HC-One Limited

Carrington Court

Inspection report

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Date of inspection visit:
13 July 2016

Date of publication:
24 August 2016

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

The inspection was unannounced and carried out on the 13 July 2016.

The service was last inspected on 12 August 2014, when we found the service to be compliant with all the regulations we assessed at that time.

At the time of the inspection there were 48 people living at Carrington Court. Carrington Court is a purpose built home in Hindley, which offers Nursing and Residential Care. The home is situated close to local amenities. The home had 48 bedrooms which were across two floors and could be accessed via a lift and stairs. The home is an accredited home with Gold Standards framework.

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 told us they felt safe living at the home. People had comprehensive risk assessments which were reviewed and updated in a timely way to meet people's changing needs. People and their relatives told us they were well informed and had been involved in the assessments and planning of the care and support received.

The home had sufficient numbers of staff deployed which was formally calculated based on people's dependency. We found staff were able to meet people's needs efficiently and all the people spoken with confirmed their needs were met in a timely way.

The staff we spoke with had a good understanding about safeguarding and whistleblowing procedures and told us they wouldn't hesitate to report concerns. People were protected against the risks of abuse because the service had a robust recruitment procedure in place.

The management of medications, promoted people's safety. Appropriate arrangements were in place to ensure that medicines had been ordered, stored and administered appropriately.

The service had a training matrix to monitor the training requirements of staff. Staff received appropriate training, supervision and appraisal to support them in their role.

People were supported in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We saw staff assessed peoples' nutritional needs and varied menu's had been developed. People were offered choice and the dining experience was interactive and relaxed.

We observed frequent, appropriate physical contact between staff and people which were natural and symbolised the familiarity and relationships that had developed between people and staff.

People's privacy and dignity was maintained and their independence was encouraged. People told us that staff were respectful of their wishes.

People's care plans were reflective of their preferences and needs and reviewed regularly in conjunction with them and their relatives.

People and their relatives knew how to make a complaint. They told us they were confident in the manager and we saw complaints had been resolved in the required timeframes.

The home had a full programme of activities in place for people and their relatives were actively encouraged to attend. Relatives spoke of feeling part of a community.

The service had links with the local community and we were told some wonderful relationships had been formed between people living at the home and a local college.

A range of audits were undertaken to help monitor and improve the quality and safety of the service. We saw actions were implemented timely following any deficits identified. Management understood their legal requirements and notifications had been submitted to CQC.

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 had up to date safeguarding and whistleblowing policies and procedures which staff demonstrated they knew in order to keep people safe.

We found sufficient skilled staff to meet people's needs. Robust recruitment ensured only suitable people were employed.

Risk assessments were clear and detailed and reviewed regularly.

Processes were in place to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had regular supervisions and completed training that was effective and relevant to their roles.

Staff understood the importance of obtaining consent and supported people's rights under the Mental Capacity Act.

People's dietary and hydration needs were met. People had access to other health and social care professionals as needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

People's privacy and dignity was respected and promoted.

People were listened to and supported to make their own decisions and choices.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in the planning and review of people's care.

People were actively encouraged to maintain their relationships and there was an activities programme to reduce the risk of social isolation.

A complaints procedure was in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The manager promoted an open culture and they were visible and accessible to people, their relatives and the staff.

Meetings were conducted regularly and feedback sought to improve the service.

Senior management visited the service on a regular basis to undertake quality monitoring. There were effective systems in place to monitor the quality of the service.

Carrington 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.

The inspection was carried out on 13 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors from CQC (Care Quality Commission).

Throughout the day, we observed care and treatment being delivered in communal lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We asked people for their views about the services and facilities provided. During our inspection we spoke with the following people:

• Five people who used the service
• Nine visiting relatives and friends
• Ten members of staff, which included; the registered manager, nursing staff and care staff from the day and night shift.

