Akari Care Limited

# Charlton Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 18 and 21 April 2017 and was unannounced. This meant staff and the registered provider did not know that we would be visiting.

Charlton Court is a 55 bedded purpose built care home providing personal and nursing care for older people and older people with dementia. At the time of the inspection there were 53 people using the service.

At the last inspection in March 2015 we rated the service as 'good' overall which meant the provider was meeting all the regulations.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives we spoke with told us they felt the service was safe. Risks to people using the service were assessed and plans put in place to minimise the chances of them occurring. However, we found some gaps in recording which meant that people may not have been as safe as they could have been.

People and their relatives told us staff at the service provided personalised care. Care plans and associated records, including for example, food and fluid charts were person centred but not always in place or fully completed.

People's medicines were managed safely, with staff showing particular kindness and respect during their administration. We found that thickeners had not always been secured as they should have been to protect people from harm. Hot trolleys in the dining areas were not always staffed and this posed a risk of harm to people who lived at the service, particularly those living with dementia.

We found some areas in connection with infection control which needed to be improved, including the continued use of gloves when they should have been discarded.

Safeguarding and whistleblowing procedures were in place to protect people from the types of abuse that can occur in care home settings. Staff were able to explain their safeguarding responsibilities and what they would do should they need to contact professionals in relation to this.

Emergency procedures were in place and monitored by staff at the service and accidents and incidents were recorded and monitored.

There were enough staff deployed to keep people safe and the provider's recruitment processes minimised the risk of unsuitable staff being employed. We recommended that the provider record any involvement by

people who lived at the service in the recruitment process.

Staff received mandatory training in a number of areas, which assisted them to support people effectively, and they were supported with regular supervisions and appraisals.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following the requirements in the Deprivation of Liberty Safeguards (DoLS), although not all decisions were being recorded.

People were supported to maintain a healthy diet and to access external professionals to monitor and promote their health.

People and their relatives spoke positively about the staff at the service, describing them as kind and caring. Staff treated people with dignity and respect. Staff knew the people they were supporting, and throughout our inspection we saw staff having friendly and meaningful conversations with people. People told us they had choice and were supported to be as independent as possible with staff acting as their advocate should that be needed.

People were supported to access activities they enjoyed. However during the inspection we noted that activities were localised downstairs and people living on the dementia care unit in particular were not benefiting from access to activities. We recommended that the provider review their activity programme to ensure that all people living within the service has access to meaningful activities tailored to them.

Procedures were in place to investigate and respond to complaints. We made a recommendation that the provider records all minor issues and corresponding actions, where a formal written complaint has not been made.

People, relatives and staff spoke positively about the registered manager and said she supported them and included them in the running of the service.

The registered manager and registered provider carried out a number of quality assurance checks to monitor and improve standards at the service. Although they had not identified all the concerns we had found during our inspection, these were to be added to their action plan.

The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

People told us they felt safe at the home. However we found some issues with safety that needed to be addressed, including those in connection with infection control and unattended hot trolleys.

Staff numbers were adequate to complete all of the tasks they had to do and ensure people's needs were fully met.

Medicines were managed appropriately, although thickener storage needed to be addressed.

Staff were able to describe to us how they would respond to any concerns of a safeguarding nature.

### Is the service effective?

**Good**

The service was effective.

There were induction and training opportunities for staff and staff told us they were supported by their line manager.

Staff had an understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

A range of suitable food and refreshments were available throughout the day and people where supported to eat and drink where necessary.

### Is the service caring?

**Good**

The service was caring.

Staff and people enjoyed positive relationships with one another and people spoke kindly of all the staff at the service.

People were involved in their care and their privacy, dignity and independence was promoted.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care records were person centred and regularly reviewed but we found gaps in recordings.

There was little evidence of suitable activities tailored to people living with dementia in particular.

There was a complaints procedure in place and people knew how to complain, but we have made a recommendation for minor issues to be recorded.

People told us they were able to make choices about how their care was delivered.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

There were issues which had not been found during quality audits and these were to be added to the provider's action plan.

The registered manager was well liked and staff told us that they enjoyed working at the service.

The provider sent notifications to us in line with their responsibilities and legal requirements.

