Arena Options Limited

James Dixon Court

Inspection report

Harrops Croft
Netherton
Liverpool
Merseyside
L30 0QP

Tel: 01519315748
Website: www.arena-housing.com

Date of inspection visit:
25 April 2017
26 April 2017

Date of publication:
02 June 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 inspection took place on 25 and 26 April 2017 and was unannounced.

James Dixon Court is 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.
During the inspection there were 17 people living in the home.

A registered manager was in post but was not in work during the inspection. 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. Feedback regarding the management of the service was positive.

We found that the safety of the environment was not always maintained within the home. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. External contracts were in place and internal checks were also completed to help maintain the safety of the building and its equipment. We found however, that chemicals were not always stored securely and fire regulations were not always adhered to as a fire door was wedged open.

People knew how to raise any concerns and felt confident that they would be listened to. There was however no complaints log available to evidence how complaints had been investigated and whether they had been resolved.

The registered manager completed a variety of audits, as well as a monthly care home checklist, which looked at the safety of the home. A member of the provider's quality team also visited the home regularly to complete an operational compliance audit; however there was no evidence that all identified actions had been addressed. We found that although audits were completed, they did not identify all of the issues highlighted during the inspection. This meant that systems in place to monitor the quality and safety of the service were not always effective.

When there were concerns regarding people's capacity to consent to care or make decisions, mental capacity assessments were completed. We found however, that they did not always follow the principles of the MCA. We found that necessary assessments and agreements were not evident for a person who received their medicines covertly (hidden in food or drink.)

Some staff had commenced an induction when they commenced in post, but no staff had completed this. Care staff had not received an annual appraisal and not all staff had regular supervisions to support them in their role.

We looked at how medicines were managed within the home. A medicine policy was available for staff to refer to and records we viewed confirmed that staff had completed training in relation to safe medicine administration and had their competency assessed. Medicines were stored safely, all administrations were recorded and stock balance checks were accurate.

People told us they felt safe living in James Dixon Court and their relatives agreed.

Staff were knowledgeable about adult safeguarding and how to report concerns.

Safe recruitment processes were followed when new staff were employed and staff only commenced in post once checks had been completed. People living in the home, their relatives and staff told us that there were sufficient numbers of staff on duty to meet people's needs in a timely way.

There were no concerns raised regarding the cleanliness of the home. A recent infection control audit had been completed by Liverpool Community Health and the service had scored 99.68%.

We found that Deprivation of Liberty Safeguards applications had been made appropriately.

Regular training was provided to staff to help ensure they had the knowledge required to meet people's needs safely.

People were supported by care staff and external health care professionals to help maintain their health and wellbeing. People told us staff arranged for a doctor in a timely way if they were unwell.

We received mostly positive feedback regarding the meals available in the home. One person we spoke with had a specific dietary requirement. They told us the chef sourced special ingredients to make their meals and that they were very happy with the food they received. Staff we spoke with were aware of people's dietary needs.

People told us that staff were kind and caring and treated them well. We observed people's dignity and privacy being respected by staff during the inspection and interactions between staff and people living in the home were warm and genuine.

We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

Care plans were written in such a way as to promote people's independence and people told us independence was encouraged. People told us they had choice regarding the care and treatment they received and could choose how they spent their day. Staff we spoke to knew the people they were caring for well and told us they were kept up to date about any change in people's needs.

We observed relatives visiting throughout both days of the inspection and everybody agreed they could visit whenever they wanted to and could visit in private if they wished to.

Staff told us that if people had no family or friends to represent them, they would support them to access a local advocacy service.

Feedback regarding activities was mixed. Activities available were advertised within the home and external entertainers also visited the home on occasion. Most people we spoke with told us they spent a lot of time in

their rooms watching television and some people told us they would like more activities. A staff member told us there was not enough resources available for activities and that the staff tried hard to ensure there were activities available for people that they enjoyed.

Plans of care contained person centred information, which showed that people had been consulted regarding their care. Relatives we spoke with were aware of the plans and told us they were involved in their family member's care. Care plans were reviewed regularly and reflected people's preferences.

