Bupa Care Homes (CFHCare) Limited

Carders Court 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**

Summary of findings

Overall summary

Carders Court is a care home providing nursing and personal care for older people. It is situated in the Castleton area of Rochdale. The home is purpose-built, single storey and comprises of five separate houses, each with 30 single bedrooms. There were 135 people accommodated in the home at the time of the inspection. There is car parking to the front of the home and there are garden areas around each unit for residents to sit out in.

We last inspected this service in December 2015. The service did not meet all the regulations we inspected and were given requirement actions for keeping the home clean. At this inspection the home was much cleaner and the regulation was met.

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present for the inspection.

During this inspection we found five breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to any incidents to. However, some of the plans of care did not contain sufficient information to protect people from possible harm. We also found some staff were not following the directions given in the plans of care, for example for people at risk of choking.

Some aspects of medicines administration were not safe. Some of the medicines records were not signed for and hand written prescriptions had only one signature, when they should for safety have two. Some staff who administered medicines, for example, agency nurses did not know who people were and a lack of photographs may mean that people who could not identify themselves could be given the wrong medicines.

The service did not always follow the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Two people who did not have the mental capacity to make their own decisions had been admitted at the care home and no best interest meeting had been arranged or application for DoLS had been submitted.

Supervision and appraisal with staff was not regular and did not give staff the chance to discuss their careers or training needs.

People who complained did not always receive a satisfactory answer.

Plans of care were not always kept up to date or had been entirely completed.

Records we asked for could not always be found.

We made a recommendation that the service look at best practice training for end of life care for all staff.

Meetings with people who used the service/relatives were not held regularly on all units.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities to help protect their health and welfare.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The home was clean and tidy. The environment was maintained at a good level and homely in character. We saw there was a maintenance person to repair any faulty items of equipment.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well fed.

New staff received induction training to provide them with the skills to care for people. Staff told us and staff files confirmed staff had undertaken sufficient training to meet the needs of people who used the service. The service were also ensuring all staff received refresher training following the induction process.

People who used the service and relatives said staff were kind and caring.

There was a range of activities people could attend if they wished to help keep themselves occupied.

There were policies and procedures available for staff to follow good practice.

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.

Some people and their relatives told us they did not always feel safe. Staff were not always given sufficient information to keep people safe. Poor record keeping meant that not all safeguarding issues raised could be analysed or future episodes prevented.

Staff had been recruited robustly and should be safe to work with vulnerable adults.

Staff had been trained in medicines administration and managers audited the system. Some of the medicines administration records had not been signed for correctly. A lack of photographs on these records meant agency staff who did not know individuals were at risk of giving medicines to people for whom they had not been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always understand their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant the rights of people who used the service may not be protected and they may be unlawfully accommodated at the service.

People were given a nutritious diet and said the food provided at the service was good.

Supervision and appraisal was not regular and therefore staff did not get the opportunity to discuss their career or performance with their managers.

Is the service caring?

Good

The service was caring.

Most people who used the service and relatives told us staff were kind and caring.

We observed that any care was given in private to protect a person's dignity.

Visiting was unrestricted for people who used the service to remain in contact with their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Plans of care had not always been completed or reviewed which may mean people were not getting the care they needed.

There were suitable activities for people to attend if they wished.

There was a complaints procedure for people who used the service to raise any concerns they had. We received conflicting reports from relatives about the way they were looked into. Not all people who complained had received a satisfactory outcome.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some relatives and staff did not feel supported by management. The new managers had improved the situation.

Some records were missing which meant they could not be used to investigate incidents, safeguarding issues and accidents.

Policies and procedures were available for staff to follow good practice.

Carders 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 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 was an unannounced inspection and was conducted by two inspectors and an Expert by Experience on the 29, 30 November and one inspector on 01 December 2016. 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 expert was experienced with people who were elderly and were living with a dementia.

