Rockley Dene Homes Limited

Carlton Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 11 May 2017 and was unannounced. The service was last inspected on 7 December 2016 and was rated as Inadequate and placed in to special measures. On 7 December 2016 we found several breaches of legal requirements relating to safe care and treatment, governance, consent, staffing levels, and training and supervision. We issued four warning notices to the provider and requested an action plan be sent to us to show us how Carlton Court Care Home was going to improve care.

At this inspection we found improvements had been made in areas of concern, the issues raised in the warning notices had been addressed and the service was no longer in breach of legal requirements.

Carlton Court Care Home is a nursing home for up to 81 people providing nursing care and accommodation. Some of the people living in the home had dementia and some people required support with their physical needs. At the time of this inspection there were 46 people living in the home.

Carlton Court Care Home requires a registered manager to be in post, there had not been a registered manager in post since 30 March 2016. 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 current home manager had applied for registration and was in the process of becoming registered.

Improvements had been made in the management of medicines but further improvements still needed to be made to pick up errors. The home was working with a new pharmacist to improve the management of medicines.

Risk assessments were more thorough, and the risks people faced were captured. Risk was discussed as ongoing issues and staff communicated risk through meetings and handovers. Safeguarding practises were more robust and staff were confident in spotting and reporting issues, appropriate referrals were now being made.

The home was clean and odour free and good infection control practices were being followed. We found the atmosphere in the home to be calmer and more organised and the staffing structure was clearer.

There were improvements in consent documents and DoLS applications were now being made and followed up. People told us they enjoyed the food and relatives said there was choice on offer.

Record keeping had improved, with fewer gaps in recording essential care and in fluid and continence charts. Staff told us they had been supported to improve record keeping and had noted an improvement in training provided so they could better meet people's needs. Staff were receiving supervision.

We saw caring interactions between staff and people and people said staff knew them and were kind. People were treated with dignity and staff knocked on doors and respected privacy where it was requested.

Activities had been recently developed but improvements still needed to be made so that every person had the opportunity to do something they liked in or out of their room. People told us they weren't always getting their preferences met in personal care.

Complaints were recorded and responded to within the timeframe outlined in the policy. Some historic complaints were ongoing but many had been resolved. We found the way responses to complaints had been worded could have been more empathetic.

Staff felt supported by the home manager and regional support manager and relatives told us they had seen recent improvements in the home. The management team were open about how the service still needed to develop and had plans in place to address this. We saw an improvement in the making of notifications to the Care Quality Commission; these were being made in a timely way.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Improvements had been made in the management of medicines but further improvements were still needed in order to pick up errors

Risk assessments were thorough, and risks people faced were captured.

Safeguarding practises were robust and staff were confident in spotting and reporting issues, appropriate referrals were now being made.

The home was clean and odour free and infection control practises were being followed.

The home was no longer in breach of legal requirements in safe care and treatment and staffing. Concerns identified in the warning notices we issued had been addressed.

Is the service effective?

Good

The service was effective. We saw evidence of people being supported with pressure sores management.

The home was more organised and staff knew what they were doing on shift. Staff were confident in their knowledge of the MCA.

People and relatives fed back that they enjoyed the food. A range of drinks were on offer throughout the day and in reach of people.

We saw evidence of visiting professionals and referrals to health services where needed.

Is the service caring?

Good

The service was caring. People told us staff were caring and we saw caring interactions throughout the day.

People were treated with dignity and respect, staff knocked on doors before entering people's rooms.

End of life care was discussed with people and families where appropriate and recorded sensitively.

Is the service responsive?

Requires Improvement

The service was not always responsive. Complaints handling and recording had improved but still needed some further improvement.

There were more activities taking place but the new programme and increased activity hours were still in early stages. There were more people out of bed than at our last inspection.

Care plans were more person centred and we saw staff engage in person centred care. However, people told us they didn't always have the personal care they wanted.

Is the service well-led?