Records showed that meetings took place and questionnaires were distributed in order to gather views from people living in the home and their relatives.

Staff meetings took place every few months. Staff we spoke with described these as 'flash meetings' and told us that they were not always planned or advertised. Not all staff had the opportunity to attend these meetings and a staff member told us planned staff meetings would be beneficial.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. Ratings from the last inspection were displayed within the home as required.

You can see the action we told the provider to take at the back of the full version 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.

Safety of the environment was not always maintained within the home.

Medicines were stored and administered safely.

People told us they felt safe living in James Dixon Court.

Staff were knowledgeable about adult safeguarding and how to report concerns.

Safe recruitment processes were followed and there were sufficient numbers of staff on duty to meet people's needs in a timely way.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always gained in line with the principles of the Mental Capacity Act 2005.

Applications to deprive people of their liberty had been made appropriately.

Staff received regular training, but full induction, appraisals and supervisions were not regularly completed to support staff in their roles.

People were supported by care staff and external health care professionals to help maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and treated them well.

We observed people's dignity and privacy being respected by

staff during the inspection and interactions were warm and genuine.

We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

People had choice regarding the care and independence was encouraged.

Visitors were welcomed to the home at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to raise any concerns, however there was no complaints log maintained to evidence how complaints had been investigated.

Feedback received regarding activities was mixed.

Care plans were person centred, reviewed regularly and reflected people's preferences.

Systems were in place to gather people's views regarding the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective.

Not all staff had the opportunity to attend staff meetings and a staff member told us planned staff meetings would be beneficial.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home and ratings from the last inspection were displayed within the home as required.

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 25 and 26 April 2017 and was unannounced. The inspection team included an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider 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 also contacted the commissioners of the service.

The provider had 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 any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with four members of the care team, seven people living in the home, three relatives, the chef and a registered manager from one of the provider's other locations. The registered manager was not in work during the days of the inspection and we were supported by the senior care staff and a registered manager from another home within the organisation throughout the inspection.

We looked at the care files of five people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

We looked around the home and found that chemicals were not all stored safely. For example, we observed prescribed creams, shampoo and other chemicals within the unlocked hairdresser room. The room also contained a cupboard with electrical devices within that was marked high voltage, however the door was unlocked. This meant that vulnerable people might have access to hazardous areas within the home. Since the inspection the provider has informed us that a keypad has been fitted to the cupboard and the room is kept locked when not in use.

We saw a fire door to a person's bedroom wedged open. This meant that it would not close in the event the fire alarm was activated. We discussed this with senior staff who told us the person would not have their door closed and wanted it to be kept open. We discussed the use of automatic closure devices with senior staff and were told staff would discuss this with the registered manager when they were next on duty to ensure they complied with fire regulations. Since the inspection the provider has informed us an automatic closure is now in place.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock checks and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs and safe administration of medicines. Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed each year.

Medicines were stored in a locked trolley which was kept in a locked cupboard. The temperature of the room and the medicine fridge were monitored and recorded daily and we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Controlled medicines were stored in a separate locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

MAR charts we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. We checked the stock balance of three medicines and they were accurate.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. We saw guidance regarding administration of these medicines was clearly recorded within people's care plans.

Most people we spoke with told us they felt safe living in James Dixon Court. Their comments included, "I always dreaded coming into a home but staff are lovely and it is fabulous, the security is great", "Yes,

everywhere is locked up and staff make sure everything is in place" and "Carers are always on hand." Relatives we spoke with agreed that their family members were safe and told us, "I feel confident and secure [relative] is in safe hands" and "I'm going on holiday and I know they'll look after [relative] when I'm away."

We looked at the arrangements in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. The fire risk assessment had been completed in June 2016 and a number of actions had been identified. We found that these actions had been addressed, such as installing new smoke seals around fire doors and ensuring covers were in place on all loft access points.

