Sefton New Directions Limited

James Dixon Court

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

Summary of findings

Overall summary

The inspection took place on 31 January 2019 and 4 February 2019. The first day of the inspection was unannounced and the second day announced. This was the first inspection of this service under the new provider, Sefton New Directions Limited.

James Dixon Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

James Dixon Court a residential care home for 30 people. It is a purpose built, single storey building, situated in a residential area of Netherton, close to local facilities and transport links. The service provides long term care for people; placement for people who require support on a short-term basis, whilst awaiting long term care; support at an alternative care service; or return to their own home. The service's own staff support people with this placement, along with the local authority and other external health professionals, such as an occupational therapist.

A registered manager was in post. 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.

During this inspection we found the provider was in breach of Regulation 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Regulation 12 was in respect of unsafe administration of medicines and Regulation 17 for concerns around the completion of records pertaining to care and the service's governance arrangements.

Risk assessments were needed to protect people from the risk of harm and to support people's plan of care. We found examples where risk assessments were not accurate to reflect current risks and the support needed to keep people safe.

People had a plan of care to support their care needs. The plan of care did not always record the care and support they needed, or had been updated to reflect relevant changes. It is important that information is recorded clearly and correctly, so that staff can safely, effectively and consistently support people with their current needs.

We found the service's monitoring arrangements for a number of key areas of the service were not all robust and effective. For example, we raised concerns regarding the completion of people's care documents, analysis of accidents and incidents, staff supervisions and safe administration of medicines. We were not fully assured by the governance to maintain standards and drive forward improvements.

Formal feedback from people who used the service and relatives was limited as they had not attended any recent meetings or given the opportunity to complete quality surveys to share their views about the home. The registered manager informed us quality surveys would be sent out in the near future and residents/relatives' meetings were planned this month. People and relatives told us the registered manager was approachable and they could meet with them any time.

Recruitment checks were carried out to ensure staff were suitable to work with vulnerable people.

Staff received induction and training to guide them in their role. .

There was enough staff to meet people's needs and keep them safe. Our observations showed calls for assistance were answered promptly.

People and their relatives said they received safe care and attention in accordance with their individual needs.

Our observations showed staff were kind, caring, polite and patient when looking after people. Support was given in a safe manner. Many staff had been at the service for a long time and knew people well. People and relatives spoke positively regarding the staff team.

People told us they felt safe and well cared for. Systems were in place for safeguarding people from the risk of abuse and reporting any concerns that arose. Staff had received training and staff we spoke with were clear about the need to report any concerns they had.

The registered provider worked in accordance with the Mental Capacity Act (MCA) 2005 and staff demonstrated a good knowledge around how this was applied in a care setting. Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act (MCA) 2005 were followed in that assessment of the person's mental capacity was made to protect them. This included applications to the local authority for a Deprivation of Liberty Safeguard (DoLS) for people. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Arrangements were in place for checking the environment and equipment was safe and well maintained. For example, health and safety audits were completed where obvious hazards were identified and contracts were in place for utilities, such as gas and electric.

We found the environment to be clean and free from any odour. Staff had access to protective clothing such as, gloves and aprons to support the control of infection.

People's nutritional needs were assessed and monitored. People told us the food was good and they enjoyed a varied menu.

The registered manager worked effectively with a range of other professionals to achieve good outcomes for people. People, relatives and staff spoke positively regarding the registered manager's management of the home.

The service had a complaints policy and procedure. People living at the home and their relatives told us they would feel confident to raise a concern.

The service planned to provide end of life care that was respectful and dignified for people.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications.

You can see what action we took at the back of this report.

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.

Medicines were not administered safely to people. Staff competencies to administer medicines had not been checked.

Risk assessment documentation was not accurate to reflect current risks to keep people safe.

Staff had a good knowledge of how to safeguard people from abuse.

Staff had been recruited safely and there were sufficient numbers of staff available to support people with their individual needs.

Is the service effective?

Good

The service was effective.

Staff received training and support though staff supervision meetings were not being held regularly.

People and relatives were complementary regarding the care and support they received.

People's nutritional needs were assessed and they us they were offered a good choice of meals.

People had access to external health professionals to keep them well and healthy.

Staff understood the principles of the MCA and a relevant DoLS application had been submitted to the local authority at the appropriate time.

Is the service caring?

Good

The service was caring.

We observed staff treating people with kindness, patience and respect. .

It was evident staff knew people well and had forged close working relationships with people and their families.