We looked at documentation including:
• Five care files and associated documentation
• Six staff records including recruitment, training and supervision.
• 10 Medication Administration Records (MAR)
• Audits and quality assurance documentation.
• Variety of policies and procedures
• Safety and maintenance certificates

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key

information about the home, what the home does well and improvements they plan to make.

We liaised with the local authority and local commissioning teams and we reviewed previous inspection reports and other information we held about the service.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at Carrington Court. People told us; "I feel a lot safer living here. I feel very safe when I am in my room." "They always come round and check on us. They check on us at night as well and I have my buzzer at all times." "Knowing there is a lot of staff around re-assures me about safety." "I feel safe. Nobody here would have the energy to do anything." "I feel safe because they answer the call bell quickly when I press it."

Relatives told us; "No concerns about person's safety." "We have no concerns. We had issues at another home and moved [person] here because of safety concerns. They've been here a while and I can say it is 100% safe here." "I am so confident [person] is safe here, that I am arranging a few days away. I haven't been able to do that for over a year. [Person] has been here for a few weeks and they have reduced my anxiety considerably in that time. I am just so grateful that [person] was able to come here." "[Person] is safe. There have been no falls since they've been here because staff support them mobilising." "It's a safe environment and a safe home."

Staff had access to relevant and up to date information and policies, including whistleblowing and safeguarding. There were systems in place to safeguard people from abuse and safeguarding incidents were reported and appropriate records maintained detailing the action taken. All the staff we spoke with had a good understanding of safeguarding and procedures to follow if they had a concern. Some of the staff comments included; "If I had concerns I would go straight to the nurse or the home manager. People being down, depressed or frightened could be a sign of abuse." "Swearing or shouting at people could be classed as verbal abuse. Using incorrect moving and handling techniques could constitute abuse." "Abuse could be; emotional, neglect, physical or financial. I'd report it to the manager. If it involved the manager, I'd follow whistleblowing process."

People were protected against the risks of abuse because the home had robust recruitment procedures in place. Appropriate checks were carried out before staff began working at the service to ensure they were fit to work with vulnerable adults. During the inspection we looked at six staff personnel files. Each file we looked at contained application forms, DBS (Disclosure Barring Service) checks and evidence of references being sought from previous employers. There were also interview questions and notes maintained so we could verify the interview process was appropriate to the role applied for.

We found there were sufficient numbers of staff working at the home to meet people's needs. Staff deployment was formally calculated based on people's care needs. The manager felt that HC-One was responsive if more staff was required and that it would be agreed in line with people's dependency as opposed to financial constraints. We found that staffing levels at the home consisted of four care assistants and two nurses at night and eight care assistants and two nurses during the day. This was to provide care to 48 people.

During the inspection, we observed staff responding to people's needs timely. People told us; "I think there are enough staff. They come as soon as I have pressed the call alarm."

Relatives told us; "I'm very pleased with the amount of staff that I see here when I'm here." "It's not just that there is enough staff to respond to people's care needs. The staff spend time with people too."

All of the staff we spoke with also said that they felt staffing levels were sufficient. Staff comments included; "Absolutely no concerns at night. There are quite a few people receiving pressure care but we manage ok." "Three is definitely sufficient on the floor at night. We work together as a team and support each other well." "I find staffing levels to be fine. We are able to meet people's needs." "Staffing levels on this floor increased from three carers to four which helped a lot. We manage and have a good understanding of people's needs."

We saw people's call bells were in reach when they were in their rooms and staff were seen to respond quickly when people called for support.

People's care records contained identified areas of risk. Risk assessments were in place for falls, bed rails, nutrition, choking, continence, tissue viability and fire. All expected risk assessments were in place and reviewed timely in line with people's care plans. We saw where risks had been identified, there was a detailed care plan identifying what action had been taken to mitigate the risk. For example, people who had been assessed as being at risk of falling out of bed had a bed rails risk assessment completed and bed rails in place. We also saw falls care plans detailed whether a pressure mat transmitter had been put in the person's room for people at risk of falls when mobilising. These mats trigger an alarm if the person starts to get out of bed so staff can offer assistance. This meant staff were identifying risks to individuals and taking action to reduce those risks.