Requires Improvement

The service was not always well led. Improvements had been made to quality assurance and audits were more robust. However, there were still areas for improvement in medicines, activities and personalised care. We felt assured these issues would be acted on and management plans were already in place for some concerns.

Staff told us they felt supported and relatives said they thought the new home manager was effective.

We saw improvements in how the home was managed and a consistent approach to supporting staff and improving care standards across the home.

The home was no longer in breach of legal requirements in governance and making notifications. Concerns identified in the warning notices we issued had been addressed.

Carlton Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 over two days on 9 May 2017 and 11 May 2017 and was unannounced.

The inspection team consisted of three inspectors, one specialist adviser in the area of nursing and dementia care, a pharmacist inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information gathered from previous inspection reports, notifications sent in by the provider telling us of incidents at the home, and sharing information with the local authority quality in care team.

We talked to 25 people who lived at the home, and 10 relatives who were visiting on the day of the inspection. We interviewed eight care staff, three nurses and the home manager, and spoke with the commercial director, hospitality manager and regional support manager.

During the inspection we observed lunch across the home, activities, a meeting for senior care staff, nurses and managers, and care provision in communal areas throughout the day. 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. We reviewed six staff files, twelve care files for people living in the home, and their daily care records. We looked at various policies and procedures and examined safeguarding and incidents records, complaints records, notes from meetings and audit records. We also spoke with four health and social care professionals who worked with the home.

Requires Improvement

Is the service safe?

Our findings

People felt safe. They said "I feel safe and looked after", "I do not worry and I am cared for well" and "everything, including me is looked after." Relatives told us they felt the same and said "I've never seen anything here to make me think otherwise" and "I consider him safe and everything he has here is taken care of."

During our last inspection in December 2016 we had sufficient concerns to issue Carlton Court Care home with warning notices relating to safe care and treatment and staffing levels and we were not assured the care was consistently safe. At this inspection we looked at the specific issues in the warning notices, as well as inspecting the wider safety of the home. We found the concerns identified in the warning notices relating to staffing and safe care and treatment had been sufficiently addressed.
Previous to this inspection we had concerns that medicines were not being managed safely. We found codes for non-administration of medicines were used incorrectly so it was not clear why a person had not taken medicines, this had now improved. There were still some minor gaps but these were starting to be being picked up by audits. We found gaps in emollients and creams records, this issue was partly resolved but had improved.

We asked the home manager how they had changed the way medicines were administered so less mistakes were made. They told us they were checking medicines administration records daily and communicating any errors with all nurses so that best practise could be shared. The home manager told us a new pharmacist was due to start at the end of the week and they would be introducing more robust checking of medicines and audit procedures.

Concerns at the last inspection that had been fully resolved on this inspection were a nurse signing for medicines later than they had been administered, unclear information on covert medicines, entries on Medicine Administration records (MAR) not being clear for people who required thickeners in liquids and gaps in controlled drugs records. We saw evidence that medicines were being more thoroughly audited to check that mistakes were not being made and where errors had occurred the home manager was investigating these and they resulted in disciplinary action because of the impact missing or mistaken medicines had on people. We saw four potential errors that we fed back to staff and the home manager and action was taken to investigate or resolve them promptly.

The clinical rooms where medicines were stored were locked and only nurses had access. All medicines were stored in locked medicines cabinets or locked medicines trolleys within the clinical rooms. The clinical rooms were clean with handwashing facilities available. Staff recorded the room temperatures of the clinic rooms and temperature of medicines fridges daily. All the temperature readings were within the recommended range which provided assurance those medicines were stored at the correct temperatures to remain effective.

Thickening agents were listed on the medicines administration record (MAR) charts. The supplies of thickener were stored separately from all other medicines and were not within reach of people. There was

information available in care plans and on the kitchen wall to inform staff how much thickener to use for those people that required it.