During the inspection we spoke with 24 people who used the service, 11 visitors, 3 registered nurses, 14 care staff members, the Admiral nurse, a member of the laundry staff, the chef and two regional support managers.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. We had received safeguarding information from the local authority prior to the inspection. This information caused us to bring the inspection forward.

We did not request 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 any improvements they plan to make. This was because we brought the inspection forward and the provider would not have had sufficient time to complete the PIR.

During the inspection we carried out observations in the public areas of the home and undertook a Short Observation Framework for Inspection (SOFI) observation during the lunchtime period on the unit for people living with a dementia. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.
During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for eight people who used the service and medication administration records for 13 people. We also looked at the recruitment, training and supervision records for four members of staff,

minutes of meetings and a variety of other records related to the management of the service.

Inadequate

Is the service safe?

Our findings

We received mixed views about how people felt about their safety at Carders Court. Specific comments people made included, "It's pleasant here and perfectly safe", "Some are so rough when they handle you. I've been bruised many times", "I like it here and generally feel safe", "I definitely feel safe", "I feel happy and safe here", I feel safe here and I have nice friends", "I feel safe enough, but there aren't enough carers. I sometimes need help at night, but they can be too busy with others to come", "I like it here and feel safe" and "Oh, I'm safe here. It's lovely".

Several other people who used the service and relatives said they felt safe at Carders Court. However relatives on Linden unit told us, "I don't feel I can go away on holiday and leave him. Some days I think he is fine. Other days I pull up on the car park and wonder what I am going to find", "I need to come in every day to check [my relative] is well. I do not feel she is entirely safe" and "There has been a major safeguarding incident and two falls which haven't been explained here."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. Staff we spoke with confirmed they had been trained in safeguarding procedures and were aware of their responsibility to protect people. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local authority's safeguarding policies and procedures. This meant they had access to the local safeguarding team for advice and to report any incidents to.

Staff had access to a whistle blowing policy called 'speak up'. This gave staff the names and telephone numbers of staff from head office to raise any safeguarding or other concerns confidentially to. The document gave staff a promise of confidentiality and to keep them informed of the progress or decisions reached. A staff member said, "I am not afraid to say what I see. I used the speak up policy (whistle blowing) at another home but not here. I feel I would be listened to by the nurse if I reported any concerns." Another staff member said, "I have used the Speak Up policy regarding the lack of staff and poor management. A staff member came in from Head Office and did an investigation but no feedback up to now."

One person's care plan we examined showed they were at risk of choking because they may place objects in their mouth. Staff were instructed in the plans to undertake regular 15 – 30 minute checks of the person to ensure they had not picked any objects while they were walking around the unit. One staff member we spoke with on the unit said that she had only found out about the risk of choking from a relative (the information had not been handed on from senior staff) and another member of staff we spoke with did not know of the risk and the observations required to help protect the person. Any observations that were undertaken were not recorded in the plan of care. This meant the person was not adequately protected from the risk of choking.

In the plans of care we noted one person had previously been found with a cord wrapped around their neck. No incident form could be found to show any action staff had made to minimise the risks. This meant there was a risk this person was not properly protected from harm.

On Linden unit we were told there were no 'handovers' currently being undertaken. This unit cares for people with late stage dementia who possibly have risks that may challenge staff or themselves. A handover is given when a new shift commences work. Staff coming on duty are given any relevant information about people's health or other needs. A handover should highlight any risks people who use the service may have. A failure to provide staff with up to date information could put people at risk of harm to themselves or others.
The lack of appropriate procedures to protect people from the risk of harm was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. Safe care and treatment and 12.1 Care and treatment must be provided in a safe way for service users.
Information we received from whistle blowers and other professionals told us there was a staffing shortage at the home. An effort had been made by the service to recruit nurses and care staff. On Brookfield Unit there were six care staff, Garfield Unit five care staff, Rakewood Unit two registered nurses and four care staff, the same ratio for Linden Unit and four care staff for Arkwright Unit. There were between 24 and 29 people accommodated on each unit. Care staff were supported by hostesses on some of the units (hostesses help serve food and drink and other general tasks around the home), cleaning staff, dedicated laundry staff, a maintenance person, chefs and kitchen assistants and clerical staff. We were told by the managers that the numbers of staff were determined by a dependency banding tool. The two regional managers both told us they would be assessing people using the banding tool for each unit and we saw evidence that further staff were in the process of being employed.