External contracts were in place to ensure gas, electric, water and lifting equipment were safe. We viewed the certificates for these checks and they were in date. A variety of internal checks were also completed, such as the integrity of mattresses, portable appliance testing, water temperatures and call bells. This helped to ensure that the building remained safe.

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were aware how to raise concerns and were familiar with the safeguarding process in relation to their role. A policy was in place to guide staff on the appropriate actions to take in the event of any safeguarding concerns being raised and details of the local safeguarding team were available within the staff office. This enabled referrals to be made to the relevant organisations.

The care files we viewed showed that staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, self-administration of medicines, nutrition, mobility and skin integrity. These assessments had been reviewed regularly to ensure any change in people's needs was identified and appropriate measures put in place, such as regular weight monitoring and referrals to other health professionals. When people were identified as being at risk of falls, there was equipment available to help support them, such as sensor mats. People also had access to a call button that could be worn around their neck so they would be able to reach it wherever they were and call for assistance if needed.

We looked at accident and incident reporting within the home and found that incidents were recorded on an electronic system and shared with relevant personnel in head office. We found that accidents were recorded and appropriate actions were taken, such as requesting emergency services or making referrals to other health professionals, such as the falls prevention service.

We looked at how the home was staffed. A senior staff member told us there were usually three care staff and a senior carer on duty each day, as well as kitchen and domestic staff and that overnight two care staff were on duty. Staff rota's we viewed showed that these levels were regularly maintained. People living in the home told us they felt there were enough staff on duty to meet their needs. One person told us, "There are plenty of staff around" and another person said, "Staff come quickly if you need them." A third person told us, "If I do call there is someone here immediately." Relatives we spoke with agreed that there were adequate numbers of staff.

We looked at how staff were recruited within the home and found that records for newly recruited staff were available, but were not organised or easy to find and staff had to contact head office for some of the information we required. Staff who had been in post longer had an individual file containing their recruitment records. We looked the recruitment records for three newly recruited staff and found evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks. DBS checks

consist of a check on people's criminal record and an additional check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. By the second day of the inspection, staff had created individual personnel files for all staff.

There were no concerns raised regarding the cleanliness of the home. A recent infection control audit had been completed by Liverpool Community Health and the service had scored 99.68%. Bathrooms contained liquid soap and paper towels in line with infection control guidance and we observed staff wearing personal protective equipment appropriately throughout the inspection.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that one DoLS application had been authorised and this was reflected in the person's care plan. Another application had been made and was awaiting a decision. Staff we spoke with were aware who had an authorised DoLS in place and this was communicated to all staff through use of handover forms. We found that DoLS applications had been made appropriately.

When able, people signed to show their consent to their care and treatment. When there were concerns regarding people's capacity to consent to care or make decisions, mental capacity assessments were completed. We found however, that they did not always follow the principles of the MCA and they were not completed consistently. For instance, one person's file contained an assessment to establish whether the person could consent to living in the care home. The assessment stated they had been assessed as requiring residential care and did not assess the person's ability to consent to this, though the person had signed to show consent to the care plan in place for them. Another person's file contained an assessment that showed they lacked capacity to consent to their care and treatment, however there was no evidence that decisions were made in the person's best interest.

We were told that one person received one of their medicines covertly. This meant that the medicine was being administered to the person without their knowledge. We found however, that the necessary assessments and agreements were not in place to support this. For instance, there was no decision specific capacity assessment regarding the person's ability to understand the consequences of not taking the medicine. There was no evidence that a best interest decision had been made by relevant people regarding this decision. Staff told us the GP had agreed for the medicine to be given covertly, however the letter from the GP that we viewed stated the capsule could be "opened and put into food to aid ingestion." It did not agree to the medicine being given covertly. There was also no information from the pharmacist to agree it was safe for the medicine to be removed from the capsule and no information within the care plan as to how to administer the medicine. This meant that consent was not gained in line with the principles of the MCA.