We looked at 12 MAR charts during this inspection. The MAR charts were generated by the pharmacy that supplied the medicines. Nurses used them to record the administration of medicines. This provided assurance that residents were receiving their medicines safely, consistently and as prescribed. All 12 MAR charts had a photo to assist the identification of the people receiving medicines. Allergy status information was also available. Whilst staff checked the new MAR charts when they were received, against the MAR charts for the previous month, we saw that some mistakes had not been identified and fed this back. There were people receiving their medicines covertly at the time of the inspection. When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the person. We saw that mental capacity was assessed for each person having their medicines administered covertly. We also saw best interest decisions around the use of covert medicines administration with involvement from nurses, a GP, a pharmacist, and the next of kin. Going forward, the new pharmacy service provider planned to review all the covert medicines administration agreements. This process would ensure each person would have a risk assessment document detailing how each medicine should be disguised.

When people were prescribed medicines that were not given each day, we did not always see information on the MAR chart to detail when the dose was due. We saw one person had been prescribed a medicine at night time which was usually taken in the morning. We flagged this to staff, and the GP changed the time of administration to morning.

We recommend that nurses review information on MAR charts relating to medicines administered less than once a day and times that medicines should be prescribed against administration times.

People said they were happy with how they were supported with their medicines and said "they give me my tablets with water", "they bring it to me and write it in the book when I take it, I think it is on time yes" and "they bring them to me and I know what it is for." A relative said "meds seem to be more organised."

At the last inspection we were concerned that pain management around wound care was not sufficient and that pain was recorded inconsistently. We spoke with one person that we met on the last inspection and they told us they were happy with their pain management now. We saw that before where we had raised concerns that the changing of dressings was not consistent there had been improvements in records of when wound dressings had been changed. One person had a very deep, large pressure sore and the home was working closely with tissue viability nurses to try and prevent it from getting worse. For this person a specialist piece of equipment was used on the wound, staff had been trained to use this equipment but were not fully confident in its use. We asked the home manager about why the piece of equipment was no longer being used and they said it was unclear if the wound was getting worse because of complications with the person's health or because the machine was not used appropriately. We followed this up afterwards and were told by health professionals that staff had followed instructions. We discussed with the manager that staff should feel fully confident before using a piece of equipment, they agreed.

At the last inspection staff were not deployed effectively to meet people's needs. At this inspection we found changes had been made to staffing deployment and people fed back that they were having their needs met. Relatives said they had noted a difference and one relative said "They are always busy but seem to be getting more organised. They seem to have been working hard to do this." Staff in the home on the day of the inspection matched the planned rota and we saw there were extra staff in the home to implement improvements and monitor care standards.

People told us there were enough staff but they were sometimes rushed at busy points. People said response to call bells had improved and "I use the bell and they come. They are quick at night. Daytime I wait a bit longer but they say that you will be next", "They are pretty quick for me, anytime." However, one person said "I use the bell and if they don't come I go to find them. At night I wait. They do come in about ten minutes. Sometimes in the morning I wait a bit longer and I can't get up to go to the toilet. They said I should use my pad if I get caught short." One relative said "bells seem to be answered quicker now and I've noticed they don't just let them ring, they go to the person and tell them they will be back soon." However, another relative told us "They keep her clean, but sometimes she is wet as not checked often enough but this does not happen often."

Staff we spoke with had a good understanding of what constituted abuse of a person and how to report any concerns both internally and to external agencies. The home manager was in regular contact with the local authority to report and follow up safeguarding concerns. We saw that concerns were recorded and followed up with clear actions in place.

We saw that risk assessments had improved and were appropriate for each person including areas of risk such as bed rails, moving and handling, falls, and pressure areas. For example for one person at risk of falls there was a risk assessment in place for falls and we saw evidence of action taken by staff after a fall. We saw where a person had become at risk of malnutrition because they had lost weight a referral to a dietician had been made and the advice was being followed and included in the risk assessment. Risk assessments were reviewed regularly and staff members we spoke with had a good understanding of the risk people faced and how to manage and mitigate this risk to keep people safer. We observed a meeting with the home manager, nurses and senior care staff where key information about their shift and any changes in people's needs were communication. This was a good tool to share risk information and keep other staff informed so they could share the information with other colleagues.

