HC-One Oval Limited

Carders Court Care Home

Inspection report

23 Ivor Street
Rochdale
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Tel: 01706712377

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Carders Court is a care home providing nursing and personal care for older people. It is situated in the Castleton area of Rochdale. The home is purpose-built, single storey and comprises of five separate houses, each with 30 single bedrooms. There is ample car parking to the front of the home and there are garden areas around each unit for residents to sit out. There were 127 people accommodated at the home on the day of the inspection.

At the last inspection of June 2017 there was a breach in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Regulation 12 Safe care and treatment. This was for some aspects of medicines management which was not safe. The service sent us an action plan to show us how they would improve. At this inspection the service had improved and there were no breaches.

There was no registered manager. However, there was a person employed by the service experienced in care home management who had applied to become registered manager. The application is currently being processed by the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We made a recommendation in relation to medicines. We asked the provider to look at best practice guidance around the returning of medicines no longer required.

We made a further recommendation in relation to signage in the environment. We asked the provider to look at best practice guidance around the signage of all units of the home where people have a dementia related illness.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff were safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and homely in character.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business contingency plan for any unforeseen emergencies.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well nourished.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of their responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work related issues and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed.

There were sufficient activities to help keep people stimulated.

People were treated in accordance to their age, gender, sexuality and religion.

Plans of care were individual, person centred and reviewed regularly to help meet their health and social care needs.

Visiting was unrestricted so that people could remain in contact with family and friends.

Quality assurance audits helped the service maintain and improve their standards of support.

Nearly all the people we spoke with and staff thought the managers were approachable and supportive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Managers understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS.

People were given a nutritious diet and said the food provided at the service was good.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

Is the service caring?

Good

The service was caring.

We observed staff had a kind and caring approach to people who used the service.

People were encouraged and supported to keep in touch with their family and friends.

We saw that people were offered choice in many aspects of their

lives and encouraged to remain independent.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns and people told us they felt confident they could raise any issues.

People were able to join in suitable activities if they wanted to.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was well-led.

The service did not have a registered manager. It is a condition for the service to have a registered manager and cannot be rated as good in this domain until a person had completed the registration process.

Records were maintained and available for inspection. This included all management audits and policies and procedures.

There were systems in place to monitor the quality of care and service provision at this care home.

Carders Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was an unannounced inspection on the 17 July 2018 and was conducted by three adult social care inspectors, an assistant inspector and two Experts by Experience. An Expert by Experience is a person who has experience of caring for older people or a dementia related illness.

We requested and received 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 this information to help with planning the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also asked Healthwatch Rochdale and the local authority if they had any information about the service they wished to share. We did not receive any concerns from them.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We spent time in the communal areas of the service and carried out an observation using SOFI.

We spoke with fourteen people who used the service, five relatives, the manager, six care staff members and the cook.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records of seven people and medicines administration records for ten people who used the service. We also looked at the recruitment, training and supervision records for six members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe at Carders Court and made comments such as, "I feel quite safe and very well cared for."

From looking at the training records and talking to staff we saw that staff had been trained in protecting people from abuse. Staff had access to a safeguarding policy and procedure. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy, which is a commitment by the service to encourage staff to report concerns with no recriminations. The staff we spoke with were aware of safeguarding issues. Staff made comments such as, "I know the procedures around safeguarding, I just pass on any information to the senior who will escalate it. I'm always passing things on, just in case, you never know!" and "I know what whistleblowing is but I'm not shy anyway. If I thought something was happening that shouldn't be I would just speak to one of the managers about it."

We saw that where a safeguarding issue occurred managers investigated the incident to seek a satisfactory resolution. We asked Rochdale Metropolitan Borough Council safeguarding team if they had any concerns. They told us the service reported any safeguarding incidents and they were satisfied the service responded to them appropriately.

We looked at six staff files. We saw that there had been a robust recruitment procedure. Each file contained two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member had a criminal record or been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and were safe to work with vulnerable adults.

We saw that checks were undertaken on qualified nursing staff to ensure they remained registered with their professional body, the Nursing and Midwifery Council.

Each unit was staffed separately. On the day of the inspection there was an overall (turnaround) manager, a clinical services manager, a head of care manager and administration staff who provided management and support for the staff who worked on the five units. On Linden house there were two registered nurses and four care staff to provide care and a hostess who assisted with meals. There were two registered nurses and five care staff on Rakewood house, and five or six care staff on the residential houses with one of the staff holding a senior position. There was also a chef and two kitchen assistants, four domestic staff, a maintenance person, two laundry assistants and a gardener.