We received conflicting information about staffing levels at the service, One person who used the service told us, "Whenever I need help they (staff) are there. I don't have to wait long". Relatives/visitors said, "I feel there are enough staff on duty", "The lack of staff is having an ongoing effect. I have been told there should be five carers on duty. This morning I found [my relative] was in a 'puddle'. I don't often find this (came in at 11am). There were no staff around. They said they had been doing 1-1 cover. I object when this takes time away from my husband", "There are more demanding people now on the unit but staffing has not increased. I feel there are definitely not enough staff" and "They are short-staffed. If one's off sick its mayhem." The main concerns around staffing levels were on Linden and Arkwright unit.

A nurse practitioner from a health centre said, "I feel there are enough staff on Linden and that this has improved recently".

Dependent upon which unit staff worked on staff also had different views on how the levels impacted upon their ability to care for people. Specifically on Linden unit staff thought they needed more to care for people with complex needs. On this unit three people required one to one support. This was being provided by external agency staff. However, when the agency staff took a break staff from the unit took over which could mean care was not being provided. One staff member said, "We always need somebody in the lounge."

There is generally a lack of trained registered nurses nationally. The service was employing agency nurses but were block booking them where possible to ensure they knew the people they were looking after and were aware of the homes policies and procedures.

One person who used the service and two relatives thought medicines were given on time. We observed a member of staff administering medicines at lunch time and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage, administration and disposal. All staff who supported people to take their medicines had been trained to do so. We looked at 13 medicines administration records (MARs) and found that most had been completed accurately.

Some past safeguarding issues had been around the unsafe administration of medicines. When we looked at the MAR records we saw that there were hand written records for three people which had not been signed by two members of staff. It is safe practice for two members of staff to sign hand written records to help prevent errors.

Other MAR records we reviewed had been signed fully completed. There were no gaps or omissions. There were photographs of people who used the service on some of the records. However, we were told by a family member that an agency nurse had asked her to point out people who used the service when administering medicines because a photographic record was not available for all and the nurse did not know who some people were. Because people who used this unit were living with dementia they could not identify themselves.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2) (g) the proper and safe management of medicines.

Medicines were stored safely within locked rooms. The temperature of the room and fridge were recorded to ensure medicines were stored to manufacturer's guidelines.

There was a separate sheet for 'as required' medicines. This gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. There was also a similar safe protocol for topical medicines. This helped prevent errors.

There was a signature list of all staff who gave medicines for management to help audit any errors. The service had a copy of the NICE guidelines for administering medicines and the General Nursing Council policies and procedures to help the service safely administer medicines.

There were sufficient supplies of medicines. Any medicines that required returning to pharmacy were done so in a tamper proof box and two staff signed to say they had witnessed the disposal.

There was a controlled drugs cupboard and register. Controlled drugs are medicines which are stronger or may be open to misuse. We checked the controlled medicines register against the number in stock and found no errors. Two staff had signed the controlled drugs register which is the correct procedure.

One person who used the service told us, "Everywhere is so clean. One day there was only a tiny piece of tissue and the cleaner spotted it and picked it up." Other people we spoke with and relatives/visitors said they found the home clean and tidy. During the tour of the building we noted four of the units were clean and there were no malodours. One unit was not quite as clean as other units but there was a person cleaning during the inspection. There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy. Management conducted a daily 'walk around' and checked cleanliness as part of the process.

There was a laundry sited away from any food preparation areas. There were three industrial type washing machines and two dryers to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand washing facilities in strategic

areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to.

