

## Speciality Care (Addison Court) Limited

# Addison Court

### Inspection report

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Date of inspection visit:  
13 June 2018  
14 June 2018

Date of publication:  
08 August 2018

### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on the 13 and 14 June 2018 and was unannounced.

Addison Court is a nursing and residential care home registered to provide care for up to 50 people. Facilities for people who used the service were provided over three floors. The second floor was a small unit that cared for people living with a dementia. All of the bedrooms were of single occupancy and had access to en-suite facilities. There was easy access to a private garden with seating available for people during the warmer months. During this inspection there were 39 people using the service.

The service did not have a registered manager in place. A registered manager is a person who has registered with the CQC 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. An interim manager was currently in place until such time as an appropriate manager was appointed.

We undertook an unannounced focused inspection of Addison Court Care Home on 9 May 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 5 and 6 February 2017 had been made. The team inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was issued with a warning notice [a warning notice specifies the timescale by which the registered person must comply] in relation to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to deploy sufficient numbers of staff to meet the needs of people living at the home. We found the required improvements had been made.

At our comprehensive inspection of 5 and 6 February 2017, we found breaches of legal requirements in relation infection control, premises and equipment, good governance and staffing. We also made recommendations in relation to the management of medicines and activities. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements and by what date. The provider told us they would be compliant by the 24 April 2017.

During this inspection we found improvements had been made; however we found further concerns in relation to medicines. We also found issues with care plans and staffing levels; in particular the high use of agency staff and quality assurance systems failed to identify issues we identified.

All the staff we spoke with confirmed they had received training in safeguarding and knew their responsibilities to report concerns.

Medicines were not always managed safely. Prescribed medicines had not always been administered as directed.

We observed nurse calls alarms were sounding for long periods of time before being answered. We noted a high use of agency staff within the service. We discussed our concerns with the interim manager who told us they had been recruiting and were awaiting recruitment checks to be completed and new staff would be commencing.

All the people we spoke with felt the service was clean and tidy. All the staff we spoke with had completed training in infection control. We saw the service was clean and tidy. We saw staff wearing personal protective equipment as and when necessary.

All the people we spoke with felt that staff members were skilled and knowledgeable. Staff members told us they had received an induction when they commenced employment, although none had undertaken the Care Certificate. We saw a significant amount of online courses were available to staff and some staff had undertaken Diploma's in Health and Social Care.

We looked at how often staff received supervision and found these were not as regular as specified by policies and procedures. The interim manager had identified this and improvements were noted from May 2018.

All the people we spoke with told us the meals were good at Addison Court Care Home. We saw people had a choice of different hot meals and cold options were also available. The service had received a 'Good' rating from the national food hygiene rating scheme which meant they followed safe food storage and preparation practices.

We observed interactions from staff that that were kind, sensitive and caring. Staff spoke kindly and sensitively with people when supporting them with their needs.

All the staff we spoke with understood what equality meant and how to apply the principles of this in their roles. We saw people were not involved in developing and reviewing their care plans to ensure their views were listened to and respected. The process of reviewing care plans helps people to express their views and be involved in decisions about their care.

We noted that that care records were held securely; this helped to maintain the confidentiality of people who used the service.

We found care plans were not person centred. The interim manager confirmed they were aware the care plans were not person centred and assured us this would be looked at as a matter of priority.

We received mixed views from people who used the service about activities. We observed a number of activities taking place throughout our inspection. Whilst there was a programme of activities in place, the activities co-ordinator told us it was not rigid and could be changed to meet people's wishes. Activities were also available for people on a one to one basis such as hand massage.

The home had an up to date complaints policy and procedure in place. This would ensure both people who used the service and staff had the relevant information to support them in acting on and dealing with complaints.

Records we looked at showed a number of quality audits were undertaken within the service. Whilst improvements had been made since the interim manager came into post and these audits highlighted issues and actions taken to address them, they were not always effective.

We saw meetings were held with people who used the service to gain their views and feedback. Staff we spoke with also told us that meetings were held where they could voice their opinions.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Medicines were not always managed safely in the service.  
Medicines prescribed were not always administered as directed.