People and their relatives were involved in the planning of care.

Staff promoted people's rights to confidentiality.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People's plan of care did not always record the care and support they needed, or had been updated to reflect relevant changes

Social activities were arranged for people. The registered manager was looking to introduce a more varied social programme which people told us they would like.

A complaints' policy and procedure was available for people to refer to.

The service planned and provided care to people at the end of their life in a dignified and respectful way.

People and relatives had not been provided with recent quality surveys to gain their views about the home. People told us however that communication was good and they could speak with the registered manager at any time.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes and systems were in place however these were not all effective in monitoring standards and driving forward improvements.

The service had a committed management and staff team.

People, relatives and staff spoke positively regarding the management of the home and the registered manager's leadership.

James Dixon Court

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 31 January and 4 February 2019 and was unannounced on the first day.

The inspection team included two inspectors 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 provider was asked to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We contacted the local authority to seek feedback about the service. We used this information to plan how the inspection should be conducted.

During the inspection we spoke with seven people who lived at the home, as well as four relatives. We spoke with three carers, the cook, the deputy manager, registered manager, domestic staff member and an operations manager. We spoke with two health care professionals who currently had input in to the service to seek their views.

We looked at the care files of four people receiving support from the service. We sampled three staff recruitment files, as well as staff rosters. We checked daily communications, records and charts relating to people's care, as well as medicine administration records. We looked at staffing which included staff training and support and we also reviewed the home's governance arrangements to help assurance the service provision. This included, for example, audits, policies and health and safety checks. During the inspection we walked around the home and observed the delivery of care at various points.

Requires Improvement

Is the service safe?

Our findings

We looked at how risks to people's health was assessed. Risk assessments were needed to protect people from the risk of harm and to support people's plan of care. For one person who had specific risks associated with their plan of care, there was a lack of recorded information about the risks and how to minimise them and support the person safely in accordance with their wishes. The risks relating to this person's support needs had significantly increased and talking with the registered manager confirmed the risks could have a potential impact on the person's mobility, skin integrity and mental health. The person also at times declined staff support and there was no record of how this lack of intervention could increase risks to their health. We were therefore concerned that the person' risk assessment was not accurate to support their plan of care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we discussed with the registered manager the person's risk management plan, as identified above. The registered manager undertook a review of the person's risk assessments to ensure they reflected current risks related to the person's health and wellbeing. Our observations, talking with staff, the registered manager and the person, confirmed everyone was aware of the risks and we observed the person receiving safe support; this was a records issue. People told us, "I am looked after well, the staff come to see me, they follow their guidance which means two staff help me" and "I staff know what they are doing, I always feel safe with them."

Medicines were not administered safely to people.

People who were administering their own medicines did not have risk assessments to show they were able to keep their medicines safely, or that they did not need any additional support.

Care plans had not been updated to reflect any changes in medicines needs. We saw that staff gave people their medicines in a kind way and signed the medication administration record (MAR) after administration. However, medicines were not always given at the right times. For example, one person prescribed a medicine to treat Parkinson's disease was given their medicine over 30 minutes late. In addition, the instructed time on the hospital letter to administer the medicine was not being followed.

Arrangements for storing and recording controlled drugs (medicines subject to extra control because of the risk of misuse) complied with the law. However, stock checks and record balances were not completed in line with the homes' policy. Medicines no longer required were not kept securely prior to disposal. This increases the risk of a medicines misuse.

The recording of the administration of medicines was not always following the home's process. Records were not always completed and where two staff have been identified as needing to be involved with the administration, this was not being followed.

Records to show topical preparations such as creams were being applied were unclear and not completed regularly. This meant there were insufficient records to show people's skin was cared for properly.

Records for the quantity of thickener added to drinks, for people who have difficulty swallowing, were not consistent, and unable to provide assurance people were safe from the risk of choking.

Systems in place to monitor medicines when people returned after a short period away from the home were not adequate to ensure all medicines were returned and any missing medicines identified.

The system used to audit the medicines at the home did not capture or identify issues found during the inspection.

There were no records available to demonstrate staff had their competency checked for handling and administering medicines safely.

This was a breach of Regulation 12 Safe Care and Treatment of The Health and Social Care Act 2008, Regulated Activities Regulations 2014.