We saw that the electrical and gas installation and equipment had been serviced. There were certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), the lift, hoists, the nurse call and fire alarm system. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. Radiators had a control valve to minimise the risks of burns. We saw that staff entered any faults in a booklet which was signed off when any work had been completed. The maintenance of the building and equipment helped protect the health and welfare of people who used the service and staff.

The fire alarm system had been serviced. Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in a folder staff could get hold of in an emergency to present to the fire brigade. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a power failure.

We looked at four staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken whether to employ the person. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that there was a system for checking trained nurse's details to ensure they were up to date with the Nursing and Midwifery Council. This ensured nurses were undertaking revalidation learning to remain on their professional register.

We looked at eight plans of care during the inspection. We took a selection from each of the five units. Each care record contained a risk assessment for falls, moving and handling, tissue viability and nutrition. The majority of risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service. However we did see one plan where the risk assessment was not reflected in the plan of care (a moving and handling risk) and other risk assessments which had not been reviewed as regularly as the risk highlighted, for example a person who was at high risk of developing pressure sores. The management team brought in to improve the service were aware of the shortfalls and senior staff were in the process of reviewing plans of care, including risk assessments to ensure they accurately reflected the needs of people who used the service.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005) so should be aware of how to protect people's rights.

We saw that there were 45 applications for deprivation of liberty authorisations in 2016, up to the inspection date from figures supplied by the service. However, two people who were accommodated on Linden ward who had been assessed as not having the mental capacity to make their own decisions had not had a best interest meeting nor had an application for a DoLS been made. This did not protect a person's rights.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (5). A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Two staff told us they had received supervision, however we did not see any records to support this. Most staff told us they had not received supervision or appraisal for some time and comments included, "I have not had supervision for a year at least", "I not had any support or supervision but now I am unit manager I have started to have supervision sessions with the staff", Formal supervision. I cannot remember the last time I had it or appraisal" and "Not had supervision for a year. We have relatives and resident meetings and staff meetings every few months. We all get a chance to say what we want." The company policy was for supervision to be provided every eight weeks. Appraisals are usually held annually. Supervision and appraisals give staff the chance to discuss their careers, training needs and any ideas they have about running the service or any factors affecting their performance. Supervision also gives managers the chance to discuss the staff performance and how best they think it can be improved.

The lack of appropriate supervision and training was a breach of Regulation 18 (2) (a) Staff must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

When we looked at the plans of care we saw that some people had signed their agreement to care, treatment and to be photographed. Some people did not have the mental capacity to agree to their care

and the plans were not signed or had been signed by a family member. There was no other information to show how this decision had been made such as a best interest meeting involving family members and professionals. Likewise we saw that there was a section for family members to be involved in the plans of care with no details as to how this decision had been made. The two regional managers we spoke with were aware of the lack of details in the plans of care and had forwarded an action plan for all care plans to be audited and amended, which included consent to care and treatment.

We saw evidence from looking at staff files that new staff completed an induction which lasted five days and taught staff the basics of what care staff should know and included topics such as safeguarding, moving and handling, food safety, fire safety, infection control, the MCA and DoLS, basic life support and health and safety. There was a record of completing the care certificate in two of the staff files we looked at, other staff had been employed prior to the need to complete this. The care certificate is considered best practice for people new to the care industry. New staff were mainly supported during their first week on the unit they were placed on until they felt comfortable to work alone. Staff told us, "On induction I did a week's training and a week of shadowing on Linden. I previously have some experience of working with people living with dementia. I completed a half day dementia training session on induction. I feel confident in my role" and "I had a week's induction which included reading policies and procedures, training in moving and handling, safeguarding and the MCA (the staff member was aware of the principles). I have not done dementia training with BUPA. I am interested in doing but not sure how to access it".

All the staff we spoke with told us they had completed basic training when completing their induction and some staff had undertaken further training in care of people who had dementia, nutrition, behaviours that challenge others and end of life care.

