safeguards and followed legal requirements in relation to the MCA.

People were provided with food and drink, which supported them to maintain a healthy diet.

People had access to external healthcare professionals when they needed them.

Is the service caring?

Good

The service was caring

People were treated with kindness and respect.

Staff respected people's own decisions and encouraged them to make choices in their care.

People were involved in planning and reviewing their care and

support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs and wishes were not always being supported. Care plans did not always contain relevant and detailed information about the care people required.

People were supported to take part in daily activities.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance systems in place to monitor the quality of service provision were not always effective.

People and staff told us that improvements had been made by the provider.

People and staff felt that the manager was approachable and supportive.

Charles Court 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 checked 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 was an unannounced inspection carried out on the 13 July 2017, with a further announced visit on the 18 July 2017. The inspection was carried out by two inspectors, a specialist advisor in nursing, and two experts by experience. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection. The specialist advisor was a nurse with experience in nursing care for the elderly. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also asked the local authority and the Herefordshire Clinical Commissioning Group for any information they had, which would aid our inspection. We received information highlighting concerns regarding the quality of care delivered at the home.

At the time of our inspection there were 60 people living at the home. There were 28 people living on the nursing unit situated on the first floor and 32 people on the ground floor in the dementia unit. During the inspection, we spoke with 12 people who used the service and 19 visiting relatives and friends. We were also handed written comments by a visiting relative. We also spoke with an emergency care practitioner, who was visiting the home.

We also spoke with the home manager, Operations Director, Quality Improvement Lead, the clinical lead for the dementia unit, four nurses, one agency nurse, three senior members of care staff, five care staff, the chef, and two activity coordinators.

Throughout both days, we observed care and treatment being delivered in communal areas that included

lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. As part of the inspection, we spent time with people in the communal areas of the home. Many of the people we spoke with were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between staff and people who used the service. Some people were unable to speak to us, so we used the Short Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received.

We reviewed a range of records about people's care and how the home was managed. These included ten care files, 12 medicine administration record (MAR) sheets, quality assurance audits and minutes from resident and staff meetings. We also looked at five staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us they were confident that they or their family members were safe and well cared for. One relative told us, "My relative is well-looked after here, I have absolutely no concerns for their safety. The staff can't do enough for them." Another relative said, "It's excellent. I've no complaints at all. My relative was in another home for a short time. Here is so much brighter and the staff are very pleasant, and they can't do enough for you. My relative has had a lot of problems in the past, but they seem to cope with them here." A third relative who visited the home on a daily basis told us, "I can't fault it. When someone gets upset, they just deal with them. I love coming here. A lot of residents don't get any visitors, so the staff make up for it. The former registered manager was poor, things have improved 100% since the new home manager arrived. It's a much calmer environment and residents and visitors can relax more."

Staff were aware of the risks associated with people's needs. There were individual risk assessments in place to ensure people were safe. These included the risk of falls, choking, malnutrition and dehydration, skin integrity, moving and handling. These provided measures for staff to take to minimise the risk of harm to people. However, risks associated with people's care and support had not always been appropriately assessed and recorded. This meant staff were not provided with a full picture of the severity of risk people faced. For example, a 'waterlow risk assessment,' which is a tool used to assess the risk of developing a pressure ulcer, had not been calculated correctly. This had the potential to increase the risk of pressure ulcers due to the lack of staff intervention. One 'falls risk assessment' we looked at stated the person was high risk of falls. However, the care plan did not provide guidance on what preventative measures could be taken by staff.

We saw one person being hoisted out of their chair and taken to the dining room. Staff undertook this manoeuvre carefully and safely. The staff involved explained the process to the person and reassured them throughout. Staff told us they kept people safe by ensuring the environment was clear of hazards, and that equipment used was in good working order and regularly serviced. We also saw two staff supporting a person with a walking frame as they walked along a corridor. One member of staff guided the person's frame, whilst the other member of staff walked behind the person with a wheelchair. This enabled the person to sit down when walking became too difficult and when they were at risk of falling.