Staff had received training in safeguarding adults and were able to tell us their responsibilities in relation to protecting people from abuse.

The service was clean and tidy. Staff had completed infection control training and knew their responsibilities to wear personal protective equipment (PPE).

### Is the service effective?

**Good** ●

The service was effective.

People were supported to eat and drink enough to maintain a balanced diet. People were given plenty of choices of food at mealtimes.

All the people we spoke with felt that staff members had the appropriate skills and knowledge to care for them. Records we looked at showed that staff completed an induction when commencing employment.

Procedures had been put in place to protect the rights of people who were unable to consent to their care arrangements. The interim manager was knowledgeable of the Mental Capacity Act and their responsibilities within this.

### Is the service caring?

**Good** ●

The service was caring.

All the people we spoke with who used the service were complimentary about the staff. They told us staff were kind and caring. We observed caring and sensitive interactions from staff.

People's privacy and dignity was respected. There were policies and procedures for staff about caring for people in a dignified

way.

All the people we spoke with felt staff supported them to be as independent as possible.

### Is the service responsive?

The service was not always responsive.

Care plans in place were detailed but were not person centred. People had not been involved in the development of review of these. End of life care plans had not involved the person or their family member.

The service had an activities co-ordinator in place. We observed activities being undertaken throughout our inspection, including one to one sessions such as nail care.

People who used the service told us they were given choices about the support they received.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well led.

There was no registered manager in place. An interim manager was running the service until such time a new manager was employed.

Audits and quality assurance systems in place within the service were not always effective. These did not highlight issues we found during our inspection.

Regular meetings were held for people who used the service and staff. We saw people were able to give feedback on issues such as menu choices and activities.

**Requires Improvement** ●

# Addison Court

## Detailed findings

### Background to this inspection

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

This inspection took place on the 13 and 14 June 2018 and was unannounced. The inspection team consisted of three adult social care inspectors, one medicines inspector 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, in particular dementia.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of the local authority safeguarding and contract monitoring team and local commissioning teams. We also contacted Healthwatch to see if they had any feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All the information collated prior to the inspection was incorporated into our planning tool to advise the inspection team.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We carried out observations in the public areas of the service and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime period. A SOFI is a specific way of observing care to help us understand the experience of people who used the service who could not talk with us.

We spoke with 15 people who used the service and four relatives. We also spoke with the interim manager, one registered nurse, the activities co-ordinator, one member of care staff, a cook, a housekeeper and one member of laundry staff.

We looked at a sample of records including five people's care plans and other associated documentation, five staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, 13 medication records, maintenance certificates and development plans, policies and procedures and quality assurance audits.



# Is the service safe?

## Our findings

Most people who used the service told us they felt safe. Comments we received included, "I feel safe here rather than in the sheltered accommodation", "Definitely safe", "I feel safe here because there are other people around", "I feel happy and safe here, if I wasn't I would leave", "I feel safe when they are hoisting me" and "Yes, always safe." However, one person told us, "No I do not feel safe, other residents come in my room all the time."

Relatives we spoke with told us they were happy with the care being provided and had no safety concerns. Comments we received included, "He is very happy and safe here", "There have been no falls. He is happier here", "Yes she is safe" and "Staff ensure he is safe when using equipment."

People who used the service told us they received their medicines as prescribed. They commented, "Staff always remember to give us our medicines", "I used to take tablets myself but I prefer they give them to me" and "At home I used to take medicines by myself. I think you should have a choice here."

We asked the interim manager how they were ensuring people received their medicines as prescribed. They told us, "We have a new competency form (done six monthly) which has come out of the accelerated plan (from head office) and we have our daily medication checklist. I have just revised the agency nurse induction and the nurse induction as it was very organisational rather than service specific. We have emailed expectations to the agency around medicines and we would not use any agency nurse again if they made a mistake."

At our inspection of 5 and 6 February 2017 we had concerns in relation to the storage of creams and the recording of temperatures in rooms where medicines were stored. We made a recommendation that the provider sought nationally recognised guidance on the proper and safe management of medicines.

