Sovereign Care Limited

Caroline House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Caroline House on the 6 and 10 October 2016 and the inspection was unannounced. Caroline House provides accommodation for up to 28 older people. On the day of our inspection there were 25 people living at the home. Caroline House is a residential care home that provides support for older people living with dementia, mental health needs and sensory impairment. Accommodation was arranged over two floors with stairs and a lift connecting each level.

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

People, relatives and staff spoke highly of the service. One person told us, "The way they treat you, is very nice." Another person told us, "They do all they possibly can for you here, I have no complaints." A visiting relative told us, "My mother made pictures and knitted squares, she never did that before coming here."

The requirements of the Mental Capacity Act 2005 (MCA) were not being met. Decision specific mental capacity assessments had not been completed and the provider was unable to demonstrate how they were working within the principles of the Act.

Deprivation of Liberty Safeguard (DoLS) applications had been made. However, care plans failed to reflect if people were subject to a DoLS and what conditions were attached to their DoLS authorisation. The provider's DoLS policy failed to reflect current policy and practice.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. One person told us, "Yes I think there are enough staff. " Staffing levels were based on the needs of people, however, the provider was unable to demonstrate this assessment and how they calculated and determined staffing levels. We have made a recommendation about the implementation of a systematic approach to determining staffing levels.

A range of activities were in place and people spoke highly of the activities provided. One person told us, "I never feel lonely, too much going on." Dedicated activities coordinators were in post and activities included arts and craft, bingo, quizzes and external outings Links with the local community had been established and the local Parish Church regularly visited the home. However observations demonstrated that meaningful activities were not available in the morning. We have made a recommendation about the promotion of meaningful activities.

Systems were in place to monitor the quality of the service provided and regular checks were undertaken on all aspects of running the service. The registered manager had a range of tools that supported them to ensure the quality of the service being provided.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. One person told us, "Excellent food, we eat everything up." Special dietary requirements were met, and people's weight was monitored, with action taken when required. Health care was accessible for people and appointments were made for regular check-ups as needed.

Risks to people were identified and managed appropriately and people had personal emergency evacuation plans in place in the event of an emergency. Accident and incidents had been recorded and monitored to identify any themes or trends.

Feedback was regularly sought from people, relatives and staff. 'Resident' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas.

People were safe and staff knew what actions to take to protect them from abuse. The provider had processes in place to identify and manage risk. Assessments had been carried out and personalised care records were in place which reflected individual needs and preferences.

Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People and their relatives were complimentary about the caring nature of staff, one person told us, "The staff are definitely kind and caring."

During our inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Caroline House was safe.

Risk assessments were in place for people to remain independent in a safe way. Staff had a clear understanding of the procedures in place to safeguard people from abuse.

Recruitment records evidenced there were systems in place that helped ensure staff were suitable to work at the home.

Medicines were stored, administered and disposed of safely by staff who had received appropriate training.

Is the service effective?

Requires Improvement

Caroline House was not consistently effective.

The requirements of the Mental Capacity Act 2005 were not always followed and decision specific mental capacity assessments were not consistently in place.

People were happy with the food provided and were able to choose what they had to eat and drink. Food and fluid charts were in place to monitor people's nutrition and hydration intake. The registered manager was taking action to ensure food charts were completed correctly.

Staff received appropriate training and support to enable them to meet people's needs effectively. People had access to external healthcare professionals such as the GP and district nurse when they needed it.

Is the service caring?

Good

Caroline House was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. Staff appeared to know people well.

Visiting was not restricted and people were supported to maintain relationships with people that mattered to them.

Staff communicated effectively with people and treated them with compassion and respect. People's privacy and dignity was respected by staff.

Is the service responsive?

Good

Caroline House was responsive.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Systems were in place for receiving, handling and dealing with complaints. However individual responses to complaints did not include the steps to take, if the complainant remained unhappy.

People had access to a range of activities which were tailored to individual needs. People spoke highly of the activities available.

Is the service well-led?

Good

Caroline House was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals' and their opinions and wishes were taken into consideration in relation to the running of the home.