Each person had a Personal Emergency Evacuation Plans (PEEP). A PEEP provides information for the staff and emergency services about what support each person would require in the event of an emergency such as a fire. Staff were aware of their responsibility to report accident and incidents. They would report any such incidents to either the nurse on duty or other managers. The home manager told us they regularly reviewed the information to ensure action was taken to prevent any reoccurrence.

During our last inspection visit, we found the provider had insufficient numbers of staff effectively deployed to ensure people were safe. During this visit, we found there was enough staff available on the days we visited to meet the needs of people and keep them safe. Most people told us they felt there were enough staff to meet their individual needs. Others believed further improvements were still required as staff were often very busy with little time to engage with people.

One person told us, "They [staff] have no time to talk. It's clean and they [staff] are cheerful, but they do not have enough time and are always rushed off their feet." One relative told us, "I did have major concerns about staffing, but there does seem to be more staff about and the same agency staff are being used, which provides continuity for residents. Staffing has improved and is safer, but things could still be improved." Some relatives felt that there were delays in staff responding to people's need when they asked for assistance and that more staff would speed up waiting times. Other people and relatives felt staff responded quickly when they used the call bell system and had no concerns about staffing levels at the home.

Most staff we spoke with did not raise any concerns about staffing levels, and felt that improvement had been made by the provider. This included a voluntary embargo on new admissions, until staffing levels had stabilised. One nurse told us staffing had improved and had stabilised as there was a restriction of new admissions. Where agency nurses were being used, these were block booked to ensure the same staff were employed. Another nurse told us, "I'm not personally concerned about staffing levels. Both staffing and management has improved. Staff are now deployed to specific areas on the floor, which includes monitoring of corridors. I feel staff morale has improved." One member of care staff told us how there had been a massive reduction in the use of agency care staff following recruitment of permanent staff since our last inspection. Another nurse told us they were happy with the current numbers of staff, but any reduction would result in less effective care. One member of staff said, "I think the embargo has helped. We need to ensure sufficient trained staff are here before we start accepting new residents."

The new home manager told us they used a dependency tool to assist determining staffing levels and monitored staffing levels on a daily basis. They confirmed that during the day two nurses and six care staff would be deployed on each floor. During the night there would be one nurse and three care staff on each floor. People receiving one to one with care staff would be additional. The home manager also told us that the provider intended to continue with the voluntary embargo on new admissions, until the necessary improvements had been made.

We looked at what arrangements were in place for storing and administering people's medicines. We found the management and administration of medicines was safe. People told us they were supported to take their medicines as prescribed and in a timely manner. One person told us, "I have to have tablets three times a day and I get them three times a day". We saw nurses on both units administering medications. The medication trolley was taken to the entrance of each person's room. The nurse administering medications locked the trolley before entering the person's room with their medicine. The nurse remained with people ensuring they had fluids with their medicine. There were fresh jugs of water on medication trolleys and the trolleys themselves were uncluttered and clean.

Records supporting and evidencing the safe administration of medicines were complete and accurate. Competency checks to ensure the staff had the relevant skills and knowledge were in place. We found medicines and Controlled Drugs were checked daily. We reviewed one person who had been prescribed anticipatory medications for End of Life Care, and found the stock check was correct. The nurse told us that they had noticed that there were no specifically prescribed dose for one person's medicine. It stated on the box to administer as prescribed. The nurse told us how they had contacted the GP surgery to ensure that a specific dosage was labelled on the box of medication, which would then correspond with what was prescribed on the MAR chart.

Staff were able to describe confidently what action they would take if they had any concerns that people were being abused. There were systems in place to protect people who lived at the home by ensuring appropriate referrals were made and action taken to keep people safe. The management team understood their responsibilities in reporting any potential concerns in line with local safeguarding procedures. One staff

member told us, "If I had any safeguarding concerns, I would approach the home manager or the clinical lead. I am confident they would respond appropriately. If not, I would report directly to social services or CQC."