Where accidents occurred, these were investigated and preventative measures put in place to keep people safe. Accidents and incidents were recorded and the registered manager told us they used 'datix,' which is a web based safety software for healthcare risk management applications. This enabled incidents to be captured and disseminated throughout the organisation. Datix can be used to analyse trends within the care home and to capture trends across the organisation to enable proactive risk management. All accidents and incidents which occurred in the home were recorded and analysed for themes and trends. Action points were recorded as an outcome and we saw evidence of these being completed.

We saw the medication administration records (MAR) were kept in a large folder. Accompanying the MAR were coloured photographs of the person, details of people's allergies and SALT (speech and language) recommendations. We looked at 10 medicine administration records (MAR) and saw they were consistently completed indicating people received their medicines as prescribed.

We saw arrangements were in place to ensure medicines to be administered before or after food were given at the correct times. Where people received variable dose medicines or medicines on set days each week, we found these medicines were given correctly and were reviewed annually.

We saw 'as necessary' (PRN) medicines were supported by written instructions which described situations, frequency and presentations where PRN medicines could be given. A relative told us; "[Person's] legs hurt but as soon as they tell the nurse and ask for something, they get the pain relief straight away. They stick to the right times too."

Medicines were kept securely; within locked medicines trolley's which were returned to the clinic following medicines being given. Medicines and topical creams were stored and disposed of safely. We saw topical administration application records and transdermal patch application records were completed separately. We confirmed with one person that they had received their creams as directed to confirm the record was accurate. We also looked at a transdermal patch to ascertain that it had been dated and supported what

had been completed on the documentation.

Temperatures of the medicines room and fridge were monitored and these were within permitted limits. Systems were in place to ensure medicines were ordered and disposed of appropriately. We looked to see that medication had not been omitted due to being unavailable and did a random stock count of medication to ascertain that the figures documented tallied with our calculations. This confirmed that people had received their medicines as prescribed.

We saw each person living at the home had their own PEEP (Personal Emergency Evacuation Plan) in place which provided staff and emergency services with all the appropriate details about how to evacuate people from the building safely in the event of an emergency. These were stored next to the front door, along with a grab bag which contained relevant aids and supplies for people to use in the interim of putting appropriate arrangements in place if required.

We saw regular maintenance checks were undertaken to ensure the building was safe. This included regular checks of portable appliances (PAT), the nurse call system, asbestos, lifts, hoists, gas safety, equipment in the sluice room, weighing scales and the electrics. The home held certificates verifying when the work was undertaken and when the next inspection would be due.

Good

Is the service effective?

Our findings

People and their relatives told us they felt the staff had the correct knowledge and skills. Relative comments included; "They are well trained and they know what they are doing." "They are all fantastic with [person]. You know the staff know what they are doing, by the way they speak about things." "Staff seem well trained. Staff do things in a similar way. It's hard to describe but it's a quiet confidence."

New staff completed an induction programme when they started work at Carrington Court. New employees were provided with a workbook entitled, 'Working together as one' which incorporated the care standards certificate. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control. New staff were supported by a mentor and completed the induction within the first twelve weeks of commencing with HC-1.

The staff we spoke with confirmed they had received an induction when they first started working at the home and this entailed training and shadowing existing members of staff which supported them to understand the systems and processes at the home. Staff told us; "I did my induction and it covered fire safety, moving and handling, safeguarding and infection control. It helped me a lot in terms of seeing how things worked at the home." "I had worked in care previously but I had to do the induction and it gave me everything I needed."

We looked at the training and support staff received to enable them to undertake their work effectively. We looked at the training matrix which showed staff had completed training in relation to catheter care, safeguarding, infection control, moving and handling, medication and health and safety. The home referred to training as 'Touch training', which was done online and could be completed in the designated training room, or accessed electronically in their own time at home.

