Care Quality Commission

Acegold Limited

Carlton Mansions Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 31 March 2015 and was unannounced. The previous inspection was carried out on 21 October 2013 and there had been no breaches of legal requirements at that time.

Carlton Mansions is registered to provide accommodation and personal care for up 26 older people. The home provides a service to people who are living with dementia. At the time of our inspection there were 19 people living in the home.

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

Staffing levels were not sufficient to meet people's needs. Some people did not receive personalised care and some people were left for long periods of time without staff interactions.

Summary of findings

Infection control guidance was not followed so the home was not suitably clean in all areas. The kitchen was cluttered and areas required deep cleaning to meet appropriate standards in relation to food preparation areas.

Care plans were not always representative of people's current needs and did not always give detailed guidance for staff to follow. This risked people's needs not being met.

Correct moving and handling techniques were not always followed. Moving aids were not always used to support people. Therefore people could be at risk of unsafe moving and handling.

Quality and safety in the home was monitored to support the registered manager in identifying any issues of concern. The registered and regional manager undertook regular audits, however not all highlighted the areas of improvement that were required.

Some people were able to tell us of their experience of living in the home and told us they were happy with the service they received. Comments included "I'm ok love" and "it's nice and warm I'm safe now".

Staff received training and understood their obligations under the Mental Capacity Act 2005 and how it had an impact on their work. Within people's support plans we found the service had acted in accordance with legal requirements when decisions had been made where people lacked capacity to make that decision themselves.

Staff had attended Deprivation of Liberty Safeguards training (DoLS). This is legislation to protect people who lack mental capacity and need to have their freedom restricted to keep them safe. Authorisations have been made for all people living in the home. Two people have had them granted and other people are awaiting assessment from the external authorising body.

We found the provider had systems in place that safeguarded people. Some people were unable to tell us if they felt safe due to the level of their dementia. However one person we spoke with told us "I'm ok love. Yes I'm safe here" and people appeared relaxed in the company of staff.

The provider had ensured that staff had the knowledge and skills they needed to carry out their roles effectively. Training was provided and staff we spoke with were knowledgeable about people's needs. One member of staff told us how they were being supported to undertake further development training that would enhance their role.

Safe procedures and a policy was in place to guide staff to manage people's medicines safely. People received their medicines in line with their GP instructions.

Activities were provided to people that lived in the home on a regular basis. This included community groups visiting people in the home.

Staff meetings took place on a regular basis. Minutes were taken and any actions required were recorded and acted on. Staff that we spoke with confirmed this.

There were systems in place to obtain the views of people who used the service and their relatives and satisfaction surveys were used.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was insufficient staff to meet people's needs. Some people did not receive personalised care and interaction.

Infection control guidelines were not followed to ensure the home was clean. Especially in relation to the kitchen area.

Staff who administered medicines were given training and medicines were given to people safely.

Staff were aware of how to identify and report suspected abuse in line with the provider's policy and told us they would have no hesitation to report concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all people received a positive dining experience as they were not given the nutritional support or choice they required.

Not all records were completed comprehensively to manage people's on going health. This included ointment application, moving and handling and fluid charts.

Staff had Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training (DoLS) and had a good understanding of the protection of people's human rights.

The service worked with external professionals to ensure people's healthcare needs were met.

Staff were supported to undertake further personal development training to enhance the care that was provided.

Is the service caring?

Good

The service was caring.

People were treated with patience, dignity and respect. Overall comments about staff were favourable. People said: "Staff are as good as gold, their eyes are everywhere they do not miss a thing"; "all staff are nice".

People were could see independent advocates as required to support them to make difficult decisions.

We found people's opinions were sought to help improve the service they received.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always representative of people's current needs and did not always give detailed guidance for staff to follow.

Best practice moving and handling techniques were not always followed.

Activities were provided to people that lived in the home.

The provider had a complaints procedure and people told us they felt able to complain.

Is the service well-led?

Requires Improvement

The service was well led.

People and staff told us the registered manager was visible and supportive.

The registered manager demonstrated an open and transparent culture in the home. People told they felt listened to and supported.

There were quality assurance systems in place however they were not always effective in identifying improvements that were needed. The registered manager undertook regular audits that were fed back to the provider as part of the monitoring arrangements.