The recruitment process was robust and we were assured that the provider completed checks to make sure staff were safe to work with people before they started at the home. We saw disclosure and barring service checks, references, identity documents, and an application, test and interview record in place.

The home was clean and odour free, a dedicated housekeeping team worked daily to support the running of the home. Staff used infection control equipment such as disposable gloves and aprons. People said "It is nice and it is clean all the time", and "I like it. They keep it clean." A relative told us "It is very clean. I think they are doing a good job at that and the people here that work are nice."

Good

Is the service effective?

Our findings

People felt more confident that the service was becoming more effective. They said "I think they do a good job", "They seem to be confident and make me feel like they are doing things right" and "I think they do know what they are doing." A relative said "They are very good with her and make me feel good about leaving her in their capable hands."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At the last inspection we found a breach in legal requirements around consent and DoLS. We saw that applications had not always been made where needed, and where they had been made, not followed up. There were gaps in consent records in care files. During this inspection we saw a marked improvement in applications for DoLS. Records showed that every application that needed to be made had been made and followed up in the two weeks prior to the inspection. Recording of consent information in peoples care files had improved and there were fewer gaps but we did find in one care file there were still consent forms that relatives signed where it was not clear if they had lasting power of attorney to do so. We fed this back to the home manager.

Staff we spoke with understood consent and the importance of giving people choice. One relative said "Most of them explain what they need to do and ask him if it is okay like going to the toilet or changing his clothes." Documents for bed rail assessments asked if people had been consulted on the use of bed rails and if they had given consent or not. They noted that if a person was not able to, then a best interests meeting would be needed. This showed an understanding of obtaining consent for care decisions that affect people. We also saw this in the decision to move people from one floor to another to ensure people's needs were being met and staffing would be less spread out. We asked the home manager to show us evidence that consent had been sought for each person that had been moved. We were shown where best interests meetings had taken place and lasting power of attorneys had been consulted, and for people with capacity to make decisions their choice was recorded.

At the last inspection we found supervision was not taking place regularly and for some care staff not at all. Therefore staff were not supported to fulfil their roles safely and effectively by a supervising manager. At this inspection we saw supervision had taken place and there was a plan in place for future supervisions. We asked the home manager how they had completed this. They told us they had to do several group supervisions first and now were able to arrange individual meetings with care staff. Appraisals were starting to take place. Staff told us they felt more supported and they were having supervision meetings.

Staff confirmed and records showed they had been on training for courses including safeguarding, moving and handling, first aid and MCA and DoLS, amongst others. A further training session for supporting people with dementia had been arranged for all staff to complete, and arrangements had been made for the pharmacist newly working with the home to run a training session with staff on administering medicines. Training was a combination of classroom based and online learning. We saw records to show that new staff attended a classroom session on moving and handling before working with people. New staff told us the induction was over a week and they did some shadowing and some classroom and online learning before working alone with people. A relative we spoke with said of training "They are better now and the training seems more consistent. [The home manager] has taken training on board and taken advice."

People said the food was good. Staff spoke highly of the chef and their team and said they go above and beyond to create meals that people want to eat. People said "It's very good. When I am well I eat in the dining room", "It is nice. I like certain things and they get them. I like fish and we have it a lot. They don't help me but I don't need it. I think they would though" and "It is much better than it used to be and you choose from a few things now. They come to my room and ask me what I would like, usually just before lunch. They help me by cutting things up because they know or I ask and they do it." A relative said "I tell the chef when something he does not like is on the menu and they give him something else."

