HC-One Limited

Carr Gate

Inspection report

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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

The inspection of Carr Gate Nursing Home took place on 27 September and 2 October 2017 and was unannounced on both days. The previous inspection, which had taken place on 26 April 2016 found the service was in breach of two regulations. Safe care and treatment and safeguarding service users from abuse and improper treatment. The provider sent us an action plan in relation to how they would address these issues. At this inspection we found sufficient improvements had been made in each of these areas. However we did find at this inspection the provider was in breach of two regulations in relation to person centred care and governance.

Carr Gate Nursing Home provides accommodation and nursing care for up to 65 people, some of whom are living with dementia. The home is on two floors and there are three units; Cherry (nursing care), Cliffe (residential care) and Holly (dementia care). At the time of the inspection 17 people were living on Holly, 14 people were living on Cliffe and 19 people were living on Cherry.
There was a registered manager, who had been registered with the Care Quality Commission to manage the service since July 2015. 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.

People were provided with care and support in line with the principles of the Mental Capacity Act (2005). One person, who remained in bed however, had no clear recording of any best interest decision around this and the rationale for them staying in bed continuously was not evident or understood by staff around this person.

Care records we looked at contained individual risk assessments although we found some conflicting information in relation to weight checks. We spoke to the registered manager who told us this should be completed monthly unless a risk is present.

People and relatives we spoke with told us people felt safe at Carr Gate Nursing Home.

Staff had received training in relation to safeguarding people and staff were aware of relevant procedures to help keep people safe in the home. Staff received appropriate induction, training, supervision and support to enable them to perform their role.

Staff were recruited safely. Staffing numbers were determined by the use of a dependency tool. However there were mixed views about staffing levels across the service in relation to staff having quality time to interact with people in the home. Whilst we felt there were adequate staff to meet people's care needs, we observed sometimes the deployment of staff was not effective in some areas of the home. We spoke to the registered manager about this.

We saw some examples of good care practice. Staff were observed to be caring and kind in their interactions with people.

We saw accident and incident records completed across the three units. The registered manager had a good insight to these and lessons learnt were consistently addressed at team meetings. The registered manager held regular meetings with people, staff and relatives and engaged with other agencies. Audits were in place around the governance of the home. However some areas around care plans would have been picked up sooner if these had been more robust and effective.

We made a recommendation the registered manager looks at all repositioning records to ensure these are all up to date around the frequency for the repositioning of the person.

You can see the action we have told the provider to take at the end 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.

Records were not always accurate in relation to repositioning charts and risk assessments.

Medicines were managed safely .People received their medicines on time.

People felt safe and staff understood how to safeguard people from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained in, and had an understanding of, the requirements of the Mental Capacity Act 2005.However one person who was confined in bed for over 5 months, staff did not understand the principles around this and why this was in place for this person.

Staff received appropriate supervision and support.

People received support from outside healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff knew how to treat people with dignity and respect and ensured people's privacy was maintained.

Staff knew the people they were supporting very well and how to meet their needs.

Staff had developed good relationships with the people who used the service and there was a relaxed atmosphere.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always planned and delivered with a person centred approach for people using the service.

People were supported to meet their social and leisure needs.

Information about how to make a complaint was available in formats to meet the needs of people using the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had some systems in place for assessing the quality of the service. However a more robust audit would have picked up issues that had been identified at the inspection.

People told us the service was well managed. Staff we spoke with told us they enjoyed working at the service.

People and their relatives were given opportunity to share their views about the service.

Carr Gate

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 27 September and 2 October 2017 and was unannounced on both those days.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications sent to us by the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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.

During our visit we spoke with 10 people who used the service, seven relatives, eight members of staff, the activity coordinator and the registered manager. Others who used the service and were at home when we visited were unable to tell us about their experience; we therefore spent some time observing care and support given to people. We also spent some time looking at documents and records that related to people's care and the management of the service. We looked at seven people's care plans.

The inspection was carried out on the first day by two adult social care inspectors a specialist advisor and an expert-by-experience who had experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection one adult social care inspector attended.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2016 we found not all potential safeguarding incidents had been reported and investigated. At this inspection we spoke to the registered manager who had sent through notifications relating to any concerns effectively in line with safeguarding reporting procedures. We also found at the last inspection systems and processes were not established and operated effectively to prevent abuse of people in the home. At this inspection we saw a risk assessment had been put in place to minimise any conflict between people in the home. One member of staff was present in the lounge at all times. We observed this throughout both days of our inspection. At this inspection we found they had sufficiently improved their systems and processes and were no longer in breach of these regulations.