Carlton Mansions 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 inspection took place on 31 March 2015 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The previous inspection was carried out on 21 October 2013 and there had been no breaches of legal requirements at that time.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

We also spoke with seven members of staff that included the registered manager, senior staff and the regional manager of the service. We also spoke with three visiting healthcare professionals. No relatives were visiting at the time of our inspection.

We reviewed the support plans of six people who used the service and five associated care records, four staff's personal files and reviewed documents in relation to the quality and safety of the service, staff training and supervision. We made observations in shared areas to see how staff interacted with people. We used 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.

Inadequate

Is the service safe?

Our findings

Best practice guidance had not been followed in relation to infection control and the home was not suitably clean. The registered manager did have a copy of 'Code of Practice on the prevention and control of infections and related guidance 2010' (code of practice). However they had not assured themselves that the systems and practices in place for infection control within the home, complied with the code of practice and guidance for the protection of people who use the service.

We visited the kitchen area at 11am. A member of staff had not turned up for work and therefore the kitchen person was working alone and was responsible for the preparation of food, cooking and cleaning of kitchen. This person was washing up dishes and then moved to food preparation and cutting of a cake that was on a work surface uncovered. A trolley was outside the kitchen door full of used breakfast crockery waiting to be washed. We observed breakfast condiments such as butter and jams were uncovered on the worktop as was a dirty chopping board that had been used for buttering toast from breakfast time. The kitchen person was also preparing and cooking the lunch at this time.

The kitchen person was moving between clean and dirty areas of the kitchen to undertake tasks and staff were entering the kitchen area to make drinks for people. This posed a risk to food contamination as hand washing and apron changing did not take place between each of these activities. At this point a member of staff came into the kitchen, put on an apron and started to wash up the dirty crockery. They told us “I don’t mind helping out with the washing up. We need to help each other when we are short”. All crockery required washing by hand as no dishwasher facility was available.

The kitchen floor was dirty with ingrained dirt and debris found in many areas. Empty plastic containers cluttered up the areas under the sink areas and corners of the room. Large cooking pots were also stored on the stained floor. Cluttering areas under work surfaces would make it difficult for effective cleaning to take place.

Material cloths were used for the washing up and were viewed in a plastic container on the side of the sink. This practice risks that these cloths could harbour germs and is not best practice. The registered manager told us “a clean one is used each day and these will be thrown out at the end of the shift”. However when we returned to the kitchen later when the shift was finished, we observed these used cloths remained wet in the container and had not been thrown out.

Colour coded chopping boards were available to use. However these were badly ‘scored’ and used. Therefore this could increase the risk of harbouring germs as they could not be cleaned effectively.

In the food storage area a tall fridge was dirty and blood spillage from meat was observed in the bottom of the fridge. The floor in this area was dirty and cluttered making effective cleaning difficult. A puddle of water was on the floor by one of the freezers. The temperature was within the correct range for this appliance. The kitchen person told us “the water on the floor is because I have been in there to get stuff out”. We discussed how it would be best to get this appliance double checked to ensure this was correct.

There was a ground floor toilet, which was in constant use by the 17 people who spent all day in this area. Although the regional manager told us people could use their ensuites should they so wish. However our observations confirmed not many people would be able to ask for this this due to their level of dementia. The toilet, which was small, had a raised frame leaving very little space for a member of staff to manoeuvre when supporting people. The wash hand basin was not easily accessible and we saw people leaving this area did not wash their hands. Used incontinence products were left in a plastic bag on the floor which risked cross contamination. There was no evidence of personal protective equipment, disposable gloves and aprons, being easily accessible and staff entered and left this area without using this protection. This area had an unpleasant smell as the door was often left open into the hallway and lounge area. No ventilation system was in place.

All of these incidents increased the risk of the spread of infections; people were not fully protected because appropriate guidance was not being followed. The provider had failed to ensure that working practices and standards of cleanliness and hygiene were being maintained.

Inadequate

Is the service safe?

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us a staffing dependency tool was used to ascertain the numbers of staff required based on people's needs. They told us this confirmed the correct numbers of staff were on duty. However from our observations and staff we spoke with there were not sufficient staff available at all times.