On the second day of inspection a senior member of staff told us they had contacted both the GP and pharmacist and would ensure the necessary assessments and agreements were clearly recorded. Since the inspection we have been advised the medicine no longer needs to be covertly.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see how staff were inducted into their job role. We found that an induction system was in place that reflected the requirements of the Care Certificate. The Care Certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff. We were told that new staff had commenced the induction, but that this had not been fully completed by any staff. One staff member's records we viewed showed that they had been in post over 12 months and had not yet completed the induction or been signed off as competent in their role.

We looked at on-going staff training and support. Staff told us that they could go the registered manager for support if needed and were confident that they would be listened to. Staff we spoke with told us they had not had an annual appraisal and records showed that supervision was not provided regularly. Records showed that three staff had received supervision in March 2017 and other staff had not received a supervision since 2016 or for some 2015. A senior staff member told us that supervision should take place every six to eight weeks. This meant that systems in place to support staff in their roles were not adhered to.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training records showed that staff had completed training in areas such as safeguarding, fire safety, nutrition, moving and handling, dementia health and safety, equality and diversity and end of life care. We also saw that staff attended additional training to help ensure they had the necessary knowledge to meet people's health needs. These courses included diabetes, Parkinsons disease, catheter care and epilepsy. Staff we spoke with told us there was sufficient training and that they completed this regularly.

Records showed that people were supported by care staff and external health care professionals to help maintain their health and wellbeing. Advice, care and treatment was sought from relevant health and social care professionals, such as the district nurses, social worker, G.P, podiatrist and dietician. People living in the home told us they could see their GP whenever they wanted to and that staff made the arrangements. People comments included, "I'd tell staff and they'd call [doctor] in", "Yes, they'd [staff] call the doctor in and the district nurse if needed" and "I've just had [an illness]. [Staff] called the doctor in immediately and I got treatment."

We received mostly positive feedback regarding the meals available in the home.
When asked about the food people told us, "The food is nice and there is plenty to drink. You always get a jug of fresh water in your room every day", "I like the meals, I really enjoyed the dinner today" and "The food is absolutely superb, you couldn't get better in a hotel." One person told us there is a food they particularly liked, but as nobody else liked it, it was not on the menu, however another person told us, "The cook will always cook something different and make me what I want." One person we spoke with had a specific dietary requirement and told us the chef sourced special ingredients to make their meals.They said they were very happy with the food they received.

We observed lunch and saw that most people sat at the dining room tables for their meal. Tables were laid with cutlery, condiments and paper serviettes and the menu was displayed on the wall. There was a lot of conversation at lunchtime, though some people found it difficult to hear other people as it was quite noisy with the kitchen door open and lounge television still on. Staff were available to provide support to people and we saw that this was done discreetly and people were not rushed.

Good

Is the service caring?

Our findings

People living at James Dixon Court told us that staff were kind and caring and treated them well. Their comments included, "Staff are great, I couldn't find better", "Staff are kind and they listen. If anything goes wrong I only have to ask them", "I'm very lucky to be in a place like this",
"They [staff] are very attentive" and "The staff are really lovely, nothing is too much trouble." Relatives we spoke with all agreed and one relative told us, "The staff's attitude is great."

We observed people's dignity and privacy being respected by staff during the inspection, such as staff knocking on people's door before entering their rooms and waiting for a reply before they entered. When people requested support staff assisted the without delay and all personal care was carried out in private. Interactions between staff and people living in the home were warm, friendly and that of mutual respect. One person told us, "Staff are very respectful because they know I like my privacy." Staff we spoke with described how they ensured people's privacy and dignity were maintained when they provided personal care. Examples included making sure blinds or curtains were drawn and doors were closed, using towels to cover people and always explain care and request consent.

We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

Care plans were written in such a way as to promote people's independence. For example, they clearly reflected what people were able to do for themselves and what they required staff to assist them with. When able, people were encouraged to manage their own medicines and one person told us they managed their medicines safely as they had been provided with a locked box to keep them safe in their room. There was a positive risk taking policy in place and this supported people to maximise their independence.