There were processes in place to help make sure people were protected from the risk of abuse. Staff undertook safeguarding training and had access to a safeguarding vulnerable adults' policy and whistle blowing policy to support safe practices. Details of the local authority's reporting procedures were displayed and the registered manager had made referrals to the local authority in accordance with this procedure. Safeguarding referrals were monitored by the registered manager, along with partnership working with the local authority and CQC to provide appropriate responses to keep people safe. Staff we spoke with were aware of the service's safeguarding procedures and were confident to use them.

People told us they felt safe living at the home. Their comments included, "I feel safe with having a key to my room as someone might just come in, I know they wouldn't do it on purpose, but it makes me feel safer", "I am never frightened I'm always safe, the carers couldn't give anymore that they do, and they always try and put you at ease, we can have a good laugh" and "When they (staff) help with manoeuvring me either in the shower, toilet or to the chair, I know I am in safe hands and I will not fall."

Our observations helped to confirm there were sufficient numbers of staff available to meet people's needs. Rotas showed that staffing levels were consistent and staff informed us that staffing levels were maintained. People told us the staffing levels were good and they received care and support at the right time. People's calls for support were answered promptly.

Staff were safely recruited by the home. We found however the staff files lacked documented evidence regarding some of the required recruitment checks. This information was at the organisation's head office. Head office were contacted for confirmation of the required checks which were made available for us. We were concerned though as to the lack of information recorded in the home's staff files to verify staff's suitability to work. The registered manager agreed to review the service's recruitment process to ensure recruitment checks were available at the home for ease and reference. Recruitment checks included, criminal records checks, known as Disclosure and Barring Service (DBS) records, along with official identification and verified references from most recent employers. This ensured that only people who were suitable to work with vulnerable adults were employed by the home.

The home was well-maintained and the safety of the environment was checked by staff and external contractors to ensure it was safe for people to live in. The home had safety contracts that demonstrated

utilities and services, such as gas, electric and fire safety had been tested and maintained. Environmental risks were also assessed though these had not been reviewed last year. Fire safety included, fire drills, fire training and people living in the home had a personal emergency evacuation plan (PEEP). Water temperature checks were undertaken to monitor and prevent the risk of legionella developing and reduce the risks of scaling. Legionella is water-borne bacteria, often found in poorly maintained water systems.

We saw evidence of how accidents and incidents were recorded. The latest accident records had not been submitted to head office for review therefore there was no current analysis to asses for emerging patterns or trends. The registered manager said the accident report would be submitted as soon as possible. This is reported further under the well led section of this report.

Staff had the use of personal protective equipment (PPE) such as, disposable aprons and gloves to promote good standards of hygiene. The areas of the home we viewed were clean. When looking round the home we noted that one bathroom did not have paper hand towels or liquid soap for people to use. The registered manager ordered this equipment to support good infection control practices. The service's infection control audits had not picked up on this lack of equipment.

Good

Is the service effective?

Our findings

People and relatives told us the staff were well trained and provided a good standard of care and support. A person said, "You know don't you when you have found the right place as when it was my first night, I thought I might not sleep too well with being a strange place etc. but low and behold I slept all night like a baby, that tells you something." A relative reported, "They (staff) have given (family member) and me a new lease of life, I don't feel I need to worry half as much as I did before, they (staff) will let me know if (family member) is ever unwell straight away, their communication is great."

People were supported to stay healthy. Each person received individualised support with their health appointments. This included referrals to dieticians, speech and language therapists, district nurses and GPs. An occupational therapist was working at the service to provide support for people who were receiving short stay care (a transitional care placement) to help improve their independence to move to a more suitable care service or to support their return home. For people returning to their own home, people were encouraged to undertake daily activities such as making a cup of tea or preparing light meals to aid this transition. Health care professionals we spoke with told us the staff worked well with them to meet people's needs.

We saw where staff had made a prompt referral for support for a person as they were concerned about their mobility and how this was affecting their health. They were working closely with the occupational therapist to reduce the risks of them falling. People's care files recorded health professionals' input and discussions and staff told us how they followed their advice and treatment plans. A person told us they had good access to medical treatment and the staff would make arrangements for them to see their doctor if they wanted an appointment. A relative said, "I'm happy enough that if my (family member) needed a doctor straight away, they (staff) would call them immediately and be here."

The service's application of the Mental Capacity Act to protect people's rights regarding decision-making was overall good. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that an appropriate application had been made to the local authority. The registered manager informed us that this application had not been authorised yet. We saw the registered manager continued to work with the local authority to monitor this.

Staff sought people's consent around day-to-day decisions and empowered people to make their own

choices. For example, how people wished to spend their day, social activities and supporting people who wished to administer their own medicines as well as key health care issues. Staff understood the principles of making decisions in people's 'best interest' if they lacked capacity to make decisions for themselves.