We asked staff for their views regarding the training received and whether it equipped them to fulfil their role. Staff told us; "I feel I'm getting enough training and being able to do my NVQ level 2 has helped a lot." "I'm getting all of the training I need. It's good to get regular refresher courses to keep us in the loop." "I'm able to do quite a lot of training in my own time. HC-One seem to provide a lot and I've never worked anywhere where there is this much training." "

All the staff we spoke with told us they felt supported to undertake their work. Comments included; "The manager is approachable and we can go to them with any concerns." "I have worked here for a long time and I have always felt well supported. I love coming here." "I feel like I receive really good support and we work well together as a team."

We saw staff received regular supervision as part of their ongoing development, with records maintained to confirm these had taken place in line with the timeframes identified in the policy. Topics covered in supervision included; training requirements, progress made since the last meeting, tasks to work towards

and any general concerns about work. The supervision matrix identified when supervision would take place. Staff told us; "The manager is very keen to ensure supervisions take place and they always do." "I have just had one recently and we receive a few each year. It's useful to discuss work and look at how we can improve."

We looked at how people were protected from poor nutrition and supported with eating and drinking. Staff assessed people's nutritional status using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. We saw people had specific eating and drinking care plans in place which detailed if people could eat independently, the food people liked to eat and any assistance required from staff. There were also diet notifications forms which informed staff about any special diets, if adapted cutlery was needed, if there were any allergies and what people's cultural needs were. People's weights were monitored weekly or monthly and timely referrals had been made to dieticians when input was required. We also saw the speech and language therapy team (SALT) had been consulted when people had specific dietary needs and clear guidance was provided to staff.

People had access to a choice of food and drink throughout the day. We observed both the breakfast and mealtime experience at the home. We saw this was a relaxed experience for people, who were able to eat the foods of their choice. For instance we saw people being offered a choice of either a cooked breakfast or cereal and toast. Staff also asked people what they would like for lunch in advance of the meal. We saw that several people required assistance to eat their meals and this was provided. Staff demonstrated a good awareness of people's dietary needs and were able to identify the people who required special diets such as soft or pureed. Several people ate in their bedrooms either through choice or because they were cared for in bed. We observed staff taking people their meals and sitting with them next to their bed, providing assistance. Staff also took the time to explain to people what the meal consisted of and sought consent before placing food into people's mouth.

People told us; "The food is good. I get enough choice." "I can only have a soft diet so I am limited but they do try and give me choices." "Most of the meals are nice. There are different choices for us." A relative told us they thought their family member had previously given up as they had stopped eating but since moving to the home their appetite had returned which they attributed to the [person] feeling more relaxed. They told us they felt that they had got their family member back.

We saw the chef at Carrington court engaged residents in menu planning and incorporated people's food preferences in the meals that were offered. The chef attended resident and relative meetings to gather feedback on menu requirements and 'mealtime experience audits' were completed to monitor people's dining experience. Carrington Court achieved the bronze award from the soil association which awards a rating based on whether food is ethically sourced.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw staff completed FACE assessment tools which are nationally accredited by the Department of Health. The FACE toolset is a complete documentation system tailored to the needs of the relevant care group. This tool set incorporated mental capacity assessments and DOLS.

We saw capacity assessments had been conducted and people's capacity and ability around making specific decisions had been recorded. The registered manager confirmed that one person living at the home had a granted DoLS authorisation in place and a further three authorisations had been submitted and were awaiting assessment by the local authority. All the staff we spoke with had attended MCA training and was knowledgeable regarding the subject area. The staff were able to confirm who was subject to DoLS and what this entailed.

We saw a large proportion of people living at the home would have their liberty, rights and choices restricted in order to meet their care needs. However, when we asked the registered manager whether people were free to leave the home, they informed us that everybody would be free to leave apart for the person who had the DoLS authorisation in place. We saw that there was one person living at the home that did not have family support but advocacy services had been involved. We saw that this person had initially come to the home subject to DoLS but this had subsequently been revoked following assessment by the local authority.