Caroline House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 6 and 10 October 2016 and was unannounced. The inspection was carried out by one inspector, a specialist advisor with knowledge of older people's care, a pharmacist 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 provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people, three visiting relatives, five care staff, acting cook, maintenance worker, activities coordinator and registered manager. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Caroline House on the 9 August 2013 where we had no concerns.

Good

Is the service safe?

Our findings

People told us that they were cared for by staff that made them feel safe. One person told us, "Yes I feel very safe here the staff look after you well." Another person told us, "The staff are like your relatives, they are like your family so I do feel safe thank you." A third person told us, "I feel very safe here, it is home from home." Visiting relatives confirmed they felt confident leaving their loved ones in the care of Caroline House.

People were supported to be safe without undue restrictions on their freedom and choices about how they spent their time. Throughout the inspection, we regularly saw people moving freely around the home. The registered manager and staff adopted a positive approach to risk taking. Positive risk taking involves measuring and balancing the risk and the positive benefits from taking risks against the negative effects of attempting to avoid risk altogether. A member of staff told us, "We encourage people to be independent and take risks. For example, although a person may be at risk of falls, we encourage them to mobilise." There were individual risk assessments in place, which supported people to stay safe, whilst encouraging them to be independent. Risks assessments covered areas such as falls, mobility, nutrition, personal care, continence care and medication. Staff confirmed that they found risk assessments invaluable as they provided them with guidance about how to support people in a safe manner.

Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "We have two ladies who can occasionally have altercations. When those occur, we diffuse the situation by asking one of the ladies to come with us, whilst another staff member stays with the other to provide reassurance." Another staff member told us, "Some people can regularly refuse personal care and often be verbally aggressive towards staff. In those instances, we advise that it's not nice to shout and we'll return later to offer personal care again." Information was available in people's care plans on behaviour that challenges along with the actions required to manage the behaviour.

Staff had sufficient knowledge about what elements of people's care routine that posed a risk. Older people with health needs such as dementia can be at heightened risk of choking. Guidance was in place to mitigate the risk of choking which included the use of thickened fluids. A staff member told us, "Where people are at risk of choking, we provide supervision at meal times and ensure they are sitting in the upright position." This was observed in practice during the inspection. Measures were in place to reduce the risk of skin breakdown. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses, regular re-positioning and application of barrier creams.

There were sufficient staff to ensure that people were safe and cared for. People, relatives and staff told us there was sufficient staff to meet people's needs. One person told us, "Yes I think there are enough staff." Staffing levels consisted of four staff throughout the day and two staff at night. The registered manager told us, "Staffing levels are based on people's individual needs and the level of support people require." Although the registered manager advised that staffing levels were based on the needs of people, they were unable

demonstrate how they had assessed that four staff was sufficient in meeting the needs of 25 people. The absence of a formal systematic approach to determining staffing levels, also meant the provider was unable to demonstrate how two staff at night was sufficient in the event of the home needing to be evacuated. From our observations and feedback from people, relatives and staff, staffing levels were sufficient. However, a systematic approach to the calculation of staffing levels was absent.

We recommend that the provider seeks guidance on the implementation of a systematic approach to assessing and determining staffing levels.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure the building was maintained to a good standard. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered as each person had an individual personal evacuation plan.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk.

Staff had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the home. They had a clear understanding of who to contact to report any safety concerns and all staff had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting concerns if they needed to do so. One staff member told us, "If someone made a disclosure or I was concerned, I would report those concerns immediately to the manager." There was information displayed in the home so that people, visitors and staff would know who to contact to raise any concerns if they needed to. There were clear policies and procedures available for staff to refer to if needed.

The management of medicines was safe. People told us they received their medicines on time and when needed. One person told us, "Yes my tablets are on time and I know what they are for." Policies and procedures were in place to support the safe administration and management of medicines. This included 'as required' medicines and people taking responsibility for their own medicines. Senior care staff completed training updates when required and their competence was assessed to ensure medicines were continued to be given safely. Medicines were regularly audited to ensure that they were maintained to a safe standard. Medicine Administration Records (MAR) charts were checked to ensure that all documentation had been completed correctly. We observed medicines being given to people and saw that this was done following best practice procedures. Medicines and topical creams were stored and disposed of safely. Medicines were labelled, dated on opening and stored tidily within the trolley and medicines cabinet. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of following safe procedures.