People we spoke with told us they had choice regarding the care and treatment they received and could choose how they spent their day. One person told us, "I wake up early so get washed and dressed myself and have breakfast in my room" and another person said, "I have my own routine, I usually get up early. Night [staff] get me washed and then bring me a cup of tea before breakfast." A third person told us, "Yes, I get up when I want to." One person's personal care plan reflected that they only liked female staff to support them. The service only had female care staff employed at present, but a staff member told us they used to have male carers and that people always have a choice as to who assisted them with their care.

Staff we spoke to knew the people they were caring for well and told us they were kept up to date about any change in people's needs through daily handovers, use of the communication book and reading people's care plans. Relatives also told us they were kept well informed and we saw that staff had open and respectful relationships with relatives who visited the home during the inspection.

We observed relatives visiting throughout both days of the inspection. The staff told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us their relatives could visit at any time and relatives we spoke with agreed. One relative told us that family members

who lived away had come to visit and the staff arranged a large room for them all to meet in and provided drinks throughout the visit.

Staff told us that if people had no family or friends to represent them, they would support them to access a local advocacy service. We found that there were no contact details for these services available within the home, however, staff told us they used to have leaflets advertising local services and would ensure they obtained more to display in the home.

Senior staff told us there was nobody living in the home at the time of the inspection that had any specific cultural or religious needs, but that they would ensure these needs were met if they arose in the future.

There was nobody receiving end of life care at the time of the inspection. Staff had received training in this area to help ensure they would be able to support people.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they knew how to raise any concerns and felt confident that the registered manager would address any issues they had. A complaints policy was available and kept in a policy folder for staff. There were no contact details on the policy to advise who to contact and the policy was not on display for people living in the home or their relatives. On the second day of inspection a senior staff member had printed a copy of the complaints' policy, they displayed it within the home and provided a copy to all people living in the home.

There was no complaints log available to evidence how complaints had been investigated and whether they had been resolved. A relative we spoke with told us they had raised some concerns in the past and that they had been resolved to their satisfaction, however there was no record of these concerns. This meant that the service could not demonstrate how they had made improvements based on complaints received, or show how the service had learned from complaints.

We spoke to the registered manager regarding this after the inspection and they told us they usually recorded any concerns raised within people's care files.

We recommend that the provider reviews its procedures regarding complaints and updates them accordingly, to ensure there is a clear and transparent system in place to record complaints and their outcomes.

We asked people to tell us about the social aspects of the home and feedback was mixed. There was no activity coordinator employed and activities were provided by care staff. Activities available were advertised within the home and included nail painting, hairdresser, bingo and films. We also saw that external entertainers visited the home when available. For instance, a local singer provided entertainment on the second day of the inspection and we saw that a number of people stayed in the lounge to listen to the music and some people sang along. Staff told us about the recent Easter bingo which people enjoyed and on Grand National day they arranged for somebody to visit the home with a selection of hats.

Most people living in the home that we spoke with told us they spent a lot of time in their rooms watching television and some people told us they would like more activities. One person told us there used to be quizzes and painting which they enjoyed, but was no longer available. A relative we spoke with also told us they thought more activities were needed and another relative told us that their family enjoyed spending time in the garden which was encouraged when the weather was nice.

A staff member we spoke with told us there was not enough resources available for activities and that the staff tried hard to ensure there were activities available for people that they enjoyed. For instance, the registered manager and staff provided the prizes for bingo and purchased nail varnish to be able to paint people's nails.

We recommend that the provider reviews social activities and updates its procedures accordingly to ensure

relevant activities are available to meet people's individual needs.

We saw that care files contained a pre admission assessment completed prior to people moving into the home; this ensured the service was aware of people's needs and that they could be met effectively from the day they moved in.

Not all people we spoke with could not recall being involved in the creation or reviews of their care plans; however we looked at the plans of care and found that they contained person centred information, which showed that people had been consulted. Signed consent forms also indicated that care and treatment had been discussed and agreed with people. Relatives we spoke with were aware of the plans and told us they were involved in their family member's care.

We observed care plans in areas such as physical health, nutrition, wellbeing, communication, medicines, relationships, mobility and finances.