We looked at how staff sought consent from people living at the home. During the day we saw several examples of how staff did this when caring for people. For example, we heard a nurse saying to people; "Good morning, is it ok for me to give you your medication." On another occasion we observed a member of staff asking if it was ok to place a 'tabard' over somebodies head and if they would like support to eat their porridge. On another occasion, staff brought a person into the dining room and they were holding a doll. Staff asked the person if it was ok to place the doll on the chair next to them whilst this person ate their breakfast. A person confirmed that staff always sought their consent and told us; "The staff always ask permission before doing things."

We saw 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNAR) forms were completed appropriately in discussion with people who used the service and/or their relatives and signed by relevant professionals. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Good

Is the service caring?

Our findings

The people we spoke with were positive about the care provided and told us they received good care. People's comments included; "They look after me well and support me when I need them." "I find it very good. I find it more like a hotel than a care home. There is definitely a personal touch to the place." "I think it's good. The care is very good and the staff are very kind. They look after me well."

People and their relatives we spoke with were complimentary about the staff. People told us; "The staff are extremely friendly. They are very attentive and are willing to help you." "The staff are all nice. They seem very genuine and caring. They take their time to chat with you and get involved with the entertainment. They are very emotional, caring and are like friends." "The staff are nice. They will help you and are kind." "The staff are very good. I can't fault them. They don't get agitated with you, they are just kind."

Relative comments included; "Staff are fantastic with [person]. [Person] is very happy here." "The staff are wonderful. [Person] is settled and happy. They have bouts of not being well and they are well looked after."

We observed people were treated with kindness, compassion and respect. We saw many positive interactions and people enjoyed talking to the staff in the home. Observations showed staff had a caring attitude towards people. We noted frequent, appropriate physical contact between staff and people which was natural and symbolised the familiarity and relationships that had developed between people and staff.

Staff spoke fondly of people and treated them with dignity and respect. We saw the home had two dignity champions. A dignity champion is a designated person who is passionate about maintaining people's human rights; person centred care and provides support to the team to achieve this. People's dignity was maintained. We saw staff knocking on people's bedroom doors before entering and they placed a sign outside stating that personal care was in progress and not to disturb. The people we spoke with said they felt treated with dignity and respect. People told us; "Oh yes. They always knock before coming in." "Staff always knock on the door even if it's open. They don't come in unless I want them to." "Staff always close the door when delivering personal care. If I need continence support, they do it quickly."

The staff we spoke with had a good understanding of how to treat people with dignity and respect. Staff said; "I close doors and curtains and ensure people have full privacy. We leave a sign outside during personal care." "If I'm giving somebody a bath or a shower I will cover them up so they don't feel exposed or embarrassed."

During the inspection we saw staff promoted people's independence where possible. For example, placing cutlery into people's hands and allowing them to try and eat themselves. People said; "I'm quite independent anyway, but the staff do encourage me as well." "The staff let me eat my meals on my own and I have a shave myself." A relative told us; "The staff encourage [person] to weight bear. The staff don't do anything to ease their task, it's all about encouraging the resident."

Staff told us how they attempted to promote people's independence. Staff comments included; "It's

important to encourage people and not take that independence away from them. If they can pick up a drink, then let them." "We build up a good rapport with people and get to know them. I'll let people have a go, but I'm there if needed. I wouldn't want anybody to struggle."

We saw care plans were personalised and the documentation supported discussion with people and their relatives to ensure people were involved in decisions about their care. Staff told us resident care is always based on resident choice. A relative confirmed this and told us; "Staff do everything in the interest of the person, care is centred around the resident."

We saw people and their relatives had been fully involved in the planning of end of life care. People's care plans reflected their preferences, choices and their fears. Information contained within the care plan included people's preferred place for end of life care. For example whether the person wanted to stay at the home or go to hospital. Healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met. We saw anticipatory drugs were ordered and used to ensure people would have access to pain relief when they needed it.