A CQC medicines inspector looked at how medicines were managed in the home. A recent review from a local medicines management team had highlighted some issues. The interim manager had begun to address the issues raised at this and subsequent internal reviews. An action plan had been produced and targets set for completion. We saw that concerns were prioritised and all actions were regularly updated. During the inspection we noted that new documentation and checking processes had been introduced; however it was too soon to measure how effective these changes had been and we also found some other areas of concern during the inspection.

We checked the medication administration records (MAR) for 13 people living in the home. All residents had personalised details in their record to help staff administer medicines safely. However, when residents were prescribed one or more medicines to be given "when required", additional information to help staff give the medicine safely, was not always seen. We checked one medicine administered when required and found the stock and balance did not match the number of signatures on the record. Another medicine that had a variable dosage also had conflicting records. We also saw cream records that did not state where the cream should be applied. This meant we could not be sure these medicines were administered safely as

prescribed.

We looked at records for people who were administered medicines in a patch. Application records were kept showing when and where the patch was applied. One person had not received their pain relieving patch regularly as prescribed. The patch should have been applied every 72 hours but on three occasions there had been a one or two-day delay. This meant their health and wellbeing were at risk. This was escalated and the interim manager took action following the inspection to prevent this happening again.

We were provided with evidence that three staff were trained to administer medicines. The manager had put measures in place to ensure that agency staff were adequately trained as three staff were not sufficient to manage medicines throughout the home.

The issues found meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines for the three floors were being stored safely in one treatment room. The medicine trolleys, topical preparations and supplementary feeds were also stored securely in this treatment room. The room was tidy though a little cramped. Regular checks were done to ensure correct room and fridge temperatures were maintained, controlled drugs stocks were accurate and the home had recently introduced medicine stock counts. A second treatment room, on the top floor, was closed so that improvements could be made.

People in the home were encouraged to manage their own medicines where possible to promote their independence. Records for one person were detailed and assessments were regularly undertaken. Two people who received their medicines covertly, hidden in food or drink, had the correct documentation in place and these medicines were administered safely.

We spoke with the interim manager about what one person had told us about administering their own medicines. They told us they would address this and the person would be assessed to self-medicate. Going forward it is good practice to ensure those who are able to and wish to are supported to manage their own medicines.

During our focused inspection of 9 May 2017, we found improvements had been made in relation to the staffing levels within the service. We looked at this again during this comprehensive inspection.

Some people who used the service told us they felt there was enough staff to meet their needs. They commented, "I think there is enough staff", "Yes there are enough staff. Sometimes they only had one at night but now they have the hoist they have two" and "Staff always have time to sit and talk to me." However, other comments we received included, "I had a fall, it took them a while to come", "When I call staff take their time to come", "Staffing levels are not so good, if we get agency they do not always pull their weight", "When I call them, staff take their time; too busy with different people", "Some people want more attention than others" and "Depends on requests made and also staff could be on the other side; delays happen a lot."

On relative we spoke with told us, "Staff haven't got time. Our relative has to wait for a considerable amount of time before staff can support them with their needs."

All the staff members we spoke with told us they felt there were enough staff on duty to meet the needs of people using the service. One staff member told us, "I think the staffing levels are ok if everyone works as part of a team. It is a little bit slow with agency but it is all about team work and as long as the care is still

provided." Other staff members told us, "There is enough staff, it is the layout of the building that makes it difficult" and "It does not matter where you go, staff will always complain about not having enough staff. For the number of residents I think the staffing levels are appropriate. It is much better now that the units have been divided. Morning is always the busiest time; nobody would turn down extra support from 8am until 1pm. Everything does get done, just not always when people want it."

On the day of our inspection there were 11 staff members on duty; this included two agency nurses, an agency senior carer and an agency carer. In addition to the care staff, two housekeeping staff, a laundry staff, cook and kitchen assistant were also on duty. During our inspection we noted on several occasions that nurse call alarms were buzzing for a long period of time, for example, in one instance a nurse call was buzzing for ten minutes. The inspector brought this to the attention of the interim manager; the buzzer had got caught on the bed frame but this had still not been answered by staff. The service was also relying on agency staff to cover a large amount of shifts throughout the week. This meant there was a lack of continuity.