Requires Improvement

Is the service effective?

Our findings

People told us they felt confident in the ability of the staff. One person told us, "Staff seem very nice, experienced and ready to help." Another person told us, "They definitely understand my needs." A third person told us, "The staff are fit for purpose, all very pleasant and helpful, I never see any conflict, I have no complaints." Despite people's high praise for staff, we found care and support was not always delivered effectively.

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. Training records confirmed staff had received training and staff spoke confidently about how they gained consent from people. On the first day of the inspection, we found decision specific mental capacity assessments were not in place. For example, where people had bed rails in place, assessments of capacity were not in place to determine if the person lacked capacity to consent to the bed rails and whether the bed rails were the least restrictive option. Staff members confirmed that people would be unable to consent to the bed rails and they were in place for their safety. Caroline House had range of restrictive practices in place, such as key coded entry to the home and key coded doors throughout the home. People's ability to consent to the restrictions had not been assessed and the provider was unable to demonstrate how they were working within the principles of the Mental Capacity Act 2005. Where family members were making decisions and signing consent forms, the provider had failed to complete decision specific mental capacity assessments to evidence that the person was unable to make the decision and required their family members to make the decision on their behalf. Where family members were making decisions, the provider had not obtained copies of their Lasting Power of Attorney to confirm they had legal authority to make decisions on behalf of their loved one.

On the second day of the inspection, the registered manager had started to complete decision specific mental capacity assessments. For example, mental capacity assessments were now in place for the decision to apply for a Deprivation of Liberty Safeguard (DoLS). However, further work is required to ensure these were personalised to the individual and in line with the requirements as defined in the MCA 2005 Code of Practice. On-going work was also required to ensure that decision specific mental capacity assessment and best interest decisions are in place where it is felt a person may lack capacity. For example, lack of capacity to consent to their care plan.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. A DoLS policy was in place, but failed to reflect current policy and

guidance. Despite the failure to reflect up to date policies, DoLS applications had been made. Staff confirmed they had received training on DoLS and training records confirmed this. Where people were deprived of their liberty, this was not consistently reflected in their care plan. Therefore for new members of staff or agency staff, this information was not readily available. Where conditions were attached to the DoLS authorisation, these were not recorded in people's care plans, which meant staff were unaware of the associated conditions.

Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' People had individual nutritional care plans in place and people's risk of malnutrition had been assessed and guidance in place to mitigate those risks. For example, where people were at risk of losing weight, they were weighed weekly and a fortified diet was in place. Input from dieticians and Speech and Language Therapists had been sought and where required, guidance and advice was followed. Where people required a soft diet, this was provided. People were provided with a wide range of options and could also request alternatives, such as salads or jacket potatoes. With permission, we joined people for their lunchtime meal. Tables were neatly decorated and laid and people were asked where they would like to sit. Condiments and napkins were to hand and people were given a choice of what they would like to eat. People were encouraged to be as independent as possible. For example, black plates were provided for some people which enabled them to see and pick up the food easily in comparison to a white plate. Where people required support to eat and drink, staff sat down at the table with them, providing support at their own pace. People spoke highly of the food provided. One person told us, "Food on the whole very good, plenty of tea. " Another person told us, "Yes we have a choice, plenty to eat and lots to drink."

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. Throughout the inspection, we observed that people had drinks to hand and food and fluid charts were in place to monitor people's hydration and nutritional intake throughout the day. However, there was a lack of consistency in some areas, which required improvement. For example, food charts consistently reflected that after 17:30 people had nothing to eat until the following morning. We brought these concerns to the attention of the registered manager who confirmed that people had access to snacks whenever they wished. This was also confirmed by people, however, fluid charts failed to reflect this. The registered manager was responsive to our concerns and started to take action immediately by informing staff of the importance of completing documentation accurately.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, district nurses, dentists and chiropodists. People confirmed that if they needed to see their GP this would be organised as required. Staff were proactive in ensuring that the appropriate professionals were contacted to maintain people's health.

Effective management of dementia care entails seeing the person for who they are and not their dementia. This was embedded into practice by the registered manager and staff. The registered manager told us, "We teach staff that people are not their illness, they are a person." Staff spoke highly of how they provided good dementia care which recognised the person for them. One staff member told us, "We really get to know people, have a laugh with them and support them how they wish to be supported."