In communal areas we observed a range of drinks being offered regularly, there was coffee, tea, orange and apple juice, squash or water on offer. When we observed lunch in one of the dining rooms we saw four people being supported to eat by four staff members. Staff sat next to people and went at the pace of the person eating so they did not feel rushed. Staff were attentive and responded to and encouraged people whilst they were eating to support them to finish their meal. Staff were aware of guidelines given by health professionals to reduce the risk of choking and were able to tell us about the assistance that people needed to eat safely.

Relatives fed back they thought the home seemed calmer and more efficient and organised. At the last inspection the shifts were not organised and staff did not have a clear structure. At this inspection we saw a day that ran more smoothly with calm staff, effective deployment of staff with people who said they preferred those staff members and a good use of skills. For example, the home had scheduled two senior care staff in extra to rewrite care plans as part of the improvement plan. The senior carers knew people well and were attending reviews for people to make sure they were capturing people's needs and care plans were focused on improving outcomes for people.

One person told us how they were admitted to the home with severe pressure ulcers and nurses had worked hard to heal them up and now they were fully healed. We saw that before, where there had been gaps in daily charts, that bowel and fluid charts were now completed appropriately and comments on behaviour were recorded hourly where this was needed.

Good

Is the service caring?

Our findings

People said "They are caring, they try their best to cheer me up", "Yes they are nice girls" and "Staff very nice. Staff look after you." Relatives told us "They are caring. They give her lots of time for a chat and if they have time they have a cuppa with her in the room" and "I think they are very caring, just busy."

We saw kind and caring interactions throughout the day between staff and people living in the home. Staff used a gentle tone when talking with people and we saw physical reassurance where appropriate and people responded to it well. We were told the home was working towards a better experience for people, including a "special dining experience" similar to a restaurant. We were told the home manager regularly ate breakfast with people so they could experience the same as people living in the home and understand their day.

People were treated with respect and staff spoke about people and to people using appropriate language. We saw staff knocking on doors and they were able to tell us how they protected people's dignity by covering them up during personal care and giving people time to finish their meals when assisted by staff. Every person we spoke with except one said staff knocked on doors, for this person they said "No knocking but they do say hello before coming in." Other people said "They knock if I am in the toilet to see if I have finished", "They are quite good at knocking and they leave if I tell them I want some privacy and they apologise for interrupting. I can lock my door if I want to but I don't need to." Relatives said the same; one relative said "They are good at knocking and explaining what they need to do. They explain all personal care and ask her if it is okay to do it."

Some people said they thought they had a named staff member who provided most of their care and they saw this staff member more often, other people said there had recently been more staff recruited and they were still getting used to them. People told us they trusted the staff and could confide in them. They said "I think I can confide in them", "I'm sure you can, I've never had to while I've been here" and "Yes I can. They deal with things between us and things are kept private which is good." People also fed back that staff knew them and their needs. They said "They know me and how I like things", "Quite well. Day staff know me better because they are the same staff each time and the night staffs change" and "They know what I need help with and things I can do myself." A relative told us "They know her very well because she talks to them and tells them everything."

One person told us "the best thing about living here is my independence, I can do what I want but staff are always there if I need them." We asked the home manager about our last inspection, before they had started in post, where we fed back there were lots of people in bed throughout the day. The home manager said "I'm completely against staff telling people to stay in bed."

We saw more involvement from family members in care planning and the feedback was that progress had been slow but communication was getting better. One relative said "they call me if she is ill and they can't get my Dad on the phone." One relative told us the home had invited him to eat the meals provided by the home with his wife as he came in twice a day to support her to eat.

We saw that the home supported people with care at the end of their lives sensitively. We saw for one person there was a large team of health professionals to make them comfortable and the home sought advice and followed it. One relative said "We discussed end of life once and they wrote it down. That's hard to talk about and they were very sensitive about it." Another relative said "He has been able to tell them things like about what happens if he get really ill and needs to be resuscitated or go to hospital. They wrote it in his files and chatted with me too." The home manager said using the gold standard framework for end of life care was an aim, and that "we are managing end of life care much better with the support of the hospice."