# Charlton 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 the 18 and 21 April 2017. The inspection was unannounced. The inspection team consisted of one inspector and a specialist advisor who was a tissue viability nurse.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are reports about any changes, events or incidents the registered provider is legally obliged to send us within required timescales.

Prior to the inspection we contacted the local authority safeguarding and contracts teams to gather their views of the service. We also contacted the care management team and the local area infection control lead for care homes. Care management is part of the local authority and supports individuals within care settings who receive funding from the state. Healthwatch was also contacted. Comments received were used to support the inspection planning process.

During the inspection we spoke with 10 people who used the service and eight relatives. We spoke with the registered manager, the deputy manager who was also a registered nurse, one agency nurse, three senior carers, six care staff, the administrator, a member of kitchen staff, the housekeeper, a maintenance person and a domestic staff member. We looked at eight people's care, activity and medication administration records (MARs). We also looked at five staff personnel files and the records related to the overall management of the service.

We spoke with a community nurse, a community psychiatric nurse and a GP who were visiting the service during our inspection. We used their comments to support our judgement.

During this inspection we carried out two observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could

not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

Staff did not always follow infection control procedures while working at the service and supporting people with their care. We observed one staff member wearing gloves while serving meals to one person and then not removing and disposing of the gloves, but carrying on to another person to provide them with support in a personal care task. We saw staff dealing with the personal care needs of one individual but then not decontaminating their hands after completion. One staff member was observed carrying red bags through the service wearing gloves throughout. Once they had deposited the bags they did not remove the gloves. They walked through the service to the dining area where they then deposited the gloves in the dining area bin but did not wash their hands before proceeding to handle cutlery. Such poor hand hygiene can result in the spreading of infections amongst people who lived at the service.

We saw one staff member of the domestic team wearing bracelets. Generally the wearing of jewellery, such as bracelets, in care environments is considered unacceptable as the jewellery cannot easily become decontaminated and this does not follow best practice guidance.

We found one room with a foam mattress which had a rip in the cover. Exposed foam in mattresses can lead to the mattress becoming contaminated and regular checks should be made to identify rips in mattress covers.

One relative was less than happy with the levels of cleanliness and housekeeping their family member received. They told us, "[Person] has been here for 14 years. Generally the carers are pleasant but it is the little things they are failing with, and they have built up, today they have come to a head and my sister has asked to speak with the manager twice …and she is still waiting." We looked in the person's room and found it to be in need of cleaning in places. Particularly around the bedside table and the pump of the mattress. We spoke with the registered manager about this issue and she told us she had spoken with the family and would ensure that this issue was dealt with and stopped from reoccurring.

During the inspection we found thickeners had been left out in the dining area of the dementia unit and also on the top of medicines trolleys within the service when staff were administering people's medicines. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. NHS England had raised an alert in 2015 which had been disseminated to care settings raising awareness of a concern in which a person had died in one care home following ingestion of thickeners. We brought this immediately to the attention of the registered manager on the first day and she told us she was aware of the alert raised. She spoke with staff and made arrangements for thickeners to be kept in locked cabinets, including installing new locked cupboards within dining areas. However, on the second day we saw staff administering medicines on the ground floor and carrying thickeners on top of the medicines trolley. The containers holding the thickeners were left unobserved as they administered people their medicines. We again brought this to the attention of the registered manager who told us, "I am disappointed as I have told the staff."

During the inspection we saw hot food trollies left unattended within the upper floor dementia unit and on

the ground floor of the service. The trollies were extremely hot and posed a risk of scalding to people who lived at the service, particularly in relation to those people living with dementia. We spoke with the registered manager about this issue and she told us that staff should be present at all times and said she would address this issue.

Risks to people using the service were assessed and plans put in place to reduce the chances of them occurring. For example, one person's health had deteriorated which had led them have a number of falls recently. The staff had developed a care plan to help keep them safe. Risk assessments were reviewed to ensure they reflected current risk. However, we found some people had not had all identified risks assessed. A number of people were found to have incomplete risk assessments in place or not in place at all, including for example in connection with bedrails for one person. This included not being signed or dated by the person who completed it. We saw other risk assessments, for example, in connection with medicines, which had not been reviewed since 2015. We spoke with the registered manager about this and they said they were currently reviewing everyone's paperwork.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other than the issues raised, Charlton Court was generally clean in appearance. There was a pleasant and clean smell to the service. All of the shower rooms and toilets were clean, well-stocked with hand gel and hand towels and in a good state of repair. Waste bins in these areas were clean with bin liners in place.