The staffing levels were not sufficient to support people safely as a robust plan to manage staff absence was not in place to ensure enough staff were available to work. One person told us "staff are rushed off their feet, they have a hard job doing everything". The registered manager told us three care staff and one senior care staff were on duty during the day time hours and one senior and two care staff at night. Separate ancillary staff were on duty during the day.

The staff rota for March 2015 showed on at least ten occasions there were only two care staff and one senior on duty. This was not in line with the provider's assessed required level of staff to meet people's needs. We discussed the rota analysis with the registered manager following our inspection and they confirmed our findings were correct. The registered manager also told us they were currently recruiting to the chef's position and care positions at this time. The registered manager told us they would cover care staff shortage as required when they were in the home. During our inspection this took the registered manager away from their management duties for most of the day. They told us staff shortages had to be covered by the existing staff team, as the organisation's policy was not to use agency staff in residential homes. Staff confirmed this and told us this led to low morale as they didn't always want to work long hours but had little choice. Another staff member told us they were unable to take their annual leave due to the staff shortages.

Staff were not available to support people consistently and most people living with dementia were unable to ask for help. Staff told us, "When we're short staffed we get people fighting" and "People are always fighting each other as we cannot always be around." During our inspection we overheard one person becoming slightly agitated with another person during lunch by telling them, "Leave it alone, you'll break everything, put it back." This person spoke roughly several times to their neighbour. However care staff were only available to intervene once, when they told the person not to get upset as they were busy with another person. Other staff told us, "We're struggling today with staff but generally it's ok", "We've had people sat at table since breakfast and need toileting at ten o'clock, but we've still got two people waiting to be got up". Another staff told us "We can't take people to the shops or in the garden; we've got pressure all the time."

Sufficient staffing was not available to observe and support people. Lunchtime was not organised to support people to eat independently or have a full meal. Three people were sitting at a table with no cutlery and one member of staff brought three spoons out for them, but no knives and forks. The three spoons were put on the table; however, only one was the right way round. Confusion occurred because the table was not laid when the people sat down to eat. A member of the care staff then brought two meals and two sets of cutlery, so the third person was left with nothing for 35 minutes, when a member of staff then brought them an ice-cream for their dessert before they had their main meal. This person would not have had a main course if we had not pointed this out to staff as they thought the spoon represented that they had eaten their main meal.

During the late afternoon one member of staff was undertaking medicines administration, one was supporting a person in another area of the home leaving only one staff member to support people in two lounges. Some people in one of the lounges were left for periods of up to 20 minutes alone without any interaction from staff. The second lounge area could not be viewed from where the member of staff was sat giving reassurance to a person who was quite upset. Therefore this posed a risk to people who may need assistance as the staff were not readily available.

The premises were spread over four floors and each floor had a key code pad in order to leave or gain access to that area. The registered manager told us this was due to the level of people's dementia and would be unsafe to use these areas independently, due to the stairwells. One member of staff told us "we are unable to let some people back to their rooms during the day even if they wanted to, as they would not be safe and we don't have enough staff to stay with them". During our inspection 17 people remained in the downstairs area as they could not use the coded key pads to move between floors. Two people did

Inadequate

Is the service safe?

return to their rooms and they had been assessed as being safe and able to do so. However staff had to visit these people in their rooms at certain times to tend to their needs, therefore reducing the number of staff in the shared area at times.

During breakfast we saw staff going in and out of the kitchen to help with the breakfast. Which meant they were unable to support people in the shared areas. We were also told that sometimes the care staff would have to serve the tea time meal when there was no kitchen assistant available which reduced the number of care staff available to support people.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who administered medicines were given training and medicines were given to people safely. Staff had a good understanding of the medicines systems in place. A policy was in place to guide staff from the point of ordering, administering, storing and disposal of any unwanted medicines. Medicines were stored appropriately in a locked cabinet and all medicines records were completed appropriately.

People were unable to have over the counter medicines if they needed them as there were none available. This was despite the organisation's medication policy stating that a small amount of medicines such as simple analgesia should be made available. One person admitted for a short stay had a very sore finger and several cuts and grazes and was crying. The member of staff told us they were upset and confused because of the new surroundings. However no pain relief was provided for them therefore couldn't rule out that their distress was a combination of pain and confusion. The member of staff arranged for a family member to bring in some pain relief for the person.