We discussed our concerns about the high use of agency staff with the interim manager. Dependency level assessments were in place and records we looked at showed the required number of staff members were on duty on a daily basis. The interim manager told us that 154 hours of the week of our inspection were being covered by agency, however, they had a senior carer waiting to start and another 88 hours of permanent care staff hours ready to be filled. They were just awaiting all the necessary recruitment checks to be completed.

Whilst we had concerns about the high use of agency staff, the provider had taken steps to address staffing levels and once newly recruited people were in post staffing levels should be improved.

We also asked staff members if they had time to sit down and talk to people without it being task led. Comments we received included, "No, I don't think we do have that quality time" and "It is task led in a morning as there is a certain amount of things that need doing. Afternoons are much more relaxed. There is a lot of entertainment goes on. More opportunity in an evening, staff will sit in the lounge and talk to people."

We looked at the systems in place to ensure staff were safely recruited. The registered manager told us, "We have a central office that manage the pre-employment side of things such as references, gaps in employment and other necessary checks. They will identify any concerns and we decide if we want to continue with the employment or not."

The service had a recruitment policy in place to guide the manager on safe recruitment processes. We reviewed five staff personnel files. We saw that all of the files contained an application form and two references. Any gaps in employment had been checked by head office. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. This meant staff had been suitably checked and should be safe to work with vulnerable adults.

During our comprehensive inspection of 5 and 6 February 2017 we had concerns about the cleanliness of the service, this included people's bedrooms, en-suite's and bathroom cabinets. Unpleasant odours were also noted in some bedrooms.

We looked at this again during this inspection and found this had improved. People who used the service told us the home was clean and tidy. Comments we received included, "They always clean the commode after use" and "We have cleaners to do our bedrooms." All the relatives we spoke with told us they felt the home was clean and odour free.

All the staff we spoke with knew their responsibilities in relation to infection control. Comments we received included, "We always have adequate supplies of personal protective equipment (PPE)" and "I have ample supplies of all the products I need." The training matrix we looked at showed that 70% of staff members had completed online training on infection control.

We asked the interim manager how they ensured staff understood their responsibilities in relation to infection control. They told us, "I bang my drum about it every day. I do an environmental quality walk round which is usually monthly but we do it here weekly, we have an infection control module within the training resources, I regularly check sluices and bedrooms; staff are getting better, making sure they are clean and tidy. We also have infection control audits and discuss them with staff."

During our tour of the service we noted communal areas, in the main, were clean, tidy and free from unpleasant odours. Where the service was having issues with one area being used as a urinal by a person who lived in the home, they had taken a number of steps to address this and minimise the occurrence. We observed staff wearing PPE at appropriate times such as when supporting people with personal care or when handling food.

We spoke with one housekeeper during our inspection. They told us, "I have done online training, I did that first and then [name of supervisor] went through all the infection control such as different coloured mops and what chemicals were used for what cleaning. We always have enough stock." The housekeeper was also able to describe how they reacted when an infection occurred within the service such as, the importance of wearing separate PPE for each room and containing the area.

Records we looked at showed there was a designated person responsible for infection control.

We looked at the laundry and found this was clean, tidy and organised. There was a system for dirty linen to enter and clean linen to leave the laundry area. There were adequate washing machines and dryers to accommodate people's laundry needs. One relative we spoke with told us that at times personal clothing had gone missing. We discussed this with the laundry staff member and the registered manager. They told us the service had a list of 'no name clothes' in a file located in the main reception area. This was put in place for relatives to look at and identify clothing.

During our comprehensive inspection of 5 and 6 February we found the provider had failed to ensure the premises and equipment was suitable, properly used, properly maintained and appropriately located. During this inspection we found the necessary improvements had been made.