People we spoke with who lived at Carr Gate Nursing Home told us they felt safe living there. Relatives we spoke with also told us they felt their relatives were kept safe at the home. One person said "Yes I do feel safe here, while living here." A second person said, "Yes I suppose I am safe really." A third person said, "Oh I do feel safe here." We spoke to a relative who said, "Grandma is definitely safe now that she is living here and more than when she was living at home alone." A second relative said, "We chose the home because it is local and mum would be safe." Staff we spoke with understood the signs of abuse and how to ensure people were safeguarded. All staff said they would challenge and report any unacceptable practice.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. People who used the service were supported by staff to participate in the recruitment of staff.

We saw staffing levels on the Holly Unit were sufficient to meet people's physical care needs, but staff did not always have time to interact with people other than their care needs. During less busy periods in the day staff made the effort to chat with people, although they were unable to sustain this for very long because of attending to people's physical care, such as supporting people with continence care, food and drinks.

Staff we spoke with said they would like more time to sit and chat with people and acknowledged some people felt lonely and in need of conversation and attention from staff.

One person we spoke with said "They always say, I'll come and talk to you in a minute, but they don't have time and when they do, it's only for a few minutes". Another Person said, "Yes I think they have enough staff; it varies some days they have more than others." This person went on to tell us that on the two occasions they had needed assistance from staff they rang the call bell which staff had answered immediately. A third person said, "There is not always enough staff." A fourth person said, "Yes, there are always enough staff. "Relatives we spoke with also told us they felt there was not always enough staff to look after people. One person said, "There is not enough staff here." A second relative said, "Bathing mum has been an issue

which I have raised, as there isn't enough staff." A third relative told us they could not fault the care and staff at the home. They told us, "Staff go above and beyond. My mum would not come out of her room but staff have persisted with her and she now comes out and spends time with staff in the lounge. I cannot believe the difference." We did however observe staff made regular checks on people's whereabouts and if people were in their bedrooms staff frequently called in to see if they were alright. We spoke to the registered manager about our findings on the day of inspection. The registered manager told us they were in the process of recruiting another activity coordinator to support the home especially on the Holly unit. The registered manager used a dependency tool which was updated monthly.

Where staff told us people were at risk of falls, we saw they had necessary equipment in place, such as walking frames or crash mattresses beside a low bed. Staff were observant of people's safety as they walked around the unit and supported them to be aware of any hazards, such as trousers falling down. One member of staff quickly noticed a person was walking round with their dinner knife and they exchanged this for a chocolate biscuit. Where people were unsteady on their feet staff were quick to respond if they saw them rise from their chair, and they accompanied them around the unit.

Staff told us they used distraction techniques to divert people's attention if there was any behaviour that challenged the service. For example, one person began to shout at another person and we saw staff acknowledged their feelings, and then engaged them in a conversation about their favourite drink and the brewery.

Care records we looked at contained individual risk assessments although we found some conflicting information. For example, one person had a risk assessment for malnutrition which stated they should be weighed weekly, yet another part of the record showed they were to be weighed monthly. One person's record showed they needed their weight to be reviewed in one week, but the last recorded date was 31 August 2017, with no entries after that. We spoke to the registered manager who told us this should have been recorded monthly and would ensure this was changed immediately.

Where people were at risk of developing pressure ulcers we saw there were repositioning records in their rooms, although these did not always detail how frequently the person was to be repositioned in all records we looked at. We spoke to the registered manager about this who told us they would look and update the records.

We recommend the registered manager looks at all repositioning records to ensure these are all up to date around the frequency for the repositioning of the person.

The home was clean. There were odours present in the morning, however as the cleaners progressed around the home the odours diminished by the afternoon. We observed that the furnishings in the communal areas such as the lounge on Cliff Unit were well maintained and we saw that people were able to get themselves out of chairs without assistance from staff. We were invited into people's bedrooms; some people were on respite care whilst other people were living at the home. We observed that people's bedrooms were clean and free from any odours. People had personalised their room with pictures and had their own television. One person who was on respite care when asked what could have improved their stay said, "There should be a TV/radio in each room. I have brought my own. It puts you in contact with the outside world. The selection of DVD's and CD's here is enormous, but if you don't have a TV/DVD player it's no use."