Some of the people and visitors we spoke with thought there were enough staff on duty and some thought

staff were under pressure and hard worked. However, when we asked if people who used the service thought staff responded to them quickly when they needed assistance they all said they thought staff did. They all agreed they got the care they needed in the way they wanted it. The manager said they used a dependency tool to determine staffing numbers and thought there was enough staff except when staff called in sick at the last moment when they tried to cover with existing staff or agency.

We saw that the electrical and gas installation and equipment had been serviced. There were other certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing, the lifts and fire alarm system. Hot water outlets were checked by the maintenance person to ensure water was delivered at a safe temperature. Windows had a restricting device to prevent accidental falls and radiators did not pose a risk of burns. We checked the water temperatures of some hot water outlets and they were safe.

Hoists and lifting equipment was serviced and staff trained to use them correctly.

Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the fire procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. A copy on the PEEP was retained at the entrance hallway on each 'house' to pass to the fire service in an emergency. The service also had a business contingency plan to ensure the service could function in the event of an emergency such as power failure or fire.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

On the day of the inspection we toured all communal areas of the home and many bedrooms. We saw the home was clean, uncluttered and did not contain any odours that people may find offensive.

There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy. Senior staff also conducted twice daily walk around audits to check for cleanliness and infection prevention and control standards.

There was a laundry sited away from any food preparation areas. There were three industrial type washing machines and two dryers to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to. However, we noted that there were no named bowls for people who required a bed bath which could pose an infection control issue. The manager said they would put a person's name on the bowls used for this procedure.

We looked at seven plans of care during the inspection. We took a selection of the plans of care from each of the five units. We saw there were risk assessments for moving and handling, falls, tissue viability (this is to prevent pressure sores) and nutrition. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service. We saw that where

necessary professionals we called in to provide information and guidance, for example speech and language therapists. We saw the risk assessments helped people keep safe and did not restrict their lifestyles.

We looked at the systems for the administration of medicines and we did not spot any errors. Overall the system was safe although we saw that the returning of unused medicines to the pharmacy posed a potential problem of misuse. We made a recommendation to the service to get a tamper proof box from their pharmacist. This is considered the safest way to return medicines which are no longer required. People who used the service told us their medicines were brought by staff when they expected them to.

All staff who administered medicines were trained to do so and had their competencies checked by managers regularly.

Medicines were stored in a locked cupboard and only staff who needed to had access to the keys. The temperature of the medicines cupboard and dedicated fridge was checked daily to ensure medicines were stored to manufacturer's guidelines.

We checked the controlled drugs cupboard and register. Controlled drugs are stronger medicines which need more stringent checks. We saw that two staff had signed for the administration of controlled drugs which is the correct procedure. We checked the numbers of controlled drugs against the number recorded in the register and found they tallied.

Any medicines that had a use by date had been signed and dated by the carer who had first used it to ensure staff were aware if it was going out of date and there was a safe system for disposal. Any handwritten prescriptions were signed by two staff which is the recommended safe method.

There was a signature list of all staff who gave medicines to enable managers to follow an audit trail for any errors. The service had a copy of the National Institute for Health and Clinical Excellence guidelines 2017 for administering medicines in care homes. This is considered to be best practice guidance for the administration of medicines.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24-hour period, the route it should be given and what it was for. This helped prevent errors.

We saw that topical medicines such as ointments were recorded in the plans of care. The service used body maps to show staff where to apply the medicines.

The medicines system was audited by staff weekly and managers regularly to spot for any errors. Staff retained patient information leaflets for medicines and a copy of the British National Formulary to check for information such as side effects.

There were systems in place to respond to concerns, incidents and accidents. We saw the manager investigated any incidents and looked for a resolution to minimise any risks of reoccurrence. All adverse incidents were also audited by the area manager to look for possible trends.

Good

Is the service effective?

Our findings

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

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005). We saw that the service assessed each person's mental capacity.

Following assessment any person who did not have the mental capacity to make their own decisions had an application submitted to the relevant authorities for a DoLS. We saw that 76 people had a DoLS application granted for them to stay in the home. We also saw that best interest meetings were held for some people who lacked mental capacity. Best interest meetings are held for people who do not have the mental capacity to take their own decisions and are attended by the person, where possible, family members if appropriate, staff from the home and professionals from other organisations such as their GP. This meant that any restrictions to a person was taken in the least restrictive way. People had access to an independent mental capacity advisor or advocate. These are professionals who act independently for people to protect their rights.

We saw that where possible people had signed their consent to care and treatment. We observed staff asking people for their consent before undertaking their care and support.