Staff told us they were well supported and had received the training their needed to be effective in their role. For new staff an induction programme was in place to ensure new starters received the appropriate training, support and guidance to enable them to provide safe and effective care to meet people's needs. New staff were able to shadow a current staff member until they were deemed competent and confident to provide care. There was a full and intensive programme of training which included essential training for staff. Training included, moving and handling, infection control and safeguarding. A programme of training had recently been delivered by the Dementia in Reach Team. Staff spoke highly of the training course. One staff member told us, "We've recently just completed a 16 week training course which covered a range of areas. I think we all found the module on sexuality and dementia really helpful. It taught me that despite living with dementia, those feelings don't go away and the training was really helpful."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. They told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "Lovely staff." Another person told us, "Staff always very polite and yes they know me." A visiting relative told us, "My loved one is treated with kindness, dignity and respect, very caring. "

Friendships between people had blossomed while living at Caroline House. People were seen sitting interacting together and laughter was heard throughout the inspection. Two people were seen sitting together with one person telling jokes. Two ladies were seen enjoying swapping jewellery and spending the morning engaging about jewellery and what was their favourite. Visiting relatives knew the names of other residents and when spending time with their loved one in the lounge, also spent time engaging with other residents. One relative was seen spending the morning sharing jokes with people.

The atmosphere in the home was calm and relaxing. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. Signage was available throughout the home to help orientate people. Toilets were clearly visible and people's bedroom doors had their individual names on them. Throughout the inspection, people were seen navigating the home, making their way to their bedrooms or the toilet independently.

People were cared for by kind, caring and compassionate staff who knew them well. Staff spoke with compassion for the people they supported. One staff member told us, "What I enjoy about working here is the 'residents'. Getting to know them, their personalities, life history and character traits." Staff told us that they took time to get to know each person by talking with them and their families and that this enabled them to get to know each person and form relationships with them. When talking to people staff directed their attention to the person they were engaging with and not being distracted or talking unnecessarily with someone else in their vicinity. For example, when a person was sitting in their chair, staff would go down to the person's level, as to not tower over them when engaging. They used the person's preferred name, maintained eye contact and people responded to staff with smiles.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identify. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. Staff told us how they empowered people to make their own decisions on what they wished to wear. Some ladies took great pride in their appearance, wearing jewellery and clothing which reflected their lifestyle preference. This helped communicate to others a very clear sense of their values and priority to look after themselves. The registered manager commented to one person, "I love your scarf; I need to get style tips of you." One lady spoke proudly about her jewellery and how she enjoyed wearing pearls. She also told us how she enjoyed brushing her hair. Throughout the inspection, she readily had her handbag to hand with her hair brush and was seen brushing her hair at intervals throughout the day.

People confirmed that they felt that staff respected their privacy and dignity. One person told us, "They always knock before coming into my room." Another person told us, "Yes I am treated with dignity and respect. "Observations of staff interacting with people showed that people were treated with dignity and respect. People were assisted to their bedroom, bathroom, or toilet whenever they needed personal care that was inappropriate in a communal area. This support was discreetly managed by staff so that people were treated in a dignified way in front of others. Staff members also made sure that doors were kept closed when they attended to people's personal care needs.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. They were able to say how they wanted to spend their day and what care and support they needed. The registered manager told us, "This is people's home and we want people to treat it as their own. If people want to spend all day in their pyjama's in the lounge, then they should." Staff also commented that people were encouraged and supported to spend their days as they chose. One lady spent the afternoon in the lounge in their night dress. They told us, "I'll get dressed shortly; I don't feel up to it now." Where people were not able to express their needs, their wellbeing was taken into account by staff as they were proactive in ensuring people's wellbeing. We heard staff constantly asking people if they were okay or if there was anything they needed. For those who preferred to stay in their bedroom, staff conducted regular checks of their wellbeing and safety.

Guidance produced by Age UK advises on the importance pets bring to older people. Caroline House recognised the importance pets bring to older people living in a care home. The registered manager told us, "We encourage relatives to bring pets in and also people can bring pets with them when they move into the home. We use to support one person who moved in with their cat." A staff member brought their two dogs into work which people thoroughly enjoyed. People were seen coaxing the dogs over and watching the dogs whilst they played in the garden. One person told us, "There lovely aren't they."