Medication records contained a photograph of the person. This helped to reduce the risk of people being administered the wrong medicine. The person's name, date of birth and any allergies were also recorded.

We checked a random sample of medication administration records (MARs) and found these were accurate. The records showed where people had been offered but had refused medicine. We observed the registered manager ask a member of staff for the MARs, in order to undertaken a spot check of medicines. We checked a random sample of medicines and they reconciled with the records.

Medicines were stored safely. Storage temperature checks were completed daily and the storage temperature was within appropriate limits.

We did have some concerns regarding the time consuming nature of the system being used however, following discussion with the registered manager we were re-assured that this system had been introduced to replace the previous system, and as a result a significant reduction in errors and omissions resulted. The registered manager informed us that the deputy manager took a lead role for medicines across the service, and conducted additional regular and random audits. The registered manager was satisfied that the present system was appropriate at the current time. We saw effective audits in place which showed a significant reduction in medication errors through this system.

We saw premises safety checks were carried out. These included fire safety checks. Records we looked at indicated weekly checks of the fire alarm and fire fighting equipment took place to ensure they were safe for use.

Requires Improvement

Is the service effective?

Our findings

People told us their needs were being met by staff. One relative told us that their relative had sores on their hip when they went to the home. They said "Grandma has a sore and they [staff] told us they are getting the GP out straight away to look at it."

Staff we spoke with said they had regular training and felt supported by the registered manager to do their work. Staff said they did not always feel supported by senior managers in the organisation. One staff member told us, "Higher management do not come to the service, we do not see them." Staff said they completed all the required training and had regular updates. We saw evidence of staff receiving appropriate supervisions and appraisals were on going within the home.

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. We spoke to staff who could tell us the principles of the (MCA). Staff told us if they had any concerns they would speak to the registered manager straight away.

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). The Registered Manager has recently undertaken a review of all DoLS records and is currently chasing up the LA's regarding updates on outstanding.

In the care records we looked at we saw evidence of mental capacity assessments and best interest decisions for most aspects of people's care. One person, who remained in bed who remained in bed had a capacity assessment in place clearly stating the rationale for this. However another person who remained in bed had no clear recording of any best interest decision making around this and the rationale for them staying in bed continuously was not evident or understood by staff. s. We spoke to the registered manager about this. She stated the home had sourced support from the vanguard team (an organisation leading the way in new developments or ideas) however this was only a few days prior to the inspection.

We saw that people were given a choice at meal times. The lunch was tomato soup, assorted sandwiches, and salmon/broccoli fish cake/chips. For dessert it was bread and butter pudding or yogurt. We saw that people were offered a choice of either tea or coffee. Where people needed clothes protectors these were provided.

We saw staff supported people effectively with eating and drinking. One person preferred to walk around the unit and we saw a member of staff walked with them and assisted them to eat finger foods. People were invited to sit together at the table although some people chose to have their lunch in their arm chair. Most people we spoke with told us the food at the home was good. One person said, "The food is all right I like it." A second person said, "The food is off and on." A third person said, "The food is ok." A fourth person said,

"The food is passable; it is not cordon bleu. It will keep you going." A fifth person said, "The food is very nice on the whole." A sixth person said, "The food is pretty good." However another person told us they did not like the food and said there was not enough to stop them feeling hungry. They said, "It's sandwiches cut into (gestured with hands to show triangle shapes) which isn't enough. I need proper meals."

We saw staff encouraged people to eat and offered alternatives and second helpings based on people's appetites and preferences. People were asked what they would like to eat and drink. One person said they wanted beer with their meal and staff provided this for them. Snacks such as fruit, cakes and biscuits were available to people and staff encouraged people to eat these. Where people had special diets, such as pureed food, staff explained what each spoonful was as they supported them.

The premises had some adaptations for people living with dementia. The environment was interesting with different textures, such as artificial grass and old pictures of the local area and landmark buildings. Some people had memory boxes on the walls outside their rooms. Not all the people's rooms had names on or things to help them locate their own room. People's rooms were personalised inside with familiar photographs and objects of personal interest. There was some signage in the building to help people to locate the toilet and bathroom areas. There were large clocks in the lounge area but we noticed these displayed different times and they were not correct. We mentioned this to the registered manager at the time of inspection.

We saw that there was interaction between people living at the home and care staff. People were having conversations between themselves and staff. We observed in the afternoon that there were jugs of juice on a tray in the lounge of the Cliffe unit and saw that one person helped themselves to a glass of juice, whilst they were watching a film with other people sat in the lounge.