There were a few people who declined their medicines. These were for pain relief and calcium supplements. The member of staff was able to tell us the action they would take if people declined critical medicines. They told us they would contact the GP for advice to ensure people's safety. Staff we spoke with who were responsible for medicines administration demonstrated a good understanding of best practice guidelines to follow.

Risks to people's safety were assessed before they came into the service. People's risk assessments were clear and detailed to guide staff. They ensured the least restrictive option for people and enabled people to be as independent as possible. We saw risk assessments for choking in people's care plans. The home used nationally recognised tools for assessing people's likelihood of developing pressure ulcers and malnutrition. We saw one care file which identified a range of behaviours which staff may need to support the person with. However, the risk assessment only provided guidance about one of the behaviours identified. Therefore staff may not have sufficient guidance to support the person with all their presenting behaviours.

Risk assessments relating to people's rooms were seen in their room files; however, we did not see any personal emergency evacuation plans. We asked staff how they knew the best way of assisting people in an emergency; staff said, "Its common sense" and "We know if people are in wheelchairs they're not going to walk out."

The provider had arrangements in place to respond to suspected abuse. Staff received training in safeguarding adults and a clear policy was in place for staff to follow. Staff were clear about what action to take if they suspected abuse and how to report any concerns.

Staff understood whistleblowing and the provider had a policy in place to support people who wished to raise concerns in this way. This is a process for staff to raise concerns about potential malpractice in the workplace.

Safe recruitment processes were in place. Appropriate checks were undertaken. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS ensures that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks were undertaken. Staff we spoke with and the staff files that we viewed confirmed this.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents The registered manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up and support plans adjusted accordingly. An electronic system was also in place for the organisations auditing processes.

Inadequate

Is the service safe?

Maintenance, electrical and property checks were undertaken to ensure they were safe for people that used the service and regular fire alarm testing took place to ensure all equipment was fit for its purpose and staff were aware of the procedure in place.

We recommend the provider reviews its 'homely remedies policy' in line with the organisations medicines policy.

Requires Improvement

Is the service effective?

Our findings

The dining experience was not personalised or positive for all individuals. Some people told us : "I don't enjoy the food, there is a lot of repetition and we have to wait a long time to get it". Other people said "food is nice" and "it is all good".

People were offered a drink of juice; however there were no choices of juice available. There was a lack of appropriate support for some people who needed assistance such as prompting. There was no adaptive equipment such as plate guards to help people maintain their independence when eating that would have helped some people that we observed. We observed one person picking another person's food up when it spilled on the table and putting it back on their plate. Because staff were not supporting people appropriately by giving dedicated one to one support, they did not observe what was happening and staff later fed this food to the person. We observed staff either stood over people to give them one or two mouthfuls of food, before moving on to another person or knelt on the floor, creating a hazard for others. We saw one care staff trying to put a spoonful of food into a person's mouth while they were still chewing. Some people had plates of food put in front of them, then waited up to five minutes for it to be cut up for them. This was not a positive mealtime experience for people.

People were not given sufficient choice. We asked staff what the vegetarian option was and they told us, "Croquet potatoes and parley sauce." After lunch, people were given cheese and biscuits. Although there was a choice of biscuits available, we saw a member of staff using a pair of tongs putting one biscuit and a piece of cheese on a plate; people were not given a choice which biscuit they wanted. One person was given cheese and a biscuit at the table, and then before they could eat it a member of staff got them up and moved them to another chair, saying they would bring the cheese and biscuit over without allowing the person to finish their meal where they were sat.

Not all records were completed accurately to assist staff to monitor and manage people's on going health. We saw a body map in a person's care file which identified a cream needed to be applied three times daily. However the recording chart to accompany this body map, showed the cream had not been applied as directed. On one occasion, the cream had been recorded as applied twice in one day, each application being five minutes apart. Some staff told us sometimes they forget to record the application but do apply it.

People's food and fluid charts were appropriately completed to monitor some people's on going health needs. However none of the fluids charts had been totalled to accurately monitor of people had sufficient for their needs.