People and relatives we spoke with told us they felt the service was safe. One person said, "What's that saying…I am as safe as houses…oh yes…very safe living here." Another person told us, "It's the little things that make you feel safe…the staff help with that though." One person we spoke with told us that they had experienced some falls and said they made sure they always had the emergency call button near them. One relative told us, "The reason why [person] is here is to keep her safe…she was the exact opposite of that at home…I can go to bed now and rest rather than be worried sick."

Safeguarding procedures were in place to protect people from the types of abuse that can occur in care home settings. Staff told us they would be confident to report any concerns they had. One staff member said, "What...no hesitation in reporting anything like that." We saw records which confirmed that staff had received recent safeguarding training. The registered manager and staff could readily explain how safeguarding concerns would be investigated, including with referrals to relevant agencies.

Accidents and incidents were recorded and appropriate actions taken. We saw that the registered manager had recorded accidents into month order with full details of the injury, what action had been taken and the outcome; which included if the person had been admitted to hospital. The provider was in the process of updating their systems to closely monitor accidents and help them to identify any trends forming.

Procedures were in place for staff to follow in an emergency. Contingency plans detailed what actions staff should take in the event of any disruption or disaster. For example, in a heat wave or water/catering disturbance. It also set out details of where people should be relocated should the need arise and gave directions to two provider services which were close by. Personal emergency evacuation plans were also in place which would support the emergency services should an evacuation of the building be required. The provider had plans in place to review all fire risk assessments within their care homes, including Charlton Court which was now due for review.

Checks of the premises and equipment were carried out regularly to ensure they were safe to use.

Maintenance certificates were in place. We saw that the cover over the small pond in the garden area was in need of repair. We spoke with the registered manager about this and she said that she would have the maintenance person address this.

People's medicines were managed safely by staff who had received training to handle medicines. Medicines were safely and securely stored, and stocks were monitored to ensure people had access to their medicines when they needed them. The provider had implemented an electronic recording system which had reduced the number of errors made. We observed a number of medicine administration 'rounds'. Nurses and senior care staff administered medicines in a dignified manner. We observed nursing staff getting down to eye level with people and talking to them throughout, encouraging them to be as independent as possible but understanding the level of support required and administering medicines in a way which was tailored to the person. For example, one person preferred their medicines being placed in their hand, while another preferred theirs on a spoon.

People felt there were enough staff to meet their needs. One person told us, "I have lived here for eight years now. The staff here are very helpful…if I buzz the staff are here straight away, they are very good."

The service was peaceful and quiet. The nurse call bell was quickly answered which meant it was not obtrusive or disturbing. We found through observations and checking staffing rotas and dependency tools that the provider had enough staff deployed to keep people safe.

The registered provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking two references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and adults. Nurses were checked to ensure their PIN numbers were valid. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN.

The registered manager informed us that one person who used the service had been involved in the last round of recruitment, although we were not able to see any evidence of this having been recorded. One staff member was able to confirm that this had taken place.

We recommend that the registered manager records all people involvement in any recruitment process and the impact this made to the person.

Good

# Is the service effective?

## Our findings

People and the relatives we spoke with told us they thought the staff were good and had the ability to provide a service which met people's individual needs. One person told us, "The staff seem to know what they are doing and help me with the things I need them to." A relative told us, "I have high praise for the staff team…they have a tough job to do but do it well." A community psychiatric nurse told us, "I am here a lot… the staff are welcoming and are always at hand, they are knowledgeable about the residents." One healthcare professional said, "I have no cause for concern for the care delivered here".

All of the staff we spoke with told us that they had received appropriate induction training before working in the service. When new staff commenced work, their induction was in line with the Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that are expected. One newly appointed staff member told us they had shadowed permanent staff and been able to read people's care plans to gain knowledge of each individual. They said, "They [staff in general] are all nice…I feel very supported."