We found home had appropriate recruitment procedures in place, which ensured staff were suitable to support people who used the service. We found appropriate Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained. A DBS check is a legal requirement and is a criminal records check on a potential employee's background. Staff told us they underwent pre-employment checks before starting work at the home. The provider checked potential staff's previous employment history, their identity and obtained suitable references.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who were motivated and trained to support them. People told us that they were confident staff knew what they are doing. One relative said, "As far as I can tell, they seem to know what to do. There is a new recruit, [Name of staff member], and they are on the ball, and very efficient". Staff spoke positively about training provided. One member of staff explained how they had found recent training in dealing with challenging behaviour very useful, which gave them greater confidence. They also said, "[Home Manager] has been putting a lot of training into place. There seems to be regular training."

A new member of staff explained how they had attended classroom based training, which included Fire Safety and moving and handling. They were also in the process of completing the care certificate as part of their induction programme. The Care Certificate is a nationally recognised training programme for care staff. They told us they had undertaken a period of shadowing more experienced staff before being allowed to work on their own. They felt their initial training had been tailored to their individual requirements. In relation to further training requirements, one member of staff told us, "Training has improved and is more classroom based. This means staff are more involved and it is a better learning environment than on-line training. I have recently undertaken training in challenging behaviour and Mental Capacity Act. I'm also waiting to go on person centred training." Another member of staff said, "The new manager is doing a brilliant job. Training is now more focused on classroom based training, which is much better. I have recently had training in challenging behaviour, Mental Capacity Act and the use of drink thickeners for people."

Staff told us they received regular supervision and one to one support for their role during, where their performance and training needs were reviewed and discussed. One member of staff said, "I certainly feel supported by the home manager. In the past you got no acknowledgement, which got you down. We have an on-call list, where the clinical leads are on call and I have never failed to reach anyone. Training has definitely improved."

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).

Staff we spoke with confirmed they had received recent training in the MCA were confident in describing the principles of the MCA legislation. We saw clear evidence of mental capacity assessments and best-interests decisions carried out for people in connection flu vaccinations and proposed use of bed rails. We saw evidence that family members and, where appropriate, a GP were involved in the best-interests process. MCA and DoLS trackers were in place to assist the management team in monitoring that aspect of people's care.

On the whole, we found the service was working within the principles of the MCA, however, some records we looked at highlighted concerns. For example, we saw that some nurses had recorded themselves as decision-maker on best-interests records. This included decisions in relation to Do Not Attempt Resuscitation decision, consent to care, consent for use of photographs and administration of medication. We also found a lack of clarity regarding the specific decision to which the assessments related. For example, in one record we looked at, decisions regarding the administration of medicines and continence care provided no information as to what was expected from the provider. We spoke to the home manager about these issues, who reassured us that they would address the matters immediately with the staff concerned to ensure they fully understood their responsibilities under the MCA.

We found that people's dietary requirements were assessed and appropriate care plans and risk assessment were in place. People spoke appreciatively of the food they received. One person told us, "The food's good. I like chicken best." Another person said, "I am dieting and they are looking after me well, I am losing weight and having plenty of fruit." One relative said, "As far as I know, my relative eats really well and they always want two puddings. But they don't give them two, because they are putting on too much weight." Another relative said, "There is plenty to eat and drink. They are encouraged to drink every 10 to 15 minutes."

We saw people being provided with drinks and snacks during the day. People's dietary requirements, likes and dislikes were known by staff. For example, one member of staff pointed out to a person they were not allowed a packet of savoury snacks and offered a chocolate bar instead. Most people could drink independently and staff assisted those who needed help. Large bottles of squash and jugs of water were available on a sideboard in the lounge and staff offered extra drinks to people or upon request.