People were supported to see a local GP or hospital, should they require it. Staff described how they worked with other professionals to ensure the person's needs could be met before they came into the service. Assessments took place before the person moved into the home to ensure they could meet people's needs. Records of G.P's, district nurses and other professional visits were kept in people's care plans and showed external professionals were consulted for advice and guidance when a person's needs had changed. Staff told us, "We have G.Ps, Deprivation of Liberty Safeguards (DOLS) assessors, district nurses, Independent Mental Capacity Advocates (IMCA), community psychiatric nurses and chiropodists visit" and "Health care professionals visit pretty much every day." We spoke with two visiting healthcare professionals who had no concerns about the home. They told us staff carried out the care as directed and contacted them if they had any concerns. Another visiting professional told us they had always observed positive interactions between staff and people that lived in the home during their visits and had a good knowledge of people's needs.

Staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training (DoLS). This is legislation to protect people who may not be able to make certain decisions for themselves. Staff were able to tell us why this legislation was important and had a good understanding of what DoLs meant for people. The registered manager had completed DoLS applications for everyone living in the home due to their level of dementia and the restrictions that stooped people moving freely around the home, due to keypads on each floor. They told us two people's applications had been authorised and they were awaiting the outcome for the others.

The service had systems in place for people to use advocacy services when they needed it. One person had an IMCA in place to support them. This is a person that is asked to support people if they lack capacity to be able to

Is the service effective?

make complex decisions for themselves. Therefore they can help be the 'person's voice'. The registered manager demonstrated a good understanding of how this arrangements supported the person and they liaised with the external agency as required.

Throughout our inspection staff were heard routinely asking people for consent in their daily routines. For example a member of staff knocked on a person's door and asked for permission to enter. Staff told us, "It's sometimes not possible to get consent when people lack capacity, but I'll leave someone and come back again if they say no" and "We let people be as independent as possible and give choices where possible."

People received care from staff who had received training that enabled them to carry out their roles. Staff told us they received a lot of training and this equipped them for the role. Training included: safeguarding adults, food hygiene, equality and diversity and health and safety. Training was a mix of face to face and eLearning. Staff felt the face to face learning was more beneficial for them as it gave opportunity to exchange ideas and good practice. An electronic system was in place that recorded staff training and indicated when this was next due.

The provider had a system in place to support staff and provide opportunities to develop their skills. For example some staff member told us how they had been supported to undertake their diploma in care. They felt this enhanced their skills and knowledge that they would share with other members in the team.

Staff we spoke with and records confirmed on going one to one supervision was provided to all staff to support their work and development. A supervision planner was viewed that evidenced this. One member of staff told us "yes I get regular supervision. But to be honest I can approach [name] anytime I need to discuss anything". Staff also received yearly appraisals. This is a process whereby staff performance and personal development is reviewed to enhance the skills of the member of staff. Records viewed confirmed this.

The dining experience was not personalised or positive for all individuals. Some people told us : "I don't enjoy the food, there is a lot of repetition and we have to wait a long time to get it". Other people said "food is nice" and "it is all good".

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Requires Improvement

Is the service effective?

People's food and fluid charts were appropriately completed to monitor some people's on going health needs. However none of the fluids charts had been totalled to accurately monitor of people had sufficient for their needs.

People were supported to see a local GP or hospital, should they require it. Staff described how they worked with other professionals to ensure the person's needs could be met before they came into the service. Assessments took place before the person moved into the home to ensure they could meet people's needs. Records of G.P's, district nurses and other professional visits were kept in people's care plans and showed external professionals were consulted for advice and guidance when a person's needs had changed. Staff told us, "We have G.Ps, Deprivation of Liberty Safeguards (DOLS) assessors, district nurses, Independent Mental Capacity Advocates (IMCA), community psychiatric nurses and chiropodists visit" and "Health care professionals visit pretty much every day." We spoke with two visiting healthcare professionals who had no concerns about the home. They told us staff carried out the care as directed and contacted them if they had any concerns. Another visiting professional told us they had always observed positive interactions between staff and people that lived in the home during their visits and had a good knowledge of people's needs.

Staff had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training (DoLS). This is legislation to protect people who may not be able to make certain decisions for themselves. Staff were able to tell us why this legislation was important and had a good understanding of what DoLs meant for people. The registered manager had completed DoLS applications for everyone living in the home due to their level of dementia and the restrictions that stooped people moving freely around the home, due to keypads on each floor. They told us two people's applications had been authorised and they were awaiting the outcome for the others.