We looked at the training matrix which we were told was under review by the regional managers supporting the home. The matrix was confusing in parts and unclear when refresher training was due although we were told the member of staff responsible for training would have that information. From looking at the training matrix and talking to 12 members of staff, basic training had been undertaken. The managers told us they were enrolling all staff on the induction training which meant staff would receive suitable refresher training. Several staff told us they would like to do more training on the care of people with dementia, "Because more people are living here have dementia". Two members of staff had recently completed a recognised training course at Bradford University which would enable them to deliver the training to other staff. One member of staff we spoke with said she had been introduced to the course and from what she had seen so far it was far more advanced than previous courses and would help staff provide much better care and support for people with dementia and how to understand any behaviours that challenge.

We toured the building during the inspection and visited all communal areas, many bedrooms, bathrooms and shower rooms. Bedrooms we visited had been personalised to people's tastes, some with furniture, photographs and ornaments.

Communal areas contained a variety of seating and were homely in style. There was sufficient seating for all people accommodated at the home although we saw that people could sit in their rooms if they wished. There were handrails to help people get around the units independently if they could.

Bathrooms and toilets had aids to assist people with their mobility to help them attend to their personal hygiene. There was a choice of bath or shower and we saw people's preferences were recorded in their plan of care. There was an accessible garden with seating for people to use in good weather.

Some units had themed areas, for example, a bar and people were able to sit with their families and have a

drink of alcohol or soft drink if their conditions allowed. There was also a tea room on one of the units. People who were accommodated in other units were welcome to use the facilities.

People who used the service told us, "The food's quite nice. I've had bacon and eggs for breakfast", I liked my lunch. I had soup and sandwiches", "The food makes you put weight on" and " I cracked my teeth on some food here and my son had to take me for a new bottom set". Relatives told us, "Food is excellent. I saw staff send the chef to someone who didn't want to eat what was on the menu. He sent her the meal she wanted. You see all this when you visit" and "Food on the whole is very good."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We observed and were told that the chef asked people what they wanted and provided an alternative to what was on offer to help encourage people to eat. The chef said, "'I enjoy my work. It's full on, but I like it when we can make a difference in supporting people. I try to chat to residents if I'm taking food across." There was a menu on display which was supported by pictures of the food so people knew what they were ordering. On the whole people were shown the choices or asked what they wanted. We observed people taking their lunch and obtained a mixed view of the dining experience, with staff on some units engaging with people who used the service and on others less so due to the pressure of getting the meal out whilst hot.

There was a four weekly menu cycle. There were three meals a day with a hot option provided each time. People could have any of the usual breakfast foods, lunch was a smaller option with the main meal served at the evening. Supper was provided and each unit had a kitchenette to make snacks and drinks. Fluids were offered at intervals during the day.

There were sufficient tables and chairs for people to sit at in order to promote a social atmosphere although if people preferred or for medical reasons could take their meal in their room. On the whole tables were set with cloths and napkins and some had ornaments to decorate the tables. On some tables we saw people had a choice of condiments for people to flavour their food. Some relatives visited at lunch time to assist their family member take their meal and fluids.

We visited the kitchen and saw there were sufficient supplies of fresh, frozen, canned and dried foods including fruit. The chefs were given information around allergens from their head office. They told us they produced pureed, mashed, diabetic and soft diets if people required them and there was a specialist provider they could contact should a person require food for a specific cultural or ethnic need such as Halal. However, one person on Linden unit from an ethnic minority background was not being offered food suitable to their taste. We were told that their family brought in food because the person did not like what was provided at the home. We brought this to the attention of the regional managers who said they would look into this person's needs and provide food suitable to the person's tastes. The chef was also aware of people who required fortified diets. Supplements were kept on the units and care staff were responsible for ensuring people received them.

We saw that people had a nutritional risk assessment and where required had access to dieticians and speech and language therapists (SALT). Family members confirmed their relatives had been seen by one of the specialists although one family member said this had now been discontinued and they did not know why. We saw that people's weight was recorded regularly so that staff could monitor any weight gain or loss.