Staff had received a range of suitable training, including health and safety, safeguarding vulnerable adults and moving and handling training. We confirmed from staff records and discussions, that staff were suitably qualified and experienced to fulfil the requirements of their posts. We confirmed that all staff completed regular refresher training. One senior member of care staff told us they had started to complete Care Home Assistant Practitioner (CHAP) training. CHAP training was originally developed in consultation with the Royal College of Nursing, Care England, and the Association of Directors of Adult Social Care. It allows carers to learn new clinical and management skills, many of which are similar to that of Registered Nurses.

Staff told us they felt supported in their roles and that if their line manager was not available, they could access other senior team members for support. Staff said they received regular supervision and annual appraisal and records confirmed this.

We checked the settings of specialist mattresses. Whilst mattress settings are usually only an indicator of comfort, the correct setting should be used especially when people are in a sitting position on the mattress. We spoke with the registered manager about this and she said that she would review all mattress settings.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is 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.

At the time of the inspection the staff were ensuring that, where appropriate, people were subject to DoLS authorisations. People subject to DoLS had this recorded in their care records and the service maintained an audit of people subject to a DoLS, so they knew when they were due to expire.

The staff told us that some people who used the service were living with dementia and lacked capacity to be involved in their care planning process. They said decisions surrounding these people's care and needs were to be made by staff, family and other professionals. Relatives confirmed that best interest decisions had been made with them and healthcare professionals. However, we could not always see that written evidence was available to confirm this. For example, one person had bed rails in place but we saw no evidence the person had agreed to this, had capacity to make that decision or if a best interest decision had been made on their behalf even though their relative confirmed there had been. We spoke with the registered manager who said she would ensure this was rectified.

We saw records to confirm that people had access to the dentist, optician, chiropodist, dietician, their doctor and other health and social care professionals as required. For example, one person was due to have a bladder scan in the next week. The deputy manager told us, "One of the things that makes a difference here is we have once weekly GP visits. This helps the staff plan care… the GP comes every Tuesday and staff get the GP to review who they feel needs to be seen, this makes a big difference." A relative confirmed that their family member had been referred to the falls clinic after they had a series of accidents. They said, "They [staff] have been very good and put things in place to help…including getting the right people (healthcare professionals) in at the right time."

One person had a wound dressing on their foot but staff could not tell us what had caused the wound or how long it had been there. It appeared freshly dressed and when we checked daily records and wound care records we found no entry. We brought this to the attention of staff and the registered manager who said they would look into this issue.

People told us they enjoyed the food which was prepared for them. One person told us, "The food is very good. I have no worries being here." Another person said, "I always enjoy my food." A third person said, "There is a choice and I choose what I like." Two relatives confirmed that their family member had put weight on since living at the service. One said, "She's [person] put weight on since being here. Could not find fault with the staff …they are dedicated."

People received assistance if required to eat in either the dining room or in their own rooms. Dining rooms were set out well and people had a choice to sit where they preferred. People were offered choices of meals and staff knew people's personal likes and dislikes. There was a choice of fresh food available to kitchen staff and we saw people receiving nutritious milk shakes throughout the day. Kitchen staff displayed a good knowledge of people's different diets and particular nutritional needs. We saw that people had individual care plans in place regarding particular aspects of their nutritional needs, for example, one person had a detailed care plan in place for diabetes. This meant that staff had considered the additional support required for particular health conditions which impacted on people's nutritional requirements.

We observed practices over the lunch time in all areas of the service. Staff member's chatted to people while they supported them with their meal. The atmosphere was calm and unhurried with people taking as much time as they required.

We checked people's weights and nutritional monitoring records, including food and fluid charts. Although not all records in connection with food and fluid monitoring had been completed fully, we found that there was no evidence to suggest that people had not received adequate amounts of food and fluid. We saw staff

ticking a list at lunch time which showed which people had received their meals. Records were reviewed monthly. Staff told us that sometimes they forgot to fill in food and fluid charts. The registered manager told us they were in the process of replacing their current food and fluid charts and would raise this issue with the staff team.

We recommend that the provider reviews their paperwork to ensure that all appropriate detail is recorded and in place.