Good

Is the service responsive?

Our findings

People's care and support was planned proactively in partnership with them and their relatives. Pre-admission assessments were carried out and people's needs were assessed before people moved into the home. People and their relatives were given the HC-One document 'remembering together' to complete which helped to develop care plans based on people's needs and preferences.

Relatives told us; "[Person] was in hospital before admission. The manager visited and completed an assessment with [person] and me. I was desperate for [person] to move here from another home. I called on the off chance and to my relief; they agreed to assess them the following day."

People received personalised care that was responsive to their individual needs and preferences. We looked at five care records. The care plans captured people and relative's contributions to the assessment process and provided detailed guidance on how care would be delivered. Care reflected people's current needs, choices, abilities and preferences. We saw people had varying complex needs that were care planned and we checked to see if the care plan was being followed. For example, we looked at a tracheostomy care plan in place detailing the management of the airway and care of the tube and stoma. We checked to see if the care plan was being followed and we saw the person had an emergency tray in their room which contained a small and larger tube if required.

We found daily checks were undertaken regarding people's needs and charts recorded when personal care tasks had been supported. For example; oral hygiene, pressure care, fluids and nutrition. A relative told us; "[Person] will sometimes let you support them and sometimes they won't. It's the same experience for me so I understand that the staff are also met with that challenge." We saw people's care had been reviewed regularly in conjunction with them and their relatives. Attendance at reviews was documented and we saw people's care plans had been updated timely following discussion. We saw records of these reviews in care plans, with relatives and people also saying they were involved in this process. We saw this provided a focus on health, any accidents/incidents, medication, nutrition and activities. A person told us; "I had a review after three to four months. I was involved." Relatives said; "Everything is discussed with us. We are asked for our opinions about how everything is going." "I only attended a formal review the other week. They keep me up to date when I visit too."

We saw several examples of where staff had been responsive to people's needs. For instance, it detailed in a person's care plan that they liked a blanket on their knee and this was provided for them throughout the day. This person also liked a glass of water with their meal and we saw staff providing this in a timely manner. This person's care plan also stated it was important for staff to allow them to make choices from the menu and we staff doing this at breakfast time. The care plan also stated this person liked to be engaged in activities throughout the day and we saw this person taking part in 'Play your cards right', bowling and bingo during our inspection.

During the inspection, the activities coordinator had arranged for people to 'play your cards right' and

bowling'. People were engaged, laughing and chatting throughout this time. We saw the home had a rolling programme of activities and people were encouraged to maintain their individual hobbies and attend activities of interest independently. For example, A person enjoyed knitting and the activities coordinator had obtained wool and patterns for them to continue this hobby. A relative also told us that the home supported their relative to attend a meeting monthly. They informed us that the home also collected them in the mini bus so they could attend with their relative. They expressed that it was lovely to see their relative in this environment as they had dementia and it triggered their memory."

The activities coordinator had also worked with the local library to have books delivered and exchanged for people who requested this. They had also organised workshops to develop a reading group within the home.

The home invited people's relatives to attend when activities were arranged and a monthly hymn service was well attended by current relatives of people living at the home and also attended by relatives of people who had passed away. Summer fetes, parties, entertainment, coffee mornings and karaoke were all well supported.

People told us; "There are lots of activities." "There is a lot going on in the activities room. I go down there quite a lot. I really like the quizzes." Relatives said; "I think it's great. There is always something going on; Coffee mornings, singing, dancing, bowling, games and entertainers." "There are always things going on. The activities coordinator is brilliant. It feels like there is a community at this home and we feel part of it."

The home did an annual resident and relative survey via 'Your Care Rating'. The last survey gave an overall satisfaction rating of 94%. The most recent survey had only just been sent and the responses had not yet been received. The home was also registered with care home uk to enable feedback. The registered manager also indicated that they had an 'open door' policy and residents, relatives and visitors could raise concerns, complaints and compliments through a formal and informal process.