From looking at the plans of care we saw that people who used the service had access to professionals, for example psychiatrists and other hospital consultants, community nurse specialists and district nurses. Arrangements were made for people to attend routine appointments to podiatrists, opticians and dentists.

However three complaints had been made that appointments had been missed. Whilst this was a small proportion of the total appointments the service had made it is poor practice for people not to receive the care they need.

Good

Is the service caring?

Our findings

People who used the service said, "I like it because it's sociable here. They try and accommodate anything we want. Staff are lovely and give me a hug", "It's better than hospital here", "The unit manager is so kind", "Staff are very kind" and "I have been here quite a while. It's brilliant; the staff are excellent." People who used the service thought staff were kind and caring.

Relatives said, "It's excellent care. There are no concerns in here and it's clean", I can see that they are understaffed, but they are caring here. I have a big family and they visit and help me a lot", "They're kind with my relative and very communicative with us", "The staff are kind and caring, but they do not have the right skills. Some staff are better than others though. One carer (who was day off) is very good. She never stops, is focussed on the residents' needs and can do the work of 10", "Excellent care. All staff are very pleasant and helpful. Nothing is too much trouble. They (staff) want a medal; they are so good", "Yes, the carers individually are kind and [my relative] has a good rapport with staff" and "Carers are absolute angels who do the best they can but there are not enough of them." On the whole family members thought staff were caring.

A nurse practitioner said, "Residents can be very challenging but interactions I see from staff are appropriate. Staff are kind and give people time" and a district nurse said, "Staff are friendly and approachable and the residents appear to be happy".

A person who used the service said, "I'm treated with dignity and they respect my privacy here. They are very caring and let me walk outside with my walker." Over the three days of the inspection we observed staff in communal areas interacting with people who used the service. We saw that staff had a caring attitude. We saw that people received personal care privately which helped preserve their dignity.

We saw that most care records were stored safely and only available to staff who needed to access them. However, an unlocked bedroom we inspected contained many personal records of people's medicines charts. We were told that a member of staff was trying to find records that were needed for a safeguarding incident. Whilst there did not appear to be a breach of people's confidentiality we pointed the room out to members of the management team and the door was locked. We were told the room would be cleared of paperwork prior to someone being admitted.

Most plans of care were personalised to each person and recorded their likes and dislikes, choices, preferred routines, activities and hobbies. There was a document called 'my life my story' which listed people's likes and dislikes, choices, hobbies and interests. We also observed that people were encouraged to do things for themselves, for example, to walk to their chairs after mealtimes to help them retain some independence.

We were told by relatives/visitors that they could visit any time. Some people came to the home every day and said they were made to feel welcome. Visiting was unrestricted to help people remain in contact with their family and friends.

Some staff had undertaken end of life training and there was a section in the care plans which informed staff of the basic wishes of people who neared the end of their lives. We made a recommendation that the provider look at best practice training for end of life care for all staff.

We saw that most people's religious or spiritual wishes were recorded in the plans of care and visiting clergy offered people the chance to attend a service or holy communion if this was their chosen way of practicing their faith. One person was from an ethnic minority background and their spiritual and cultural needs had not been explored fully.

Requires Improvement

Is the service responsive?

Our findings

We had received five complaints about the service since the last inspection. On the day of the inspection people who used the service did not have any concerns. There was a suitable complaints procedure located at various points around the building. Each person also had a copy in the documentation provided on admission. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission. We looked at the complaints records and saw the registered manager had investigated the concerns but had not relayed the findings to everyone who had raised a concern.

We received conflicting reports on the way complaints were investigated. Three relatives told us, "My sister has raised concerns about mum's falls, but nothing seems to have changed", I would speak to the senior carer if I had any concerns; she always listens. The manager is also nice and helpful" and "I appreciated the registered manager's depth of enquiry after [family member] got out. The registered manager emailed the report to us and gave us one to one feedback."