When we visited the kitchen area, we found some items of dried food had been decanted. These did not all have expiry dates placed on them. We raised this with the registered manager who said they would speak with the kitchen team and ensure this was addressed.

Good

# Is the service caring?

## Our findings

People and their relatives were complimentary about the support provided by staff at the service; describing them as kind and caring. One person said, "The staff here are very good, the food here is okay too, I like teatime best." Another person said, "I have been here months, ever since I gave up my bungalow. It's lovely, the staff are very friendly." One relative told us, "The care here is good. Mum has been here for three years now. The staff are lovely, I have no concerns." Another relative said, "When [person] goes out for the day, the staff keep her food for her so there is always something for her to eat if she gets back late."

Throughout the day we noted staff interacted positively with people. Staff knew people well. For example, we saw a member of care staff recognised that one person was restless; the staff member knew the person needed to use the toilet without them having to ask. We also overheard one member of care staff say to a person, "It's hot in here [person's name], do you want the window open?" When the person responded with a "Yes", the staff member said, "Do you think we should put your shawl on just in case?" The staff member then said, "Will I get your hot milk or tea…milk is a bit more nourishing …is that okay?"

Staff treated people and their families with dignity and respect and kindness. We saw that staff addressed people by their preferred names and spoke with them in a friendly way at all times. Staff knocked on people's doors and waited for a response before entering their rooms or took them to quieter areas of the service to discuss private matters. One family member whose relative had recently passed away was visiting the building and we overheard a senior carer giving their condolences and explaining "If there is anything we can do, just ask."

All of the staff talked about how the ethos of the service was to make sure the needs of people who used the service were always put at the centre. One staff member said, "Everything we do is to make sure that residents are happy and looked after properly."

When we spoke with staff they appeared to know people well. They were able to tell us about people's preferences and what kind of support they required. People's life histories were being recorded in their care records. This provided staff with information to help build good relationships with the people they supported. Staff showed genuine concern for people's wellbeing and we found that staff worked in a variety of ways to ensure people received care and support that suited their needs. People were encouraged to remain as independent as possible.

Information was available in reception on a wide range of local and provider specific data. Including local facilities, for example, libraries and churches or resident 'user' guides. A newsletter was also published which informed people and their relatives what activities were taking place and included other general information, for example, if it was a person's birthday. People were able to have their spiritual needs met with visits from a local church to provider communion. We were told by staff that if this was not the person's faith, staff would make alternative arrangements for them if they wanted.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of

the registered manager or senior staff any issues or concerns.

Relatives who had family members receiving end of life care confirmed that staff were kind and had made their family member's comfortable. One relative said, "A testament to the care here is that five weeks ago I was told by mum's GP that mum only had 24 hours to live, and she is still here now." Care records contained evidence of discussions with people about end of life care so that people could be supported to stay at the service if they wished, including making funeral arrangements; although people who did not wish to discuss such matters had their wishes respected.

Requires Improvement

# Is the service responsive?

## Our findings

Where care plans were in place these were hand written and individualised. It appeared the staff who had written these records knew the person well enough to write a comprehensive plan for that element of care with effort and thought having gone into its formulation. These were reviewed regularly and people and their relatives had been involved.

There was no evidence of harm to any person living at the service, including unprecedented weight loss or increasing cases of pressure damage, but we found record keeping needed to be improved. Records were either not in place, incorrectly completed or had not been completed at all, including care plans, topical medicine administration records, risk assessments, monitoring charts and MCA assessments and best interest decisions.

Care plans were not always in place, for example, one person had no pressure ulcer prevention care plan in place. Pressure ulcers are skin injuries which can be caused by unrelieved pressure or shearing forces. Factors which are considered contributory to an individual developing a pressure ulcer include friction, humidity, temperature, incontinence, medication, age, and malnourishment. The person used a pressure relieving mattress and had been identified on their Waterlow score as being at "very high risk" of pressure damage. A Waterlow score is an assessment which estimates the risk of a person developing a pressure sore. There was no evidence to suggest that the person had not been cared for as equipment was in place to support their needs, however, they required a care plan in place to monitor and address their needs with regards to further pressure ulcers and support the healing of current ulcers.