We toured the home on the day of the inspection. We saw that the home was clean, tidy and did not contain any offensive odours. We went onto all the units. Signage on some of the houses was good which would help people know which was a bathroom or toilet. People had a memory type box outside their bedroom doors. However, one house where people with a dementia related illness were accommodated we found the signage was not as good and made a recommendation. We recommended the provider look at best practice guidance for the signage of a building for people with a dementia.

We did see bedrooms were personalised to people's tastes and were suitably furnished. The communal areas contained sufficient seating and areas to dine in. Some communal areas had a theme, one being a pub and another a tea room. There were gardens for people to sit out in good weather with some areas safe for people with dementia.

There were both baths and showers for people to have a choice in the way they wanted to be kept clean and hoisting aids to assist people with mobility.

Most of the people we spoke with said they thought the home was kept in good condition and some areas had been redecorated. One family member thought the house their family member was on would be better with new carpets.

Most of the people we spoke with thought the food served at the home was good. Comments included, "Mealtimes are very good and we don't go short of drinks or snacks if we want them"; "You can get a snack when you want"; "The food is very good, they take me down to the dining room for my meals" and "We get good food here. I really like all the meals". However, two people said, "The food's good and I've put weight on which is good" and "I'm not impressed at all with the food, but it has improved a bit because you can have a salad instead of the usual sausages for a change." A relative said, "The food could be improved; chicken nuggets aren't really the best thing."

The kitchen had been rated as five star, very good by the local authority which is the highest rating. This meant the kitchen staff had followed safe practice in the storage and serving of food and had effective systems to keep the kitchen clean. We saw there were good supplies of fresh (including fruit), frozen, canned and dried foods. We spoke with the chef who had a list of which people required a special diet or needed their food fortified to help them gain weight. The chef also had a list of any allergies to food people had. The cook said they produced as many desserts or puddings they could for people with diabetes so they could have what was on the menu. On the day of the inspection the trifle was made with diabetic jelly.

We observed mealtimes on two of the houses. We saw the meals were not rushed and there were enough staff to support people to take their meals. The tables were set with tablecloths, flowers, napkins and condiments for people to flavour their food to taste. One of the inspection team was invited to sit with people who used the service and said staff interaction was good, as was the meal.

People had what they wanted from the normal range of breakfast foods, there was a lighter lunch with the main meal served in the evening. A supper was also available for those who wanted it. Drinks were served at mealtimes, at other set times and when people asked for one. We saw people had a drink of their choice often during the day. There were hydration champions on each unit who ensured that people were hydrated in the hot weather.

The cook recorded the meals served to provide an audit trail should any problems arise. Each care plan showed a person's dietary needs, referrals made to a Speech and Language Therapist (SALT) if required and people's weights were recorded to see if they were gaining or losing weight.

All new and current staff were completing the homes induction called the learning and development program. This included staff undertaking the care certificate which is a nationally recognised training course. The induction covered key policies and procedures, personal development, all the mandatory training such as safeguarding, the care of people with dementia, privacy and dignity, fluids and nutrition, an awareness of mental health issues, basic life support, health and safety, handling information (confidentiality) and infection prevention and control. There was a separate booklet for nurses with training around their specific practice needs. We saw booklets were being completed by staff.

New staff were shown around the home, introduced to staff and people who used the service and had the terms and conditions of working at Carders Court explained to them. They were supported by an experienced member of staff until they were confident and competent to work on their own.

The training also included how to safely manage people whose behaviours may challenge, food safety, medicines administration, nutrition and hydration and care planning. Two registered nurses were completing end of life training at the local hospice which would enable them to pass on their knowledge to other staff. The manager said they were hoping there would be more placements for other staff.

Other staff had completed more training to become 'champions'. They were then able to pass on the extra knowledge to other staff. This included a champion for hydration, the care of people with a dementia, dignity and completing supplementary charts.

Staff told us they had regular supervision with a manager and they had the opportunity to bring up their own needs including training. We saw the records that showed supervision was held around every three months and enabled managers to assess staff performance. Appraisal of staff was held annually.

We saw the service liaised well with other organisations and professionals. Each person had their own GP and had access to professionals such as specialist nurses, hospital consultants and speech and language therapists (SALT). People were also supported to attend routine appointments with opticians, dentists and podiatrists.

Good

Is the service caring?

Our findings

People who used the service who we spoke with said, "The staff are all very good and really caring"; "I can't fault the care home or the staff, it's all very good. They are so good that I am convinced I would be better off here long term, living here does seem to suit me"; "They look after me well, we're well-looked after here"; "The staff are very nice"; "I like it here; the staff are OK" and "Staff are lovely, but they don't always have time to chat."