Where appropriate, people or their relative had signed to indicate their consent and people were involved in the day-to-day decisions which were taking place in relation to the care being provided. We saw staff seeing people's consent when supporting them and people and relatives we spoke with confirmed that staff sought consent as a matter of course. This we saw, for example, in respect of support with personal care, medicines and meals.

The registered provider's training matrix provided a basis for staff learning and development. The staff training matrix recorded a 96% completion of courses to ensure staff were skilled to look after people. This included training in areas such as, moving and handling, safeguarding, food hygiene, managing health and safety and infection control. When reviewing other training records, we noted that two staff required fire training; the registered manager made arrangements for them to complete this. Staff undertook formal qualifications in care with most staff having obtained a National Vocational Qualification in Care (NVQ) at Level 3 and 2.

New staff received an induction and the registered manager informed us two night staff were undertaking the Care Certificate. The Care Certificate is the government's recommended blue print for induction standards.

Staff told us they had access to a good training programme and they were very well supported by the registered manager with their day-to-day practices and attended staff supervisions. A staff member said, "The manager is so supportive in all ways and you can go to (them) with any concerns." Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. The registered manager advised us that supervision meetings were held every 12 weeks. We saw supervision dates however not all the meetings held were within this time frame. The registered manager was unsure of the due dates and agreed to review the process for staff supervisions to ensure their completion. This is reported further under the well led section of the report.

Staff annual appraisals had not been completed; the registered manager said they would be undertaken this month as the home has now been opened a year.

Staff assessed people's dietary needs and requirements and were given a good choice of meals from a four-week menu. People had a plan of care to support their nutritional needs and had their weight monitored if assessed as needed. The cook informed people of the daily choices and the menu of the day was hand written on a menu board in the dining area. The writing however was small and was difficult for people to read. We discussed with the registered manager individual menus for people or menus to be placed on the dining room tables to enhance the dining experience. People told us they enjoyed the meals. Their comments included, "You always get enough food that is never in question."

Lunch was a sociable occasion with most people attending the dining room. When people needed support, staff provided this in an unhurried manner. The dining room tables were laid for lunch and people were offered a selection of juices and hot drinks following their meal.

To promote people's independence, we saw adaptions to the premises had been made and equipment was available to make it easier for people to get around and receive safe support. A number of people had their name on their bedroom door. There were no signs to help people find their way to the communal areas or

bathrooms however the registered manager said these were being sourced. Bright coloured crockery was available to help improve the contrast between the plate/cup and the background to encourage people to eat and maintain their independence. This is particularly important for people who suffer with memory loss.

People had personalised their rooms with their own pictures, items and furniture. Overall, the atmosphere and appearance of the home was very warm, bright and homely. People told us they found the environment to be comfortable and that they enjoyed living at the service. A person said, "The home is just lovely, does not feel like a care home at all."

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring, polite and attentive to their needs. Relatives told us, "You know it's like a hotel here, the carers, cleaners, staff are all lovely, they will have a nice chat if they can and have the time."

We spent time with people in the lounge and dining area and with people in their own room. Our observations showed staff interactions were not only to provide support with people's care needs but also to have a general chat with them and meet with their visitors. This engagement was very well received, there was plenty of chatter and laughter throughout the day. The home presented with a homely cosy atmosphere.

Staff understood people's rights to be treated with respect and dignity and staff we spoke with demonstrated a genuine positive regard for the people they supported. Staff addressed people by their preferred name and discussed and offered people support in a respectful, caring and unhurried manner. Staff knocked on bedroom doors and waited to be asked in before entering. Staff spent time with people who wished to stay in their room or who were being nursed in bed due to frailty. We noted that for people who needed their food cut up to a more manageable size, this was carried out in the kitchen to remove potential embarrassment in front of others.

Visitors arrived at different times of the day and were offered light refreshments. It was evident staff knew family members well. Relatives said, "The staff make you feel welcome and you can talk with them at any time" and "They (staff) have given (family member) and me a new lease of life, I don't feel I need to worry half as much as I did before, they will let me know if (family member) is ever unwell straight away, their communication is great."

Talking with staff confirmed their knowledge of what people were interested in and staff took time to sit with people and talk about family, friends and forthcoming events, such as Valentine's Day. A person told us how much they appreciated the how staff supported them to attend a special service at a local cathedral to commemorate the war. They described the staff as "So very caring around this special event."