We looked at the lunchtime meal experience for people in both units, which was well organised and presented. There was a choice of main meals and deserts, and other options were also available if people were not happy with the choices offered. People were offered a choice by the kitchen assistant, who had plated up two different meals and allowed people to then chose, which meal they wanted. Meals were prepared in the main kitchen and served from a heated trolley. People sat together at circular dining tables. The atmosphere in the rooms was cheerful and relaxed with staff singing along to the music playing and interacting with people. We saw one person was given 'finger food,' which they ate unsupported. People were encouraged to eat and drink by staff. We saw the chef came into the dining rooms to check that everything was ok and to ask people if they were enjoying their food.

People told us their health care needs were well supported. People told us that the GP, the chiropodist and dentist were regular visitors to the home. Where required people were supported to access health professionals, which included supporting people on appointments if family were unavailable. One visiting health care professional told us that staff managed people's physical health needs very well. They said staff were quick to report any concerns about people's health, and always followed through any recommendations made. They told us that they had no concerns regarding their observations of people's care and treatment at the home and spoke positively about current manager's influence on the home.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and caring and knew people well. One relative told us, "Staff are very respectful and caring with residents. I'm happy with the care my relative is getting. Seems that things have improved and certainly residents get more stimulation." Another relative said, "I think the whole atmosphere has changed for the better. The carers are fantastic. I'm very happy with place." A third relative told us that their relative was always clean and well-presented. They also said that they had confidence in the way staff supported and cared for their relative.

Throughout our visit, we noticed that staff engagement with people was confident, relaxed, and warm. Staff knew the people they supported. Both staff and people enjoyed each other's company. We saw a member of staff enter the lounge area and greet a female resident with a kiss on their cheek. The person's expression showed that they were pleased to see the staff member. We did not see any impatience towards people by staff, who were very busy at times. We saw one person sitting at the end a corridor. We saw a member of staff approach this person and invite them into the lounge to watch tennis at Wimbledon as they knew they used to play tennis. Staff smiled at people and went around their duties in a warm and friendly manner.

People looked clean and tidy, they were comfortably and appropriately dressed. The hairdresser was in the home on the day of the visit and many people had had their hair washed and styled. We did not notice any lingering unpleasant smells. One visitor told us that staff cared for people really well and never saw people inappropriately dressed. One relative explained how their family member, following an personal care issue, needed a shower. It was late in the evening and staff were due to go home but, they stayed on and gave their relative a shower. Most people were addressed by their first names. One person liked to be addressed as Mr/Mrs [second name] and staff respected this request. We saw staff engage and distract people who showed signs of challenging behaviour. The weather was fine and warm on the days of our inspection and people from both units sat out in the garden with staff or visiting relatives.

We saw staff encouraging people to retain their independence. People were encouraged to use their walking frames, during which they were reassured and supported by staff. We saw one member of staff encourage a person to find their way to their room to collect something they had misplaced. The member of staff reminded the person where their room was and the person walked off and collected the missing item. Staff told us that people were encouraged to be independent in order to have a better a quality of life by being more active. People were encouraged to make choices around what they wore and ate, and were encouraged to dress themselves and assist with their own personal care.

Staff told us the home was better run and more organised for people. People were encouraged during warm weather to go into the garden and engage with others. One member of staff told us that staff were more focused on what they need to do to support people and corridors were now being regularly monitored to ensure people were safe.

During our last inspection in January 2017, we made a recommendation relating to good dementia care with care homes. During this inspection, we found that some improvements had been made. We saw most

bedroom doors displayed the name and a photograph of the person and some had memory boxes, which contained personal items and pictures. There was clear signage for bathrooms and toilets. We saw rummage boxes, a cot holding soft toys, and a pram in the corridor for the stimulation of people living with dementia. The home manager told us they intended to make further improvements in the environment and garden for the benefit of people living at the home.