We saw evidence in people's care plans around healthcare need. We saw regular visits from GP's and tissue viability nurses. (TNV).

Good

Is the service caring?

Our findings

Most people we spoke with told us they thought that the staff were caring and treated them with respect. One person said, "The daytime staff are good. The night time staff some of them are just in it for the money." A second person said, "The staff are fantastic, but they are put on. We have a good crew, but they are not appreciated." A third person said, "Lots of them are young, but they are all right. [Name of staff] who showers me and washes my hair, she is very good." We spoke to a relative who told us, "All of the staff are friendly." A second relative told us, "The care here is amazing but there are not always enough staff I don't feel, it would be nice to have more staff."

Staff were kind and caring in their approach and relationships with people were supportive. Staff we spoke with knew each person well and they understood their needs overall. We did not see any poor interaction as everyone appeared to be relaxed in their surroundings.

People we spoke with all confirmed that their friends and relatives could visit at any time and there were no restrictions. Relatives we spoke with also confirmed that they were able to visit at any time. One relative said, "We visit every week. There are no restrictions for visiting. We are always made to feel welcome." A second relative said, "There are no restrictions apart from they do prefer you not to come at mealtimes."

Staff told us they enjoyed their work with people. One member of staff said "We are honoured, it's a privilege to be able to care for these people"

Staff respected people's privacy and dignity. One person requested to watch television in their room with their door shut and staff respected this. Staff knocked on people's doors before entering and they supported people's continence needs discreetly. For example, they noticed one person needed a change of clothes and discreetly suggested they accompany them to the bathroom. Staff made sure people's clothing was neat and tidy as well as their hair, although some people had very long fingernails which were not always clean. We spoke to the registered manager about this.

Staff respected and promoted people's religious and cultural needs. One relative told us how holy communion was a very important part of their family member's life and said even with their family member's swallowing difficulties staff supported them to have thickener in the wine so they could safely join in when the priest visited on Sundays.

Relatives told us staff's attitude was caring towards them as well as their family member.

We spoke with relatives who confirmed Do Not Attempt Resuscitation (DNAR) s had been completed for their relative and that their wishes/information regarding end of life had been communicated with staff at the home. We saw in two peoples care plans this had been discussed with families.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that they were able to get up and go to bed as they wished. One person described their morning routine. One person said, "I can get up and go to bed as I wish." Another person said, "I do what I want to. A third person said, "I go to bed when I am ready and get up when I want to."

Care records were task focused and there was limited information about people's social histories or backgrounds for staff to be able to understand each person well. Some staff had a very good knowledge of people and their preferences and they knew what people used to do for their work or hobbies. Where social history was recorded we saw it was buried in the care plan and not easily accessible. One person had a one page resident profile, but we saw it was dated January 2014 and the information was no longer relevant or current.

Staff noticed when people were becoming anxious and used the information they knew to divert their attention. For example, staff knew one person used to love cars and had many cars over the years, so they reminded them about this, which stopped the person feeling sad.

Care records were evaluated regularly, although comments such as 'care plan remains relevant and on going' were sometimes written, even when people's needs had changed. For example, one person's care had changed due to a loss of mobility but this was not properly documented. It was not always clear what action had been taken when a concern was noted. For example, one person's care plan said they suffered from depression and were often weepy, but it was not evident what was being done about this.

We found a contrast in the quality of person-centred care on one of the units. For example, we saw one person had plenty of staff attention and they were supported to be as independent as possible. However, another person had sustained a fracture in May 2017 and had been confined to bed since their operation, which meant they had spent the last five months nursed in bed. We asked staff if there had been any reviews of the person's care and they said they did not know and that other than the fracture, they did not really know the reason the person remained in bed. We saw the person was awake frequently during the day, but alone in their room other than staff periodically checking their position and supporting with food and drink. Although the person had the radio playing, there was no other stimulation and often they only had the blank wall to look at. Staff told us there had been no assessment of the person for any specialist seating, or any attempts to support the person to access communal areas.

We spoke with the registered manager who told us they had requested a review two days ago and this was something the unit manager would be attending to on their return from leave. Although we saw this was documented on a flash meeting record, we expressed concern this review had not taken place sooner as the person had spent a considerable number of months confined to bed with no evidence of the reason for this. We told the registered manager we were concerned for the quality of this person's life and daily experiences and the care plan did not reflect the person's change in need or actions taken. We concluded this is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Person-centred care.