Two visiting professionals said, "Staff communicate well with us and keep appropriate records. I've had good feedback from relatives about the care their loved ones receive. Staff seem really amenable and kind to people. I've never seen anything of concern, people always look cared for and well presented, calm and happy" and "I've no concerns. People always seem happy and settled. People receive effective pressure care in terms of their skin care and people always looked clean and well kempt. Staff seem to follow the guidance we provide and make accurate records."

Two staff members we spoke with told us, "I love caring for people, I've done it all my life. I feel like I am doing something really worthwhile" and "I have been here for many years and seen a lot of changes. We have some great staff though, it's a real family environment."

A person's communication needs were recorded in the plans of care. In one plan of care it showed how the service had recorded a person's abilities to communicate in a non-verbal way. Staff observed the person's body language to help determine what the person wanted.

We observed staff during the inspection during the day and our lunch time observations. Staff were seen to be kind and have a good but respectful rapport with people who used the service. A lot of staff had worked at the service for some time and knew people well.

We saw that staff were discreet when offering personal care which helped maintain people's privacy. We also saw that where one person was incorrectly dressed the staff member spoke in a quiet voice to point this out to the person which helped maintain the person's dignity.

People were encouraged to do things for themselves. One person told us "I get up during the night and get myself a drink. I can do what I want when I want, it's very good". Other people told us they could do what they wanted. Plans of care informed staff what a person could do for themselves and to encourage people to perform the tasks they could do. For example, it was recorded if a person could perform part of their own personal care. This helped people retain some independence.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We spent time in the communal areas of the service and carried out an observation using SOFI. We observed people were comfortable in their surroundings with no signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly and there were easy

conversations taking place. We saw that staff were never far away if someone needed help and encouraged people to be independent. For example, we observed a staff member waiting discreetly and patiently whilst a person carried a drink to a table, rather than doing this task on their behalf.

Plans of care showed people had been consulted about their known choices and preferences. This included if a person preferred a particular gender of staff, their religious needs, what foods they liked or how a person preferred their oral health care to be delivered.

All records were stored confidentially in an office and staff were taught about confidentiality and data protection topics. Staff were also informed about not putting confidential information on social media.

We saw that people could attend religious services if they wished. On the day of the inspection a member of the clergy was visiting people in the home. This person told us, "I do not have a lot of experience of this home but I find the place to be pleasant, calm and, for the staff, busy. They do seem to be organised and all appear cheerful and relaxed with the residents. I have been made welcome here and the lady I am seeing is fully capable of making her opinions known if necessary so I take it that all is well."

Visiting was unrestricted and visitors told us staff were welcoming. Several people went out to visit their relatives including one person who said they went home most days. This helped people who used the service to remain in contact with family and friends.

We saw that people had access to advocates. Advocates are independent people who act on behalf of people who live at a care home to ensure their wishes are followed and rights protected. We saw an advocate entering one of the houses on the day of the inspection to attend a meeting and act on behalf of someone.

There is an organisation where people can put independent reviews online. We saw comments made were positive and included "The staff are friendly and helpful, they have treated our relative with respect and given unlimited care and attention" and "A loving care home and staff."

Good

Is the service responsive?

Our findings

The service had introduced new technology into the home, specifically around infra-red sensors that would alert staff if a person who was at risk of falling got out of bed. The service also used a sensor mat which would notify staff if someone was having an epileptic fit.

There were five activities co-ordinators working at the service. This meant there was someone to provide activities all week. People we spoke with said they could attend activities if they wished and tended to 'pick and choose' what suited them. On the day of the inspection we saw people playing dominoes and enjoying various games which encouraged exercise.

People who used the service told us, "The gardens are beautiful, and they take me out there if I want to. We can go out if we want to"; "The trips out are good" and "I go when the singers are on, if there's anything on I go to it. (Activity Co-ordinator's Name) did a competition yesterday."

The service provided a range of activities people could attend if they wished. Activities included watching television, pamper sessions, gardening, baking, coffee mornings, games, quizzes, arts and crafts, music and exercise, playing dominoes and card games and going out with staff into the garden.

External entertainers came into the home occasionally and special events laid on during the year, such as Easter, Christmas and Birthdays. People were also taken on trips to seaside towns and had been to Llandudno and Blackpool. Further trips were planned to Llandudno for people who were not able to go on the first trip there and a barge trip on a local canal. If people wished they could attend activities suitable to their age and gender. There was a bar in one of the houses where people could go for a drink and if people were able to also had alcoholic drinks in their own house.

Staff attended a handover at the start of their shifts. These sessions gave staff the chance to pass on any relevant information about a person to each other to ensure there was good communication around any appointments and/or report on a person's health and well-being.