The service had systems in place for people to use advocacy services when they needed it. One person had an IMCA in place to support them. This is a person that is asked to support people if they lack capacity to be able to make complex decisions for themselves. Therefore they can help be the 'person's voice'. The registered manager demonstrated a good understanding of how this arrangements supported the person and they liaised with the external agency as required.

Throughout our inspection staff were heard routinely asking people for consent in their daily routines. For example a member of staff knocked on a person's door and asked for permission to enter. Staff told us, "It's sometimes not possible to get consent when people lack capacity, but I'll leave someone and come back again if they say no" and "We let people be as independent as possible and give choices where possible."

People received care from staff who had received training that enabled them to carry out their roles. Staff told us they received a lot of training and this equipped them for the role. Training included: safeguarding adults, food hygiene, equality and diversity and health and safety. Training was a mix of face to face and eLearning. Staff felt the face to face learning was more beneficial for them as it gave opportunity to exchange ideas and good practice. An electronic system was in place that recorded staff training and indicated when this was next due.

The provider had a system in place to support staff and provide opportunities to develop their skills. For example some staff member told us how they had been supported to undertake their diploma in care. They felt this enhanced their skills and knowledge that they would share with other members in the team.

Staff we spoke with and records confirmed on going one to one supervision was provided to all staff to support their work and development. A supervision planner was viewed that evidenced this. One member of staff told us "yes I get regular supervision. But to be honest I can approach [name] anytime I need to discuss anything". Staff also received yearly appraisals. This is a process whereby staff performance and personal development is reviewed to enhance the skills of the member of staff. Records viewed confirmed this.

We recommend the provider reviews its dining experience to ensure choice, dignity and personalised care is followed.

Good

Is the service caring?

Our findings

People were treated with patience, dignity and respect. People made favourable comments about the staff and one person said: “Staff are as good as gold, their eyes are everywhere they do not miss a thing”; “all staff are nice”; “everything is good, I like being here”; “they help me when they can, they are kindness itself”. However, one person commented: “dignity is not in it, they make you feel invisible, and they refer to you to others as ‘she’ as if you have no intelligence”. This person’s comment was not indicative of our observations or other people’s views. However we did feed this back to a member of staff.

People who were unable to give us their verbal feedback looked comfortable and relaxed when staff approached them. However staff were very busy and most of the interactions were task orientated and responsive to their care routines. This was due to the number of staff that were available that day. Staff spoke with people in a caring manner, using suitable volume and tone of voice, listening to and responding to their requests in a prompt and considerate way. For example, one person was distressed and staff spent time speaking with them reassuring them and leaving them in a much calmer way. Minutes later this person became distressed again and staff responded in the same caring, reassuring manner. Another person was assisted to a seat in the dining room. Staff spoke kindly to this person and walked slowly, allowing the person to take their time as they needed to.

Several people spent their time walking around between the two sitting rooms, often bumping into each other. At this, one person began to verbally chastise the other. A member of staff diffused the situation by offering cups of tea and escorting the other person to another area of the sitting room. This was a frequent occurrence during our inspection and demonstrated the member of staff understood this person’s needs as they became more settled at that point.

People’s privacy and dignity was respected. Staff knocked on people’s doors before entering during our inspection. A member of staff told us “People are involved in decisions about their care and support as much as possible”. Staff we spoke with had a good knowledge of peoples’ likes and dislikes and we saw people responded positivity to staff interactions.

As part of the provider’s quality monitoring, people’s opinions were sought through surveys on a yearly basis and at residents’ meetings. Residents’ meetings were held monthly and minutes were viewed dated February and March 2015. Minutes included; people being reminded how they could make a complaint, food, activities and laundry systems. An action plan was compiled and included the need to have a meeting when the new chef is in post and staff to arrange musical sessions regularly. The minutes recorded that people were informed and involved in the service changes.

People were supported to maintain links with their families and friends. We were told people could have visitors throughout the day in the home. However no relatives were visiting at the time of our inspection for us to gain their views. Documentation showed that relatives were asked for their opinions as part of the yearly surveys and comments that the service received were positive.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not sufficiently detailed to help staff provide personalised care based on people's current needs.Some people's mobility needs had not been assessed and detailed in their care files to guide staff. We saw a member of staff trying to persuade one person to stand. Despite encouragement, the person was unable to stand unaided and suitable guidance was not recorded in the person's care plan. Staff tried for a few minutes, then left the person and returned shortly, altogether spending 40 minutes attempting to persuade the person to stand when eventually the person did stand with staff support.