One person had contradicting information recorded regarding their appetite. A nutritional assessment identified the person as having a "reduced appetite". While a Waterlow assessment completed on the same day identified them as having an "average appetite".

Daily charts had not always been maintained, for example, food or fluid or turning charts. A number of people did not have their fluid or food balance charts completed with their daily intake. For example, one person had no fluid recorded on one day from 9.50am until 18.30pm, another person was recorded as having less than recommended amounts and the nurse in charge had not signed to confirm they had checked this record. Although there was no nurse signature on another person's food charts there was evidence in this person's progress chart that their GP was aware of their deteriorating food and fluid intake and there was extensive evidence in care records that their GP had reviewed them very frequently.

One person had not had their 'turn' charts completed as indicated in their care plan, for example, the care plan stated that they should be turned in bed every four hours and their records indicated this had not occurred.

We checked a sample of financial records of people who had their money held with the provider for safe keeping. These were all in order, although we were told that one person's finances we checked had appointed a Lasting Power of Attorney (LPA), but we found no copy of this information held. (LPA) is a way of

giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they were in the process of introducing daily delegations to the staff team including, for example, the checking of food and fluid charts and checking equipment. They said, "This will make sure that everything is completed properly."

People we spoke with told us they were very happy living at the service and told us they took part in a range of activities. Comments included, "Its bright and airy and I have made friends with staff and some other residents, which is nice for me"; "They [staff] do things that I want and not what they want to do…it's not institutional like I thought it might have been" and "If I want help I get it, if I don't want help, they [care staff] watch me but don't interfere…which is exactly how I like it."

Relatives told us that staff rung them immediately if they suspected a change if people's care needs or an incident had occurred. One relative told us, "[Senior staff member] will ring me straight away…any issues… they are on the ball all right." Another relative said, "[Person] has been here 10 months so far, I wouldn't change a thing about the place. This is the first time in five years that [person] has not been admitted to hospital…when she lived at home [person] would get admitted every Winter, since she has been here any small illnesses are picked up straight away and this has avoided [person] going to hospital this year."

People and their relatives confirmed they had been involved in the care planning process. One relative told us, "Fully involved right from day one." Staff showed us diary entries which confirmed relatives had been invited to care review meetings. We saw one note which stated that a relative had been informed and could not attend, but was happy for the meeting to go ahead.

An activities coordinator worked Monday to Friday. We made a number of observations over the period of the two day inspection. On both days we found little sign of any activities taking place in the upstairs dementia care unit. During the morning of both days, we saw that 'Jeremy Kyle' was showing on the TV in the dementia unit and the volume was particularly loud on the second day. We viewed this as possibly detrimental or a trigger to distress for those people living with dementia due to the levels of arguing and shouting on the programme, although there was no evidence that this was the case because people in the room were asleep. We spoke with the registered manager about this and she agreed with our views.

Activities appeared to be taking place on the lower ground floor. We saw a range of activities displayed throughout the service, including Zumba, bingo and singers. People had activity care plans held with the activity coordinator and these documented what people preferred to be involved with and how staff could support them. We saw evidence that a review of information held about individuals past histories was being updated via a document called, "This is me". This meant that the staff would have more detailed information about each person's background and life histories.

The activities file showed a range of activities had been offered, including; crafts, animal petting visits and gardening opportunities (seed planting). Consideration had been given to events such as Easter and themes such as royal family events. Board games and reading material were evident and people were observed enjoying watching television in the communal lounges.

One person told us, "There is entertainment on… I go to it sometimes. Mostly there are singers and they are good." Another person told us, "They [activities coordinator] are always raising money for us…think it pays for the entertainers to come in…it's all very good. It's just enough entertainment for me." A relative told us, "They seem to have a good selection of things for people to do…they are usually advertised on the board. [Person] will sometimes take part…but only if she wants to and no one makes her go. She has always told us that she enjoys it."

However, one relative said, "I would also prefer if [person] was involved in more activities, she can be disruptive but the home should manage that better, I feel she is getting isolated in her room." Two staff members also thought that there should be more activities for people living on the dementia unit. One said, "There is too much focus on fund raising…it's a shame that the people on that unit cannot have more activities planned for them.