The lack of responding to a person's concerns was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16.1 Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

We looked at eight plans of care during the inspection in depth and three more for details around end of life care. The plans of care were of greatly differing qualities depending upon which unit people were accommodated in. Where there was a stable staff team, rather than agency staff, the plans had on the whole been well written and contained sufficient information for staff to understand their needs. However, several staff told us they had not had the time or had not read the plans of care. This meant they may not be fully aware of a person's care needs.

Plans of care were divided into headings, for example senses and communication, choices and decisions, my day my life (a background history with details of hobbies and interests), continence, eating and drinking, healthier happier life, mobility, skin care, washing and dressing, breathing, religion, mental health and safety. On three of the units the plans had been completed and reviewed monthly. This meant staff should be able to provide individualised care to each person.

On one unit (Linden) we saw a plan which told us the person had behaviours that might challenge others, however there was no guidance in the plan of care for staff to follow in order to appropriately manage these behaviours. In another plan there was a risk assessment for a person who had fallen but this had not been reviewed since September although a referral had been made to the falls team. In another plan of care we saw following assessment in August that a person needed to be referred to a dentist. The nurse on duty did not think that this had been completed because the person had received no treatment. In other plans of care we saw the plans had not been reviewed for three months, some details for mental health, well-being and future wishes were blank. A person who chose to be called by a different forename was often referred to

in the plans as the name he did not want to be called. In the same plan of care there was a section for how to keep the person occupied but we saw little evidence staff followed the directions.

On another of the units (Rakewood) we saw that a plan of care contained very little personal details to help ensure the person concerned receive person centred care. In addition a risk assessment for moving and handling was not developed into the plan of care. This meant the details were not available for staff to help prevent any possible falls.

We saw that one person's chosen language was not English and we saw staff had made minimal effort to communicate with the person. A specialist nurse had amended the care plans to include specific details for the care of this person to help with their cultural needs and language needs which encouraged staff to learn some words from the person's family. The trained nurse on duty told us she did not know this had been completed and other staff had not read the plans of care.

The regional managers we spoke with were aware of the issues regarding the poor updating of some care plans. They told us all care plans were to be reviewed. There was a third regional manager who was completing a full review of care plans during the inspection and a new clinical services manager had commenced work and would also be available to improve care records.

This was a breach of Regulation17 (2) (c). The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority may also have provided their own assessments to ensure the person was suitably placed. This process helped to ensure that people's individual needs could be met at the home.

Over the last several months there had been a high turnover of staff and the use of agencies to provide nursing and care staff. This meant that at times people were being looked after by staff who did not know them well.

People who used the service told us, "I've lots of friends and I play dominoes with people here. I also enjoy singing and dancing", "I love reading. My daughter and also my friend bring in books. Staff also take me home to pick up my favourite books. A mobile library comes weekly and I got two books from there", "'I love singing and dancing and we can do both here" and "I like the quizzes that they have from time to time here."

We spoke with the activities co-ordinator who said, "I come onto this unit for an hour or so every morning or afternoon and rather than have a set programme, the activities are varied in accordance with what the residents feel like doing. We have some links with a school and have intergenerational opportunities in gardening and in other school projects. We also visit the school." Activities co-ordinators moved round the units offering activities to keep people who wished to be occupied.

We saw a programme of activities that included games, singing and dancing, trips for residents to places of interest such as seaside towns or pantomimes, film shows, quizzes, meals out, gardening and one to one sessions for people who had difficulty communicating or suffered from dementia. Outside entertainers often

came into the home and included a zoo where people who used the service could handle or look at insects, butterflies, spiders, snakes and other creatures, a visiting art club, external music to exercise entertainers and a visiting music workshop. People were also able to remain in their rooms and watch television, read or complete crosswords.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present for the inspection due to illness. The service was therefore being run by regional management staff.