We observed people being given choices throughout the day, we saw people being offered a choice of seats and what they wanted to drink. People told us "I get up when I like. I choose when to have a shower" and" I get up when I like. I have my hair done when it needs doing." A relative said "He has choices to choose what he likes and dislikes."

People's religious beliefs and cultural background were recorded in care files. People told us "I think I am free to believe what I want and do things how I want to", "I am respected when I pray." Relatives told us "A Priest comes to see me sometimes. They would take you to church if you wanted to go" and "They respect our religion and what we feel as a family."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection there was a breach in legal requirements around the recording of and responding to complaints. At this inspection we saw there had been improvements in how complaints were recorded and each complaint was now captured on a complaints log. Complaints were starting to be resolved and relatives on the whole were happier with historic complaints. However, we found that some of the responses were worded in the interest of the home rather than focussing on the concern that people or relatives had. For example, information about a move for several people from one floor to another was communicated to relatives by explaining how it would benefit the home but failed to explain the benefit for each individual.

During the last inspection we saw the majority of people spent a lot of the day in their rooms in their beds. People told us they would like to do more. One person said "I don't do much. I stay in my room" and another said "I would like to do things out of the room." At this inspection we saw some people still in their rooms, and some lounges did not have people in during the day but many more people were out of their rooms and taking part in activities in communal spaces. We observed one person waiting up to 20 minutes for staff to respond to them calling out for support with continence. They could not see the call bell and had an agreement they would call out if they needed help. We fed back to the nurse on the unit they could check on this person more regularly if they knew they could not use the call bell.

We saw where care plans had not been person centred at our last inspection, they had improved at this inspection. The home manager told us two senior carers had been rewriting the care plans and had been on training on how to create more person centred records. We found the records to use more person centred language and mention people's likes and dislikes. The files contained documents which explained a person's history, who was in their family, past occupations and likes and dislikes. These were updated for some files but not for others where the care plan had not yet been reviewed. A relative said "They are identifying individual needs better and so things get done quicker and it is more person centred." One person told us they had a shower every day and this was recorded as a preference in their care plan. Another care plan informed staff not to correct a person when confused as it made them upset and another care plan told staff which name to call a person by, which matched what the person told us. These were good examples of person centred care.

However, some people we spoke with said they weren't always getting their preference met, especially in the area of personal care. One person said "I don't have many [showers or baths]. I go to bed when they say. After dinner I get ready." Another said "I like a shower but they don't give many. Sometimes just a wash" and "I have a bath once a week. I would like more but they don't do it like that. I can stay up or go to bed when I want to." Relatives said "He needs to have baths or showers more and not just a wash. He isn't always as fresh as he should be" and "They wash him. Sometimes a bath but he complains. He could do with more washes. He goes to bed when they say after dinner."

We found activities to be lacking in stimulation at our last inspection, particularly for people who had a staff member with them at all times during their waking hours. At this inspection improvements had been made but there was still work to do to engage people in things they wanted to do and for every person to be

stimulated. We spoke with the new hospitality manager who said part of their responsibility was activities. They explained activities hours had been increased and activities staff put together packs to do with people when they went into people's rooms. We saw records that showed activities staff had been into people's rooms, we discussed that these did not show how much time they had spent with people. The hospitality manager said there had been a real focus on encouraging people to come out of their rooms more and activities staff tried to have daily chats with everyone and used a reminiscing newspaper to engage people who had dementia and who might respond well to it. The home manager showed us a new programme of activities not yet started, designed specifically for people with dementia and said that health professionals in the dementia field had been consulted on and there was going to be more of a focus in the home and through activities on wellbeing.

We did see for one person who had a one to one care that there was an individual activity plan in place and there was evidence that efforts had been made to engage them in activities they or their family said they enjoyed for the previous eight days. During the inspection the downstairs communal area was used a lot more, with the hairdressers salon open and people coming down throughout the day to have hot drinks and pastries throughout the day, creating an open café feel. At one point there was a singer, and we saw 19 people taking part, many singing and dancing with the music. The home manager told us an area for improvement was outings for people so they could leave the home and enjoy the wider community and explore their local surroundings more.