We recommend the provider reviews their activities programme to ensure that enough staff hours are allocated to all people in the service, including tailoring activities to those people who are living with dementia.

People told us they had a choice in what they had to eat and what they did on a day to day basis. One person said, "If I don't like the food I get something else in its place. I get a choice every day; I always have enough to drink too." Another person told us, "I choose when I do things…the staff help me, but it's down to me that sort of thing (choice)."

We asked people and their relatives if there had been any issues which had arisen during the time they had lived at the service. One relative told us, "The only issue I have had is that the staff do not always get laundry back to the right resident. We raised this issue with the registered manager who said she would check procedures.

Procedures were in place to investigate and respond to complaints. Where complaints had been received the registered manager had investigated them and provided the complainant with a response. One relative said, "The care here is lovely, the staff and the manager are really good. [Person] was unsettled here initially as there was a chap in the room next door who was noisy… the staff moved [person] without anyone having to ask as they recognised she was unsettled…now she is much happier." We could not find a record of this issue having been raised or addressed in records.

We recommend the provider keep a record of minor issues that have not progressed to more formal complaints, in line with good practice.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager in post who was present and supported us throughout the inspection process. They had worked in adult social care for many years and had worked for the provider since 2012.

The registered provider had systems in place for monitoring the service, which the registered manager had implemented. The registered manager completed monthly audits of all aspects of the service, such as medicine management, health and safety and care planning. The provider had visited the service on a number of occasions and completed their own separate review of service provision and identified some areas which needed to be addressed. The registered manager confirmed that they were working through these, most of which were areas we had identified through our inspection, although not all. The registered manager had an action plan which they were working through to address the areas which the provider had highlighted during their checks, including for example, having health and safety as a set agenda on all staff meetings. One staff member told us that health and safety had been discussed at the last meeting they attended. The registered manager made a note of all the issues that we had raised with them and told us they would include this as part of their action plan.

We found issues with record keeping at the service and although the registered manager was aware of some of the issues we raised, these had not always been rectified.

The majority of people and their relatives we spoke with were positive about the service and told us that they felt the home was well led and that the registered manager and staff were approachable. One person was seen interacting with the registered manager on a number of occasions and the registered manager clearly knew them extremely well. Another person was seen chatting with the registered manager, and again, they clearly had a good rapport between them. We saw the registered manager acknowledged visitors to the service if she was in the vicinity.

Healthcare professionals we contacted prior to our visit spoke positively about the management of the service. Comments included, "Their communication is good and concerns raised have always been addressed and followed through by senior management." and "The manager's and staff at the home are approachable and efficient. I have a very good working relationship with them. During the visit we spoke with a number of healthcare professionals. One said, "The manager is approachable. If we CPN's (Community Psychiatric Nurses) set care plans, the staff always take them on board and integrate the care plans we set."

Staff felt the management of the service was good and a positive team spirit was in place. One staff member told us, "The manager has been here for about five years now, the morale here is good, we give good care and we can have a laugh too, the manager is very fair." Another staff member said, "Here, there is good support, good senior carers and good staff…I have worked in lots of care homes but I came back to this one as I have a good relationship with the manager and the staff."

The management and staff team operated in, what appeared to be an open and positive culture. When we

spoke with staff, we found them to be friendly, approachable and they appeared open in their responses to questions asked of them. Staff appeared happy in their work with some overheard singing in corridors. When we asked one staff member whether the provider had an award scheme they told us, "I am quite rewarded in other ways…not just pay…with me, it's the residents."

People who lived in the service were asked for their views about the service provided. One relative told us, "We have had a couple of surveys…went through with mother. We are quite happy with what they do. Filled another thing in the other day asking what her likes and dislikes were." We saw that there were regular meetings where people were asked about their views and for any further improvements that could be made. One meeting had covered a range of topics, including meals and activities within the service. We saw action had been taken in response to requests from people in the service, for example, changes to meals prepared.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not fully protected because the provider had not stored thickeners securely and not ensured hot food trolleys were staffed when in use during all meal times. Infection control procedures were not being fully adhered to. Risk assessments were not always in place.<br><br>12 (1) (2)(a)(b)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records relating to people were not always accurate or fully maintained.<br><br>Regulation 17 (1)(2)(c) |