Staff celebrated people's successes and special events. For people's birthdays, the home was decorated with banners and flowers. The registered manager told us, "We've just celebrated a very special birthday for someone; we had a party to celebrate." On the first day of the inspection, relatives were visiting one person and they observed to enjoy opening their birthday presents. They later proudly showed off their presents to both people and staff.

People's equality and diversity needs were respected and staff were aware of what was important to people. One staff member told us, "We have one person who attends Church regularly and they are supported to do so. We also have good links with the local Parish Church." People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting and being welcomed by staff.

Good

Is the service responsive?

Our findings

People and their relatives told us that the service was responsive to people's needs. One person told us, "They are very cheerful, kind and caring, they always give attention." People felt the registered manager and staff listened to them and would not hesitate in raising any concerns. One person told us, "Yes I would complain but I don't need to. We don't have much to complain about."

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for all people, particularly those living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. People spoke highly of the activities available. One person told us, "I never feel lonely, too much going on." A visiting relative told us, "My Mother made pictures and knitted squares, she never did that before coming here." Another person told us, "The activities are very good, quizzes, skittles and entertainers." The provider employed two dedicated activities coordinators who worked seven days a week in the afternoons. A wide ranging activity timetable was available. The activity coordinator told us, "We try and make sure we have a good variety of activities. A lot of people like quizzes, word games and indoor bowls. We also offer bingo, singalongs, music and movement and arts and crafts and card making." The activity coordinators had also involved people in knitting and making bags for the zimmer frames. One person told us, "We made those bags, they are very handy, I keep all my goodies in it." On the first day of the inspection, Pet Pals visited with a visiting dog. People thoroughly enjoyed the interaction with the dog. One person told us, "The dog is lovely, I love getting cuddles."

Staff were mindful of people who chose not to go to the communal lounge and ensured that they were not isolated in their rooms. For people for preferred to stay in their bedroom, the activity coordinators provided 1:1 interaction. The registered manager told us, "The activity coordinator spends 1:1 time with people in their bedroom so the risk of social isolation is minimised. At the moment, they are reading a book with one person; another person just loves a chat." One person told us, "I'm quite happy staying in my bedroom, I have my paper to read and TV with my favourite programmes, staff pop in for a chat."

Observations showed on both days of the inspection that no activities took place in the morning. The registered manager told us, "We have reviewed having activities on offer in the morning, however, we found that a lot of people preferred to get up later in the morning and often there was only two or three people in the lounge in the morning and from experience, people are more engaged in the afternoons." On both days of the inspection, we spent time with people in the communal lounge. Between 10.00am to 12.00pm, there ranged between nine to 12 people sitting in the lounge with only the television for stimulation. People were seen interacting with one another, reading papers or their book. However, other people sat passively. People raised no significant concerns about the lack of activities in the morning. One person told us, "Sometimes it feels like God's waiting ground." However, there was a period whereby there was little stimulation for people.

We recommend that the provider review activity provision in line with best practice guidelines

People's social, physical and health needs were met. People's needs had been assessed when they first moved into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. Care plans covered a range of areas from: dementia, religion, personal care, medication and continence care. Care plans were detailed and included information on the individual's assessed need, associated risk, the person's individual abilities and expected outcome. One person's mobility care plan identified they were unable to move independently due to a range of factors. Factors included pain and contracted limbs. Guidance to safely move and transfer the person included; the aid of a hoist and a small fast fit sling. In the event of the person needed to be hoisted, two staff members are always required and be should be done for the shortest time possible to minimise pain and discomfort. The expected outcome was noted as '(person) would like to maintain current level of independence, ability and confidence when moving.'

Staff spoke highly of the care plans and felt care plans provided them with sufficient guidance to provide responsive care. A recent initiative had been transfer to an electronic care system. Staff members now accessed care plans via tablets and computers. Staff members commented that the electronic system was working well. One staff member told us, "I love that care plans are electronic now, it's so much easier to record daily notes." People and relatives told us that they were fully involved in decisions that affected people's care and were regularly involved in reviews of care and care plans. One relative told us, "We are involved with her care plan and reviews."