We looked at how complaints were handled. The home used a central system known as 'Datix' which was used throughout HC-One. We saw that complaints were responded to appropriately and detailed any actions taken to resolve the issue. One person told us about how they complained that another resident kept coming into their room, however told us this was responded to quickly when they told staff. Other people we spoke with said they would speak to staff or the manager if they had any complaints about the service they received.

The home also logged compliments made by friends, family and residents. Some of the compliments included; 'To all the staff, we would like to thank you for the excellent care provided'.'Thank you very much for providing excellent care to our family member. We appreciate everything you have done'. 'To all at Carrington Court. Thank you so much for all you have done for our Mum/Grandma'. 'My mother is very well cared for. Excellent service. No complaints whatsoever'.

Good

Is the service well-led?

Our findings

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. The registered manager was available throughout the inspection.

There was a clear management structure and the registered manager had the immediate support of a deputy manager. There was also a regional operations manager and assistant operations manager who visited the home regularly to carry out quality assurance checks. The registered manager told us they felt supported by the organisation and senior management team.

The registered manager told us that they had an open door policy in which people who used the service, relatives and staff could approach them at any time. This was confirmed by the people we spoke with.

People and their relatives spoke highly of the home and the manager. People told us; "The managers alright. This is a good home and I'd definitely recommend it to others." Relatives told us; "The manager is so accommodating and they've always got time for you." "I always have a chat with the manager and I would say this home is very well-led." "I like that the manager is visible. I have confidence in the manager. If I have had any concerns, they've addressed them and come back to me to let me know what they've done."

The staff we spoke with felt the home was well managed. Staff comments included; "The manager is always willing to help and is very supportive. If there is a problem then they are there." "It's definitely well managed. I think they are really good at their job. I really do." "You can go to the manager with anything. The manager runs a tight ship and checks we are doing ok."

Staff told us morale was good and they were happy working in the home. We found there was a positive atmosphere within the home and the staff team worked well together. Staff said; "It's all going fine. I like helping people who can't help themselves. I like helping people." "I'm really enjoying it. It's a nice place to work." "It is like my second home here. It's very nice and I'm happy working here."

We saw team meeting were conducted regularly. Minutes were taken at all team meetings and were displayed with an action plan. We looked at the minutes from the most recent staff meeting. We saw topics such as recent achievements, training, paperwork changes, personal care charts and infection control were all discussed. Staff said these meetings were regular and felt able to contribute. One member of staff said;" We have them regularly and I recall about three in the last year. We talk about how things can be improved."

We looked at the minutes from recent relatives meetings that had taken place. We saw the agenda covered upcoming events at the home, use of the mini bus, trips and outings, laundry, new and old residents and future meetings/topics for discussion. There were also an 'Any other business' item where people could raise any other concerns.

We saw that there were various systems in place to monitor the quality of service. This included regular audits and checks undertaken by both the home manager and management from HC-One. These audits provided a focus on care plans, health and safety, medication, infection control, weights, the dining experience, how people were presented and any feedback people had. We saw there were agreed objectives and actions set if any discrepancies were identified. The registered manager also undertook a daily walk around of the home. This provided the manager with the opportunity to observe care practices and make improvements. The home also completed their own self-assessment tool. This was centred around the CQC five 'Key Questions' and presented the opportunity to state what supporting evidence would be required to meet each standard and how regulations would be met.

All accidents, incidents, near misses and feedback were recorded so they could be monitored and trends analysed to ensure lessons learnt.

We saw community links had been formed with a local college whose students had a range of physical and learning disabilities. Students visited the home and people from the home attended the college for coffee and a chat. The home also took students on short work experience placements in the home. We were told some wonderful relationships had been formed and that it had been a pleasure to watch the students grow in confidence by interacting with people in the home and sharing their experiences.