Most people with spoke with told us they were involved in their or their relative's care. One relative told us, "I'm fully consulted about my relative's needs and have been involved in regular reviews." Another told us that they had contributed to their relative's care plan and confirmed that care needs had been reviewed since admission. Another relative told us that they had been consulted about their family member's likes and dislikes, which had been noted as part of the care plan. One member of staff told us that families were consulted in order to gather information relating to people's individual 'life stories.' This allowed them to understand and know the people they supported.

Requires Improvement

Is the service responsive?

Our findings

Most people told us that the care and treatment they or their family member received met their needs, however others felt there was still room for further improvements. One relative told us, "We are very pleased with our relative's care by the whole team. They cater for all their needs. Their care plan changes in accordance with how they are. If I have any concerns, I feel I can approach members of staff and nurses of which they are all helpful." Another relative said "Things have improved for my relative and I can only be a voice for them. You have some excellent staff and others are not so good. I would like to see the nurses on the floor directing care staff more." A third relative told us that they didn't think the home was meeting their relative's needs. When their relative needed personal care, staff did not come quick enough. A fourth relative told us they had no concerns with the care their relative received who was visited regularly by family. They said there were times when their relative had been wet, but this was not often and that they always had a good response from staff.

We witnessed an example of how a member of staff communicated with a person who was hard of hearing. The member of staff apologised for disturbing the person and asked them whether they would like a drink. They went right up to the person and with a combination of hand signals spoke clearly and slowly, knowing the person had had learnt to lip read. The member of staff also made the person laugh with their hand gestures.

We found inconsistencies in the quality of care plans we looked at. Though overall, we found the provider was meeting people's needs, this was not always reflected in people's care plans. For example, a diabetic care plan did not detail what the normal blood sugar level was for the person, which would impact on whether appropriate medication was given. In another care file we looked at, the End of Life care plan for a person had not been updated to reflect the person's current wishes. The End of Life care plan had been completed with the family, which stated the person was not for resuscitation. This decision was subsequently changed, however this was not reflected in the care plan or handover sheets. We spoke to the nurse on duty who reassured us immediate action would be taken to address this issue

We also looked at examples when there was no care plans in place for wound management for two people at the home. Life stories for people had not always been completed. We found inconsistencies in the completion of positioning, personal care and bowel movement charts. In one example, the last entry for a person's positioning was recorded as 11.40pm, with no further entries made after that time during the night.

We asked people what they thought about the activities simulation they received at the home. One person told us, "There is good entertainment we have singers and someone who plays the keyboard and someone who comes in with two enormous cats for comfort. The memory man is very good and also gets us all thinking. We had a barbecue last week and had everything, the chef cooked it all fresh for us. It was lovely." Another person said, "Sometimes, the days are very long. I used to knit and sew and dig the garden and plant things, but my fingers and arms don't let me now." One relative told us, "It's difficult. They've [provider] got games and things but 99% of people are not interested." One relative told us their family member responded better to one to one engagement they received rather than group activities.

During our visit, we saw eight people from the nursing unit were sitting out in the sunshine. An activities co-ordinator was sitting with them and chatting. They spoke about various outings they would like and things they would like to do.

We spoke with the lead activities coordinator about meeting people's needs with meaningful stimulation and activities. They confirmed that they were responsible for activities on both units and worked full-time. They were now supported by two activity assistants who had recently been appointed by the provider. This increase in hours meant there was now an opportunity to include people who would have otherwise been excluded. They told us activities included trips out in the minibus, visits from external bodies, such as local arts and craft groups, animals to stroke, music groups. There were also staff led activities such as reminiscence, physical exercise, and one to one engagement. We were also shown templates for recording individual people's activities, life stories, 'My life at Charles Court' and 'Social Diaries.' We were told that this was very much work in progress.