There was a staff handover between shifts. These provided staff with a clear summary of what had happened during the course of the day and gave them the opportunity to plan for the shift ahead. For example, staff used it to allocate duties and discussed individual updates on people. Staff used the time productively to ask each other questions and share ideas and views. Staff felt communication within the home was positive. One staff member told us, "Information is shared that we need to know."

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. One person told us, "Never had to make a complaint but the manager is very approachable and always has time to speak with us." Complaints that had been made had been investigated and responded to within the providers own timescales. However, responses did not inform the complainant of what action they could take in the event of being dissatisfied with the outcome and response to their complaint. For example, the details of the Local Ombudsman had not been included in the response to the complainant.

We recommend that the provider reviews their internal complaints procedure.

Good

Is the service well-led?

Our findings

People, their relatives and the staff spoke highly of the registered manager and said that they believed the home was well run. One person told us, "The manager is very good." Another person told us, "We get on quite well, she is always quite nice." Staff spoke highly of the leadership style of the registered manager. One staff member told us, "Couldn't ask for a better manager."

People, staff and relatives were actively involved in developing the service. Satisfaction surveys were sent out on a regular basis. The latest staff satisfaction feedback from July 2016 found that 100% of respondents felt that the service offered enough training and all respondents confirmed they felt supported by the manager. Satisfaction survey results for people in July 2016 found that 32% of people felt the food was excellent and 68% felt it was good. Results from the visitor's quality survey noted that 88% of respondents rated the quality of care as good. Where satisfaction surveys raised concerns, the registered manager took action to improve the quality and running of the service. For example, 12% of visitors reported that they found the response to their telephone calls as poor. Visitors reported that they found responses to their telephone calls at weekend were extremely poor. Action taken by the manager included telephoning the service at weekends to monitor how long it takes staff to answer the telephone and raised the issue with staff during staff meetings.

Systems and forums were in place for staff, people and relatives to make suggestions or raise any concerns or queries. Resident meetings were held on a regular basis. Minutes from the last meeting in September 2016 demonstrated that plans for Christmas were discussed with people making suggestions as to what they would like to do. People confirmed they found the forum of residents meetings very helpful. Staff meetings were held and staff commented that they found these meetings helpful. Minutes from the staff meeting in July 2016 demonstrated that medication, people's care needs and documentation was discussed.

The registered manager had a range of tools that supported them to ensure the quality of the service being provided. They undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety, medication, infection control, care plans and environmental. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. For example, we saw that in light of one internal audit, it was noted that a window pane on a door was broken. Action had been taken and a company was due to replace the broken window pane. The provider conducted monthly visits, however, the visit reports did not document whether the actions from the last visit had been met or were on-going. The provider visits also didn't explore whether the service was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. We brought these concerns to the attention of the registered manager who confirmed they would address these concerns with the provider.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the Caroline House had

informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved, details of the incident/accident and the action taken. On a monthly basis, all incidents and accidents were collated and analysed for any trends, themes or patterns whilst also considering how improvements could be made following individual accidents and incidents. The registered manager told us, "On a monthly basis, I review the incident and accidents and also complete a falls tracker which looks at when people are falling; the times and what staff are on duty." Where the registered manager had identified people at high risk of falls and experiencing a number of falls, action had been taken. For example, one person at high risk of falling had been referred to the physiotherapist, falls prevention team and a falls sensor mat had been sourced.

The home maintained good links with the local community. A staff member told us, "We have good links with the local parish church; they've recently come in for a Harvest festival which people enjoyed. We also have links with a local school and the school children come in and sing which again everyone enjoys."

There was a friendly, warm and homely atmosphere and a positive culture. People appeared to be at ease, happy and comfortable. Staff and relatives further confirmed people's positive comments. When asked what was positive about Caroline House, people told us, "A caring happy atmosphere." Another person told us, "Our privacy." A third told us, "The way they treat you, I looked to come here, and it is nice." A fourth person told us, "They do all they possibly can for you here, I have no complaints."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a service user was 16 or over and was unable to give such consent because they lack capacity to do so, the registered person was not acting in accordance with the 2005 Act. Regulation 11 (3)