People who used the service said, "I have no complaints at all about the care I get here. I think they do try to encourage my independence and generally they do come when I call for assistance" and "There's never been any issues, but I know who to complain to if I need to." Six of the people we spoke with said they had been encouraged to raise concerns when necessary and three said there was no need as there was nothing to complain about. All nine were agreed that their health and wellbeing was managed appropriately and they could choose freely enough on everyday issues.

A staff member said, "I have never needed to complain but felt listened to when I raised 'gripes' with the manager. I am satisfied that the manager listened to my concerns and I saw improvements."

There was a suitable complaints procedure located at various points around the building. Each person also had a copy in the documentation provided on admission. The complaints procedure told people how to

complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission. All complaints were recorded and showed the manager investigated and where appropriate took action to provide the complainant with a satisfactory response.

We also saw that any accidents, incidents and safeguarding referrals were investigated and ways to minimise repeat episodes sought.

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority had also provided their own assessments for some people to ensure the person was suitably placed. This process helped to ensure that people's individual needs could be met at the home.

We looked at seven plans of care during the inspection. Plans of care showed us what level of support people needed and how staff should support them. Plans of care had been developed with people who used the service or a family member. Each heading, for example personal care, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. Each person's day was recorded with what they had done and how they had been. The plans were regularly reviewed. We also saw that supplementary records such as fluid balance charts were accurately maintained.

We saw that people had access to professionals if it was noted that a person's needs were changing. We saw in one plan that people were referred to the mental health team and other plans showed people had attended hospital appointments. This meant people's health care needs were monitored and they had access to current treatments.

Two staff were currently undertaking an end of life care course at the local hospice with plans for more staff to attend when places became available. This is external training provided by qualified staff and will enable staff to plan for people's care if their condition deteriorates. Staff who have had this training will pass on their skills to other staff. There were some details recorded in people's care plans, which meant that their wishes would be known to staff when they came to the end of their life. We were told that where possible people would be transferred to a nursing unit for terminal care. One person had commented on a web site 'Our relative was extremely well cared for. We could not have asked for more. So well treated on end of life care."

Meetings were held regularly with people who used the service although several of the people we spoke with had never attended one and did not wish to. The home changed hands in January 2018 and is again being put up for sale. People who used the service, staff and relatives are uncertain as to the future of the home. This was discussed at the last meeting with details around the plans for maintaining morale, retaining staff and dementia workshops to improve the understanding of the care of people who had a dementia.

Good

Is the service well-led?

Our findings

There was no registered manager. However, there was a person employed by the service experienced in care home management who had applied to become registered manager. The application is currently being processed by the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people who used the service what they thought about the management of the home. People we spoke with thought the home was well-led and people made comments such as "The unit manager is great" and "The staff and the management are all very good and easy to talk to."

Staff told us, "To be honest, if you ask about things, you just get flannel really. They just tell you what they think you want to hear"; "I feel happy to share issues with my managers, they are very approachable" and "I get good support from the unit and general manager. The unit manager is excellent and understands the work that the carers have to do."

Staff meetings gave staff the chance to have their say about the home was run. Items on the agenda on the meeting of June 2018 included effective recording, the keyworker system, tidying up, staffing, safety, incontinence aids, recording people's weights, cleanliness, personal care needs and incentives for staff who wished to do overtime. Staff were able to bring up topics of their own. Each morning heads of houses, managers and other key staff met to discuss any issues, news or specific care needs of people who used the service.

The registered manager undertook many audits to check how the service was performing. The audits included health and safety, medicines administration, infection control, plans of care, the level of cleanliness, accidents and incidents, specific reportable incidents like pressure sores, the environment, dignity in dining and clinical reviews. We saw where any shortcomings were spotted the service completed a plan to show who was responsible for completing the improvement and when it had been completed.

Managers conducted twice daily walk around audits to check that the home was functioning to a good standard and where possible talk to staff and people who used the service. The area manager was at the home and completed audits to check on the progress the service was making. The area manager looked at all aspects of running the home, checked that any agreed actions had been completed and who had completed them.

There was a service user guide and statement of purpose which told people who used the service, other professionals and relatives of the facilities and services provided at Carders Court. The current rating was available for people to view in the care home and on their web site as required by the CQC.

We looked at some of the policies and procedures which included infection control, safeguarding, whistle

blowing, complaints, health and safety, care planning, recruitment and medicines administration. Policies and procedures were updated regularly and available for staff to follow good practice.

Incidents, accidents and DoLS notifications were sent to the CQC as required under the regulations in a timely manner.

Quality assurance questionnaires had not yet been completed for the current year but were planned for later in 2018. They had been completed for 2017.