We spoke to people, relatives and staff about the activities in and outside the home. One person told us, "I would like to be out of here as I do feel confined, although me and another chap were taken out not so long ago. We went out for a meal to a pub with staff which we enjoyed."

Another person said, "I have a greenhouse outside at the back of the home, which I love looking after." This person was on their way out to visit a garden centre on their own in their electric wheelchair. They told us the garden centre was just five minutes away from the home. Staff we spoke with said people often engaged in activities and we saw some of these taking place, such as decorating photo frames. Relatives also told activities took place at the home.
One relative said, "They have loads of activities on here." Another relative said, "There are always activities on; exercises on Monday, baking and knitting." There was photograph evidence of people going to enjoy pub lunches as well as exercise sessions and coffee mornings. Staff told us the activities coordinator was for the whole home and they felt a dedicated activities coordinator for dementia care would be beneficial to the unit in offering person centred care.

The relatives we spoke with said they would know how to make a complaint and felt it would be dealt with. One person said, "I would speak with the management about a complaint." A second person said, "I would speak to [name of manager] if I had a complaint." A third person said, "I go straight to the manager." We saw complaints were dealt with appropriately in relation to the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Staff and relatives said they thought the home was well run and found the registered manager was visible and offered support if they asked for this. One person said, "Yes I would recommend people to come here. It gives you basic care. Overall, my experience has been ok." A second person said, "Overall, I would recommend the home 100%." A third person said, "Yes, I would recommend coming to live here." Two relatives we spoke with told us they were satisfied with the overall care at the home. One relative was not satisfied as they felt that the home did not meet their relative's requirements as they were more independent than most people living at the home. One relative said, "Overall, we are happy with Grandma's care and we would recommend the home to people." A second relative said, "I would definitely not recommend the home to people." We spoke to another relative who told us, "I am fed up of the home getting a poor write up. [Name of person] is very happy here and we as a family are. Staff work very hard to look after people."

We saw only 50 % of the care plans had been audited in the home. We spoke to the registered manager about the concerns we found at the time of inspection around documentation of care plans which had not been audited. The registered manager told us this was a priority and would be completed straight away. We saw provider audits in relation to the home and environment in place. Actions had been completed in relation to these. However the audits had not picked up the issues we found around the person confined to their bed for over 5 months. A more robust audit would have identified these areas including the conflicting information around weight checks of people in the home. We concluded this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The home had well established links with professionals in the local community. There is evidence in care records of involvement of Community Psychiatric Nurses/, Community dietitian, Physiotherapy, TVN, and active GP visits. We saw evidence of this at the time of inspection.

We saw evidence of monthly staff meetings taking place, the most recent meeting was on 23 August 2017. Each meeting had a 'policy theme of the month' where different policies were reviewed at each meeting such as Infection Control and Oral Care. Medication and care plans were also regularly discussed as well as staff sickness. One incident was discussed where a staff member was heard using inappropriate language. Staffs meeting dates were already set for the remainder of 2017.

At the most recent meeting on the 23 August fire drills and practices were discussed. The minutes stated 'We will be having a practical fire evacuation at some point and not just a standard fire drill. Thank you all for completing and returning the PEEPS. This is helpful as it gives a thorough explanation of the residents needs during a fire'. Minutes were fully documented and actions from previous meetings were discussed and generally completed.

We looked at the last staff survey this was taken on the 26 August 2016, nine staff participated and were a mixture of care staff, senior care workers , domestic and kitchen staff. Most feedback was generally positive

however some responses were poor, we saw evidence of an action plan to improve the scores following the survey.

We saw evidence of resident and relative meetings from July 2017. Discussions included communication and confidentiality of people in the home. Actions were put in place to improve this and family was satisfied with this.

We looked at the last resident and relative survey which took place in July and August 2017; the documents did not specify how many residents took part. Comments included, 'The food is poor' And 'There is no quiet area'. Following this survey an action plan was put in place in response to these comments and residents were responded to appropriately.

Providers have a responsibility to notify CQC about certain significant events such as safeguarding, serious injury and police incidents. Before the inspection we checked our records and found we had received notifications appropriately from the provider. The registered manager kept CQC up to date with any issues or concerns in relation to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services care plans did not always reflect the change in need or actions taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective audits were not always in place in relation to people's care plans.