We saw that meetings for people and relatives were more frequent and addressed concerns. The commercial director said "relatives meetings are now really positive, we have made tremendous progress." Records showed that two meetings had taken place for people and relatives in 2017. We saw from the notes of these meetings the home manager outlined to relatives the things staff were doing to address the concerns raised in the last inspection. We asked the hospitality manager how relatives were being involved and kept up to date. They told us every relative was emailed a weekly newsletter to keep them up to date with what was happening at the home and gave the example of a recent activity day organised for Mother's day with pampering sessions, a chocolate fountain, and afternoon tea.

Requires Improvement

Is the service well-led?

Our findings

Carlton Court Care Home requires a registered manager to be in post as part of its registration requirements. There was no registered manager in post at the time of the previous inspection, and there had not been since 30 March 2016. There was a manager now in place and they were in the process of being registered with the Care Quality Commission. We had positive feedback from staff, people and relatives about the new home manager. Staff told us "[its] Much, much better. You feel more supported", "It's easy to approach the manager to discuss anything", and "His door is always open."

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the home. During the last inspection the registered provider had not always informed us of significant events they were required to. For example if a safeguarding concern was raised by a visiting professional or if there was an allegation of abuse. This did not show an understanding of what was required of the provider in terms of making statutory notifications. We issued the provider with a warning notice in response to these findings. Since the last inspection notifications were made by the home manager and other members of the management team and communication had been open when we had followed up or asked for further information. We found notifications about important events were being made to us so the service was no longer in breach of legal requirements in this area and the concerns identified in the warning notice had been sufficiently addressed.

At the last inspection we found the provider was in breach around governance and issued a warning notice. The home's management had missed many concerning issues we had noted that had resulted in breaches of requirements. They failed to note errors in medicines and gaps in care records around consent and DoLS. Supervisions were also not always taking place. During this inspection we found there had been an improvement in how quality assurance was managed within the home and the home manager had started to implement some new audits to make their quality assurance system more robust. We found that there were some issues that the provider and home manager had missed but these were minor and the improvements made had been noted by staff and relatives and visiting professionals. We fed back about any concerns we found and that activities still needed improving and some staff had made medicines errors and the home manager acknowledged these. We found the home manager and regional support manager to have either implemented an improvement plan around this or acted immediately on our feedback, showing a willingness to be open about what areas the home still needed to be developed in. At this inspection we found that the provider was no longer in breach in terms of governance of the service and had sufficiently met the concerns raised in the warning notice.

Audits and quality checks were completed for kitchen cleanliness and temperatures, wellbeing of people through daily visits by the activities workers, daily medicines checks and spot checks on audits. The nominated individual said the home had worked hard on quality assurance at all levels and showed us a detailed quality assurance framework which gave specific information on what quality controls were in place, how often they should be completed, by whom and where it was to be recorded or shared. This document showed the breadth of quality controls the home had in place from corporate issues to monthly audits of care records. The audits that we saw showed learning had taken place and the home manager

followed issues up with staff in person and where necessary used a disciplinary route.

We asked the home manager what had changed since the last inspection and what improvements they thought had been made. They described a new staffing structure with unit managers in place who had more accountability, a reduction in agency staff, and lots of meetings with people and relatives to get concerns aired in the open. They said "We are caring and better at communicating and leading each other. There is more openness and transparency and we have a shared objective."

Staff noted a shift in culture and several said they liked the management style of the home manager that they always knew where they stood but the management style was discreet in communicating mistakes or concerns about individual staff. Staff told us they had more productive team meetings, and had noticed training had improved and messages about raising standards such as recording on food and fluid charts had been clear. Relatives told us "[the manager] deals with things very discreetly and gets things done" and "you can have private meetings with management in the office which is good. They have time for this."