During the inspection we became aware that records which should have been available to investigate safeguarding or other incidents were not able to be found. This meant that medicines errors or incidents could not be investigated fully to minimise further risks. We had previously been contacted by the local authority who were concerned with the number of complaints and safeguarding issues being raised. They also told us information to investigate the concerns was not forthcoming or could not be found. We contacted the service the day after the inspection to help gain more information. The regional manager who is now based at the service told us they had managed to find the missing documents and was liaising with the local authority to help them investigate the safeguarding concerns. We have since received confirmation from the local authority that the information was now available and they were able to proceed with their investigations.

We asked people of their opinion of the management of the home. A person who used the service told us, "I don't really know the registered manager. I've only seen her once, but not to speak to". Relatives said, "I've had no personal contact with the manager and didn't know about the residents' relatives monthly meetings", "Things seem to be improving since the (regional manager) arrived. Communication has improved" and "I feel that the registered manager and the office staff have been approachable. The registered manager took time to ask us if everything was OK on Rakewood since the move from Brookfield."

Staff had mixed opinions of how the service was managed. All staff appeared to be satisfied with their unit managers or nurses in charge but had little contact with the registered manager. Several staff did tell us management in the service had improved since the regional staff had taken over.

Resident/family meetings were not held being held regularly on all the units. One three units there had been a resident/family meeting in October 2016. Topics discussed included food and people said they were pleased with their meals, people said they enjoyed the activities and thought the laundry service was good. People were also asked if they were satisfied with the care and services and said they were. Following the meetings people who used the service were encouraged to help plan the Christmas party and make greetings cards. The last quality assurance survey was sent out in October 2016. A new survey had been sent out and the service was awaiting the forms to be returned so they could be collated into a summary. On each unit there was a selection of thank you cards where people who used the service or their families expressed their gratitude for the care provided by staff at Carders Court. This showed the views of people who used the service were listened to and acted upon.

Unit managers held a 'take ten' meeting each day. Prior to the meeting a manager walked around each unit

and recorded any observations about the home to bring to the meeting. Department heads came to the meeting and discussed any care or other issues. Clinical issues were discussed and action taken for any issues to improve the service. There was a general meeting for all staff planned for the 11 December 2016.

The service had employed a clinical services manager. This staff members duties were to look at and try to minimise falls, clinical concerns, admissions and discharges, GP visits and any raised safeguarding issues. This meant that the service now employed a staff member who would be able to focus on some of the shortfalls we identified during the inspection. The staff member was on induction but said she was looking forward to her role.

There was a service user guide and statement of purpose which told people who used the service, other professionals and relatives of the facilities and services provided at Carders Court.

During our inspection our checks confirmed the provider was meeting our requirements to display their most recent CQC rating. A copy of the latest inspection report was also made available for people to read.

We looked at some of the policies and procedures which included Infection control, safeguarding, whistle blowing, behaviours that challenge, mental capacity and DoLS, complaints, confidentiality, moving and handling, health and safety and medicines administration. Policies and procedures were updated regularly and available for staff to follow good practice. However staff did not always follow the policies and procedures, for example the MCA and DoLS.

Managers conducted audits regularly. The audits included the quality of care plans, any safeguarding referrals, DoLS, infection control, health and safety, pressure sores (none), comments, complaints and compliments, accidents, falls, medicines and other aspects of running the service. From the evidence we saw the audits were not always effective, especially around care planning and the MCA/DoLS.

The area manager conducted audits regularly. They looked at how the home was run and this included previous matters arising from the audit, a review of accidents and critical incidents, any hazards in rooms, fire prevention, fire drills, training, infection control, falls and complaints related to health and safety. We saw that an action was recorded to improve the service and which member of staff was responsible for completing any action, for example a drink thickener found in one room was removed and the service updated the business continuity plan to include more up to date details. Actions had not always been completed due to the absence of the registered manager.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems for protecting people from harm were not always safe. The administration of medicines was not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Not all complaints received were investigated or necessary and proportionate action taken in response to any failure identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in

relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.