People's mobility needs were not always assessed or documented in their care plans. We saw two people being assisted out of their seats at lunchtime, in a way that did not follow best practice guidance; one of these people was the person we saw staff being unable to support to stand. Their care plans did not identify the level of need that we observed. For example, the care plan hadn't identified their individual needs or highlighted the use of any equipment that they required. The moving and handling needs assessment in the room folder for one of these people said, "No manual handling needs other than walking stick and wheelchair for long distances." However this person was unable to stand independently. Staff did not use the hoist available that was stored upstairs or any other moving and handling equipment when some people would have benefited from this . Staff were seen to hold people's hands and another ushered people out of their chairs from behind. Staff told us, "We've got a hoist upstairs but we can't use it" and "A stand aid would be perfect for some people, but we haven't got one." We asked a member of staff we observed using inappropriate manual handling technique. For example they did not use moving and handling equipment that would have supported the person, if they were happy with the support they had provided to the person to help them stand. They told us, "To an extent. The only alternative is them never walking again." Some staff told us they had moved people on their own when staff weren't available as they had no choice. Therefore best practice in moving and handling was not always followed.

We saw some moving and handling care plan profiles which contained contradictory information. For example, one person's care file said: "Not independently mobile but fully weight bearing. Two CA's, one hand on shoulder blade and one hand supporting lower back" while the information in the person's room said: "Not independently mobile, 2 CA's or use of wheelchair." Therefore due to this contradictory guidance for staff to follow the person could be at risk of not receiving the care and support required. We spoke with one member of staff .They told us the home had a hoist but it was only to be used in emergencies for falls and said, "We're a residential home so don't look after these needs". They told us the home had slide sheets, mobility frames and handling belts. Another staff member told us "by the time we would get the hoist down it would be too late. It should be here in the lounge when we need it but there's no room".

Some information contained in people's care plans was incorrectly completed. For example we saw one care plan that identified the person as having diabetes, but erroneously recorded the person did not have diabetes in two other places. Therefore the conflicting information could lead to the person's assessed need not being met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

They told us a hoist was available and stored on an upper floor for staff to use at any time and equipment would be purchased to support people if they required it or didn't have it available.

External professionals were positive about the service that was delivered. One healthcare professional we spoke with said, "It's been great, we've used this service a lot for respite. They're quite flexible and good at settling people on a short term basis. Staff are always friendly, affable and insightful."

People's needs were assessed before they came into the service. We saw six care plans contained descriptions of how people were supported and included; pre admission information personal hygiene, mobility, communication and pressure care. Life histories were in place however not all were completed fully as they lacked detailed descriptions of the person and their life history. Do not attempt resuscitation (DNARs) were in place for some people and were completed appropriately and were signed by a G.P. Care plans were reviewed monthly.

Requires Improvement

Is the service responsive?

Care plans contained information about people's likes and dislikes as well as their needs. Some people told us they felt staff had a good understanding of their individual needs. One person told us "staff have a hard job but they know what they are doing" This was confirmed when we spoke with staff.

People were given opportunities to engage in meaningful activities to them. Staff told us how one person assisted the maintenance person with jobs around the home and described how they enjoyed this. They said "they really enjoy this; they have been involved in planting hanging baskets and pots in the garden and have also helped to paint the front wall of the house".

We were told there were no permanent no activities co-ordinators in post at this time as they were currently advertising the post. However we were told the previously permanent co-ordinators were working on alternate weekdays until new staff were appointed and care staff were filling in at other times. A structured programme of activities was not always available as staff would only be able to provide this if time permitted. However during the afternoon of our inspection staff put a CD on in the quiet lounge for people and had a short activity session with balloons and beanbags in the other lounge. There was a typed list of the week's activities on the board in the shared area of the home. This included ball games, sing-a-long, film afternoon, pampering, arts/colouring, 1/1 life story, dancing and fun, reminiscence, holy communion and Easter service.