All care plans were reviewed regularly by staff and appropriate actions taken when there was a change in people's needs. For instance, one person's plan reflected that they had lost weight and so had been referred to the dietician. The plan stated that the person's weight should be monitored weekly and records showed that this was completed.

Care plans were specific to the individual person and most were detailed and informative. For example, one person's plan described the clothes they liked to wear, how they liked them to be coordinated and to look smart. Another person's plan described their preferred night time routine and what support they wanted the staff to provide overnight. People's preferences were also reflected within their care plans, in areas such as daily routine, meals, activities and support requested. This meant that staff provided support to people based on their needs and preferences.

Staff we spoke with told us they were informed of any changes in people's care needs through daily verbal and written handovers between staff, use of a communication book and by viewing people's care files. This helped to ensure that staff were aware of people's current care needs so that they could support them effectively. Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. For example, staff we spoke with were aware who had a DoLS authorisation in place and knew if people had any specific dietary requirements.

We looked at processes in place to gather feedback from people and listen to their views. Records showed that meetings took place for people living in the home and their relatives and people we spoke with confirmed this. A quality assurance questionnaire had been recently distributed to relatives and visiting health professionals in order to gain their views regarding the service.

Requires Improvement

Is the service well-led?

Our findings

During the visit we looked at how the registered manager and provider ensured the quality and safety of the service provided. We viewed completed audits in areas such as medicines, which included daily MAR charts checks as well as a monthly audit; no actions were highlighted following these audits. The registered manager also completed a monthly care home checklist, which looked at the safety of the home, certificates in place, first aid boxes and fire safety. The audit identified actions and these had been signed off as completed. Other audits included infection control, mattress audits and kitchen checks. Senior staff were not able to locate care plan audits during the inspection, but told us they were completed. The registered manager told us after the inspection, that care plan audits were included within the monthly reviews which they regularly observed.

A member of the provider's quality team visited the home regularly to complete an operational compliance audit and this had last been completed in January 2017. This audit covered areas such as care plans, complaints, medicines, quality assurance surveys, training, risk assessments and the environment. Identified actions were recorded at the end of the audit; however there was no evidence that these actions had been addressed. For instance, one action was to ensure the quality assurance results were communicated to staff, relatives and people living in the home, but people we spoke with were not aware of the results. The visiting registered manager was able to obtain the collated results from the survey which indicated some comments that required action to be taken to address them, however there was no evidence to show that any action had been taken. For example, there were comments regarding the lack of activities and clothes not being put into the correct person's room.

We found that although audits were completed, they did not identify all of the issues highlighted during the inspection, such as those relating to consent, complaints, staff support systems and the safety of the environment. This meant that systems in place to monitor the quality and safety of the service were not always effective.

We looked to see if people were provided with information regarding the values and objectives of the organisation; however senior staff told us there was no service user guide available for people to provide information regarding the service. On the second day of inspection we were shown an old service user guide from 2011 which did not provide up to date information regarding the service.

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

The home had a registered manager in post, although they were not in work at the time of the inspection. We asked people their views of how the home was managed and feedback was mostly positive. People living in the home told us they knew the registered manager and they were, "Approachable" and "Attentive." Relatives we spoke with agreed and one relative told us, "The new manager has been excellent and there is good practice across the board." Staff we spoke with felt supported.

Records we viewed showed that staff meetings took place every few months and covered areas such as training, updates regarding the home and CQC inspections. Staff we spoke with described these as 'flash meetings' and that they were not always planned or advertised. Not all staff we spoke with had the opportunity to attend these meetings and told us planned staff meetings would be beneficial. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home.

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 were able to monitor information and risks regarding James Dixon Court.

We saw that the ratings from the last inspection were displayed within the home as required. From April 2015 it is a legal requirement for providers to display their CQC rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection was displayed within the service for people to see.

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 11 HSCA RA Regulations 2014 Need for consent Consent was not always gained in line with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safety of the environment was not always maintained as chemicals were not all stored safely and a fire door was wedged open.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess and monitor the quality and safety of the service were not always effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported in their role through induction, supervision and appraisal.