People who used the service told us, "Staff have to hoist me and I feel safe. I explain to them how I want them to do things" and "They maintain my wheelchair to check it is alright." All of the people we spoke with told us they were happy with their bedrooms and facilities within the service.

Records we looked at showed staff were trained in moving and handling and were practically assessed in the application and removal of a sling, using a wheelchair and hoist, assisting with standing and walking with a person, hoisting from a chair to a chair and hoisting on a bed. This type of training should ensure staff were competent to manually assist people as required.

During our tour of the service we found corridors were free from clutter such as equipment no longer being used. Communal areas were tidy and had ample seating for people. We did not see any equipment or furniture being stored in these areas. The top floor of the building was undergoing renovation during our inspection. The interim manager told us they were decorating the corridors so they were more suitable for those people living with dementia. One corridor was being decorated in a theme of the beach and another in the theme of a garden. People also had memory boxes outside their bedrooms to assist them in recognising which was their room. There were signs specifically suitable for those people living with dementia to recognise communal areas such as bathrooms and lounges.

Records we looked at showed that all equipment in the service, such as hoists and slings, was checked and serviced at regular intervals by the service's own maintenance team or by external contractors. This ensured that all equipment was safe to use.

All the staff members we spoke with were aware of safeguarding and understood their responsibilities in relation to this. One staff member told us, "We go through the line manager first if you need to report a problem/concern." Another staff member told us, "Obviously if I found something or saw something that concerned me I would let the management know. I am also quite happy to raise my own safeguarding with social services." The training matrix in place showed that 70% of staff members had completed training in safeguarding adults.

We asked the interim manager how they ensured staff were aware of their responsibilities in relation to safeguarding. They told us, "There is a safeguarding module in training and we discuss safeguarding every day at the flash meeting. We also ensure it is featured in induction. [Name of two staff member's] take the lead on safeguarding." The registered manager also showed us 'staff information flash cards' they had in place. These were small cards which were a prompt for staff in relation to safeguarding; for example, what is meant by safeguarding, why it is relevant to their role, the ten categories of adult abuse and what to do should they suspect someone was being abused.

All the staff we spoke with confirmed they were aware of the safeguarding and whistleblowing (reporting of poor practice) policies and procedures in the service and would have no hesitation to whistle blow. All of them felt they would be supported by the service and the registered manager should they report any concerns.

Records we looked at showed that potential risks to people's safety and wellbeing had been assessed. Risk assessments showed identified risks, however there was little information included in these on how to minimise the risk. Instead the care plans we looked at identified how to minimise any risks. We spoke with the interim manager regarding this. Risk assessments should include detailed information for staff on how to manage any identified risks. Risk assessments that were in place had been reviewed on a regular basis.

General risk assessments had been undertaken to assess the risks associated with the environment such as clinical waste, hot surfaces, electricity, first aid, slips, trips and falls. These risk assessments showed control measures in place and were reviewed on a regular basis.

We looked at all the records relating to fire safety. We saw records to indicate regular safety checks were carried out on the fire alarm, fire extinguishers, emergency lighting, fire doors, fire control panel and break glass units. We saw there was a detailed fire risk assessment and management report in place. This highlighted concerns and actions that needed to be addressed and showed potential hazards throughout the service. All the required actions had been addressed and were deemed safe. Regular fire drills were also undertaken which highlighted the name of the staff members which had attended. The training matrix we

looked at showed that 67.5% of staff members had completed online training in fire safety.

Arrangements were in place if an emergency evacuation of the home was needed. People had personal emergency evacuation plans (PEEPs) which recorded information about their mobility and responsiveness in the event of a fire alarm. These detailed how many staff would be required to support the person, any mobility issues and any other special considerations that needed to be taken into account. This should ensure that staff members know how to safely evacuate people who use the service in an emergency situation.

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, electrical installations and portable appliance testing (PAT).

There was a business continuity plan in place to respond to any emergencies that might arise during the daily operation of the home. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

We noted records were kept in relation to any accidents or incidents that had occurred at the service, including falls. All accident and incident records were checked and investigated where necessary by the interim manager. This was to make sure responses were effective and to see if any changes could be made to prevent incidents happening again.