Community links were maintained for people and there were good connections with the local organisations. Once a month members of the local church visit, bringing a portable keyboard to engage in an hour of singing a mixture of old songs and hymns. This was occurring on the day of our visit in the quiet lounge and was popular with the people who participated in it. Students from the university also visited one afternoon a week to sit and chat with people. .

People knew how to make a complaint. One person told us "oh yes my [name] would tell [name]". A complaints policy and procedure was in place. The registered manager had a system to review and respond to any complaints. One was viewed on file that showed this was responded to in line with the organisation's policy with a satisfactory resolution. Staff told us they were aware of the process for dealing with complaints, and would inform the registered manager if they received any. We saw people had a copy of the complaints procedure in their room files.

Requires Improvement

Is the service well-led?

Our findings

The auditing system did not always identify areas that required improvements. The provider had a system to regularly assess and monitor the quality of service that people received. However they were not fully effective. Audits undertaken included: medicines, environment, call bell response times, complaints and incident and accidents. The registered manager told us they had just introduced a 'falls report'. This enabled the senior management team to identify any trends to people's falls against particular times of day.

The regional manager undertook monthly quality monitoring visits. Minutes that we viewed confirmed action plans were put in place and followed up at the next meeting. For example one identified the registered manager needed to ensure they audited care plans and monitoring charts for people's food and fluid records. This was because staff were not always aware of what and where to record things. This demonstrated some areas we identified, had also been identified via the auditing process and this was already work in progress. For example, work around recording in care plans and recording charts. The regional manager told us they had also noted the state of the kitchen during their quality monthly visit the day before and told us arrangements would be made to immediately address this. This was not typed up at the time of our visit but was sent via email following the inspection. It stated 'kitchen and store need attention. Manager to discuss with chef and complete supervision regarding completion of records and cleaning schedules'.

Staff told us the service was well-led, they received support from the registered manager and felt they really had a good team in place. Comments included: [name] is very good at talking to us when we need extra support"."[Name] is very approachable and I can ask things at any time". One member of staff told us "I wish there was more flexibility in the rotas. This sometimes causes low morale". Overall staff told us they felt the home had an open and supportive culture. This was confirmed by the registered manager who told us "we have a lot of things to put right and I am working through them and we will get there".

We were told the registered manager was visible in the home most days and sometimes worked shifts at times of staff shortage. The registered manager told us this also gave them opportunities to observe the delivery of care. However they also recognised this distracted from their management duties and service development plans. They confirmed an active recruitment programme was underway and they thought a full complement of staff would be in post in the near future. This would enable them to concentrate on leading the developments that they wanted to make. We were told they had put a lot of systems into place since they had come into post, but their vision still had 'a way to go' as there were many things to put in place.

The registered manager communicated with staff about the service. Team meetings took place on a regular basis. An agenda was arranged and staff could add anything for discussion. Staff confirmed this and told us ad hoc meetings were also arranged if necessary. Minutes confirmed this and noted any actions that were to follow.

Staff were supported by the registered manager and were provided with regular one to one supervision. Staff confirmed this took place and was at suitable intervals to meet their needs. One staff member told us "I don't have to wait until my formal supervision. I can ask at any time". Records that we viewed contained evidence of what staff thought they did well and also detailed if they required any support

A yearly 'compliance report' was undertaken by internal auditors. This audit was aligned to the CQC's five questions covered at inspection. Action plans were in place and followed up. For example it stated an action as 'review care plans to correlate to dietary preferences'. This was followed up at the 6 monthly review and was signed as being achieved.

The registered manager audited incidents and accidents to look for any trends that may be identified. This ensured the registered manager was fully aware of any events that took place that may require actions or follow ups.

Satisfaction surveys took place to help develop and improve the quality of the service. Surveys were sent to people that used the service and their relatives. All the comments reviewed from February 2014 were positive. The information that we viewed stated 24 surveys were sent out and nine were returned. Results showed that 94% of people who returned the survey rated the home as good or very good. We were told any individual comments were

Requires Improvement

Is the service well-led?

responded to by the registered manager on a one to one basis and an action plan would be compiled in relation to the ongoing service development. We were told a new survey was due to be sent out.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Infection control guidance was not always followed. The kitchen did not meet cleanliness and food safety standards. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Not all people received care in line with their assessed needs. Some people's moving and handling assessments were not reflective of their needs.

This section is primarily information for the provider

Action we have told the provider to take

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.