People told us that staff respected and supported them to be as independent as possible. A person said, "The carers do encourage you to get up, washed and dressed every day, they (staff) are not pushy but help you to be independent." We saw staff supporting people with their social arrangements and helping them with their walking. A staff member said promoting independence was an important aspect of their care.

People's needs in relation to equality and diversity were considered by staff and the registered provider under the Human Rights Act 1998. Consideration was given to protected characteristics, for example, age and disability when completing a care needs assessment and formulating a plan of care. Information relating to people's social background, religious and cultural preferences was recorded to help staff treat people as individuals. For a person whose first language was not English, staff were supportive of their cultural differences and were using phrase and pictorial cards to promote effective communication. People

living at the home had access to pastoral support and were supported to maintain links with their church.

We saw that the home had supported people who required the assistance of advocacy services to do so. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights.

People's confidentiality was respected. Records containing personal information about people were kept in an office that were locked when unattended. Where information was stored electronically, this was password protected to prevent unauthorised access.

Requires Improvement

Is the service responsive?

Our findings

Individual care files were in place for the people living at the home. People's plan of care did not always record the care and support they needed, or had been updated to reflect relevant changes. It is important that information is recorded clearly and correctly, so that staff can safely, effectively and consistently support people with their current needs.

For one person who needed support with their mobility and had requested support to be given in a specific way, there plan of care had not been reviewed and updated to reflect this. The person' plan of care recorded the need for four hourly assistance and staff had completed care charts for the person, for example, for personal care and pressure sore prevention, turning/repositioning to evidence the support they provided. The person's records did not always record this four-hourly staff support. One day there was only one staff entry and for another day four staff entries to evidence the support offered to the person; four hourly care had therefore not been recorded. The registered manager informed us that the person now needed four-hourly pressure relief to ensure their comfort and reduce the risk of skin damage. This frequency was not recorded on their plan of care or supporting care documents, for example their turning/repositioning chart.

For another person their support plan stated they need to be 'repositioned when in bed'. It was however unclear as to when and how this support was offered. Staff said the person could move when awake however their care records did not always record positional changes for the person at other times. It was therefore unclear from the records when this support was provided.

The above examples are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With respect to the people above and others, our observations showed people were receiving the care and support they needed throughout the day. People confirmed staff provided good, safe and consistent care. People told us, for example, that if they walked with a frame, then the staff always used this equipment or if two staff were needed then two staff attended. Another person said, "The staff know how I wished to be looked after they (staff) come in regularly to see me and make sure I am comfortable and offer me the bathroom, this is what we have agreed."

A number of support plans were written in a personalised manner and people and their relatives (where appropriate) had been involved with drawing up their plan of care. This included personal information, social background, likes and dislikes and preferred routine. This information helped staff to provide care that is based on how people wish to be supported. A person said the staff knew they loved snuggling up in bed with tea and toast in bed of an evening to watch television. Another person said they liked their personal belongings kept in 'such a way' and the staff understood this. Several people told us they were not aware of any care reviews however staff spoke with them about their care and checked they were happy with the support.

During the inspection we saw good examples of responsiveness to people's needs. Staff were prompt in

seeking medical attention for a person who became unwell and for a person who suffered a fall. Both people were well cared for and reassurance was also provided for a visitor who was present at the time. Staff supported a person who went home each weekend to visit their family; this included providing their medicines for the time away.

We saw people's choices being respected regarding how people wished to spend their day. People's comments included, "They (staff) always ask for your permission you know when they are working with you, that's what I like, they just don't go ahead and do it as I am still very independent" and "If you want to eat a bit later, no one minds, or stay up late, you can decide."

There were some social activities arrange for people living in the home however people and relatives concurred that they would like more arranged 'in-house' and trips out. One person said they read a lot, watched television and would like more musical entertainment. The home had visits from school children once a week and people told us how much they enjoyed talking with children and doing colouring with them. A staff member was decorating the home for Valentine's Day and told us about the craft sessions they arranged. The registered manager said they would looking to introduce a more stimulating and engaging programme for people to enjoy. They appreciated this was an area that needed improving.

We checked if the registered provider was following the Accessible Information Standard (AIS). This Standard is important as it is there to ensure people who have a disability, impairment or sensory loss get information they can easily access and understand. We saw that information relating to how people liked to communicate was recorded and where people were hard of hearing, staff were encouraged to speak slowly and clearly. There was information recorded around the impact of poor hearing or sight and staff support. The registered manager informed us that information such as, care documents, would be made available in pictorial or large font size to support people's communication on request. We saw how effective a phrase book had been to support a person whose first language was not English.