We asked people who they would talk to if they had any concerns or wanted to make a complaint. People told us that they were confident in approaching staff if they had any concerns. People told us about the complaints they had made and were satisfied with the response they received. One relative said, "[Home manager] is absolutely brilliant. They are very hands on and you can them anything." A copy of the complaints procedure was displayed in the home. This gave people information about how to complain if they had any concerns. We also looked at minutes from resident and relatives meetings, where issues such as food, mealtime arrangements, the provision of snacks and activities were discussed.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection visit in January 2017, we identified a breach of regulations as the provider had failed to effectively assess, monitor and improve the quality and safety of services provided. As part of this inspection, we checked to see what improvements had been made. Though we saw improvements had been made through a range of checks that were undertaken, these still failed to identify and address poor practice around care planning and accurate record keeping.

We found care plans did not always address people's medical needs, such as the provision of care planning around wound management, which were often missing in the care files we looked at. End of life care plans were not always updated to reflect people's wishes. Pre-admission assessments had not always been fully completed. We saw some fluid intake charts often did not contain details of target fluid intake that was required for the person. Some repositioning charts had not always been completed at required four-hourly intervals. Some hourly mattress and bed rail checks for had not been completed at consistent hourly intervals. MUST assessments (malnutrition universal screening tool) and body weights were not always updated on a weekly basis where care plans stated they should be. Life stories had not always been completed for people, which meant staff were not provided with information that was important to people about who they were. We saw that some care plans did not reflect people and their family wishes following a review.

We found that prescribed cream application charts were not always completed. We looked at two examples were people who were prescribed several different skin preparations. One person had no records, while the second person's records were incomplete and not signed by the administrating person.

We found no adverse impact on people's health as a result of the concerns we identified, nurse's were knowledgeable and aware of people's needs. We were told that nurses monitored people's charts, however this was not reflected with the inconsistencies we found. The provider's systems for checking on the quality of people's care files were ineffective. They failed to address missing information and to ensure the records were relevant and up to date for the person concerned.

This is a breach of Regulation 17 of Health and social care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This was because the provider had failed to effectively assess, monitor people's needs and ensure that records were up to date and accurate.

People looked happy and relaxed throughout our time in the home. Staff described a culture within the home in which they were able to speak openly about any issues. People and staff credited the new home manager with the changes and improvements that had been made at Charles Court since our last inspection. One relative told us, "I see the home manager two or three times a day, they are more involved than the previous manager. Very caring and won't stand for any nonsense. We all want them to stay." Another relative told us, that they believed things had definitely improved.

Staff told us that staffing levels had improved, the home manager was approachable and hands on, who

showed appreciation for the work undertaken by staff. As a result morale amongst staff had improved. One member of staff told us, "Things have changed, they are so much better now. The manager is good and is really trying to improve things and it is starting to change. The staffing rota is better, and there is more stability with staff, not so many temporary staff." Another member of staff said, "The manager is very hands on and gets stuck in and provides personal care. Previously you never saw the manager on the floor. We are more organised with staff and how they are deployed. Residents are more stimulated and there are less falls."

Following our last inspection in January 2017, the then registered manager retired. A new manager was then appointed who resigned followed by the deputy manager after several months. The current home manager was appointed at the end of April 2017. We spoke to the current home manager and the Quality Improvement Lead for the provider about our concerns regarding stable governance at the home. They acknowledged that the uncertainty with the management team over recent months had delayed the amount of progress they would have liked to have made by this time. They accepted that there was still room for significant improvements and confirmed that the current home manager intended to register with CQC as the permanent registered manager. They also confirmed that the embargo on new admissions would continue until further improvements had been made.

People and their relatives were offered the opportunity to take part in surveys about the care provision in the home. The results were collated by the head office team and the information used to identify shortfalls to improve future services for people. There had been no recent surveys undertaken since our last visit.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that we had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor services and ensure that records were up to date and accurate.

The enforcement action we took:

CQC have issued a 'warning notice' with a requirement that the service is compliant with regulations by 29 September 2017.