People and their relatives said they would feel comfortable if they had to raise a complaint. A relative told the registered manager had been very responsive when they had raised concerns with them.

The complaints' policy was displayed for people to access. Complaints received had been logged. We discussed with the registered manage ways of improving these records a some were not sufficiently detailed complaints were also recorded in a bound book, rather than an individual log. The registered manager informed us they would review how complaints were recorded to improve the content and the way confidential information was stored.

We saw decisions relating to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had been recorded in some people's care files. Staff supported people with end of life care at the appropriate time, along with the district nurse team, people's GP and other health professionals. Advanced care planning included recording people's wishes on how they wished to be supported at this time.

We saw the home utilised assistive technology to support and enhance people's care. This included the use of call bells for staff support and sensor mats and alarms to alert staff when a person may have fallen.

Requires Improvement

Is the service well-led?

Our findings

The service had a quality framework which was to oversee standards and drive forward improvements. Our findings evidenced that this framework, which included monitoring processes and systems, was not fully effective to assure the service provision.

We saw a number of checks and audits of key areas of the service and these did not always identify and assesses risks to people's health and safety. The care audits were recorded as 'bi-monthly' however none had been completed since November 2018 and there was no review at management level with regards to the findings. The care plan audits provided a tick box for completion with no actual details of the review and people's or relative involvement. The care plan audits did not raise the anomalies we found regarding the lack of documented evidence to support risks to people's health and to support their plan of care. The medicine audits also did not pick up on our concerns around the safe administration of medicines. This brings into question the effectiveness of the tools used to monitor, reduce risk and improve these key areas of practice. We were not fully assured by the current support arrangements for staff. The registered manager informed us staff supervision meetings were held every 12 weeks. We saw these meetings were not held in accordance with this timescale and we were not shown a current programme of staff supervision to support the staff's development. With regards to monitoring accident and incidents that affected people's safety, the most recent hand-written reports had not been uploaded electronically and forwarded to head office for review; the analysis to identify any possible patterns or trends so that lessons could be learned and shared with staff things went wrong or could be improved was therefore not current.

We saw audits in other areas such as, health and safety and infection control, it was however unclear as to how often these should be completed and how these findings were analysed at service and senior management level. We were not shown any monitoring reports or evidence of visits at senior management/provider level to support the registered manager and to assure the overall service provision.

This is a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

We recognised that the registered manager commitment to the service and their responsiveness to our findings. The registered manager took prompt action to commence a full review of people's care records. They also told us they would drawn up other actions to help mitigate other risks we identified.

People and relatives told us the registered manager was approachable and they could meet them with at any time. We asked people to tell us about the atmosphere in the home. They described the home as 'very friendly', 'caring', 'a big family' and 'well run'.

Quality surveys had not been sent out to people who were living permanently in their home and their relatives since 2017 to gain their views about the service provision. The registered manager said they would be sent out over the next few months to collate people's views. Residents/relatives' meetings needed to take place more frequently to keep everyone informed and involved. The registered manager informed us two residents/ relatives' meetings were taking place later this month. People and relatives said despite not

attending formal meetings, communication in the home was good and they were kept informed of changes such as, decoration, maintenance or forthcoming events. Staff told us they attended staff meetings; they said these were informative and provided an opportunity to share good practice and views about the service. Staff were complimentary regarding the registered manager's leadership and support.

The registered manager worked closely with other agencies to ensure good outcomes for people. They promoted links with external organisations within the local community and to support people to return to their own home where able. The external professionals that we spoke with spoke positively about the effectiveness of the close working relationships to support people's transition home and to provide ongoing support for people whose permanent residence was James Dixon Court.

Policies and procedures provided guidance to staff regarding expectations and performance in accordance with current legislation and best practice. We reviewed some of the provider's policies which included, safeguarding, whistle blowing, infection control, medicine and equality and diversity. Staff were aware of the range of different policies told us how these were discussed at staff induction and on-going training.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC could monitor information and risks regarding James Dixon Court.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered safely to people. Staff competencies for administering medicines had not been checked to ensure they could undertake this practice safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes to assess, monitor and improve the quality and safety of the service were not fully effective. People's plan of care and risk management did not always record the care and support they needed, or reflect relevant changes, to ensure they received safe effective care.