We asked the interim manager how lessons were learned and action taken when things went wrong. They told us, "Sometimes it is putting tools into place, sometimes it is supervision and supporting an individual. There is training, there is also action such as an investigation or a disciplinary. If we are looking at accidents or incidents we would look at updating care plans etc." Records we looked at and discussions with the interim manager showed lessons learned were shared with the staff. An aide memoire was in place which highlighted key risks and things about people's care 'at a glance'. The interim manager told us that incidents were discussed in 'daily flash meetings' and within staff meetings.

# Is the service effective?

## Our findings

We asked people who used the service if they felt staff were skilled and knowledgeable. One person told us, "Staff know us and the way we like things." Relatives we spoke with told us, "Staff know what they are doing", "Staff know about dementia" and "Yes staff know what they are doing."

We asked the interim manager how they ensured staff had the right skills, knowledge and experience to deliver effective care and support. They told us, "We have some fantastic carers who have come with no experience, no bad habits. We allocate them to someone who is experienced. We should be putting people on the Care Certificate [The Care Certificate is an identified set of best practice standards that health and social care workers adhere to in their daily working life]. We do have people enrolled on the Care Certificate; a lot have started but not finished so we need to re-focus on this."

Staff members we spoke with all told us they had an induction prior to commencing employment within the service. One staff member told us, "I had an introduction to the service, showed around the building, introduced to residents and shown where the care files were. I was given a sheet that informed me of people's support needs. I got a very good induction from [name of staff]. Another staff member told us, "Yes I had an induction. I was fully shown around the building, given instructions for all the fire escapes and what to do in the event of a fire. There were a few online training modules to read and complete which I found helpful and I spent two days shadowing someone." None of the staff members we spoke with mentioned the Care Certificate. As recognised by the interim manager this is good practice for those working in health and social care.

We asked staff what other training they had completed in the past 12 months. One staff member told us, "I have done first aid, moving and handling, safeguarding, health and safety, all the modules on the training site from foundations of growth. We have to complete them, we have deadlines and if you don't pass you have to keep doing it until you pass."

Records we looked at showed a significant amount of online courses were available to staff as well as face to face training. Some of the courses we saw available included, end of life principles, nutrition and hydration, positive behaviour support, dementia, equality and diversity, food safety, privacy and dignity and person centred support. We saw the deputy manager had completed specific training in relation to pressure ulcer care entitled 'react to red'.

Training records we looked at showed that nine people had achieved a Level two Diploma in Health and Social Care and one person had achieved Level three. Other staff members told us they would like the opportunity to undertake a Diploma in Health and Social Care.

Registered nurses were supported with their revalidation with the Nursing and Midwifery Council (NMC). Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the NMC in order to continue to practice.



Staff members we spoke with told us they had received supervisions and appraisals. Records we looked at showed that only three out of 39 staff members had received supervision in March 2018, six had received a supervision in April 2018 and 20 had received supervision in May 2018. The interim manager was aware that supervisions were overdue and they had been taking action to address this since May 2018.

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 make 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.

We asked people who used the service if staff asked for their consent/agreement before they provided any care or support. Comments we received included, "We can do whatever we want. I stay up late sometimes watching television and that's fine. You have a free choice, what you want to do" and "Staff always ask my permission before they do anything." Throughout our inspection we observed staff members gaining verbal consent from people for many aspects of support.

Records we looked at showed a detailed mental capacity assessment was completed for each person who used the service. This demonstrated if the person lacked capacity or if they had varying capacity to make some decisions about their personal care needs. Best interests meetings had been held when necessary, the details of which had been fully documented. Both the mental capacity assessments and best interests decisions had been printed on blue paper so they were noticeable in the care file. We saw DoLS applications had been made when it was deemed necessary and any restrictions to a person's liberty had been applied in the least restrictive manner.

We checked how people were supported to eat and drink enough to maintain a balanced diet. People we spoke with told us the meals were good and there was always plenty to eat and drink. Comments we received included, "They feed us well", "The food is ok, we get a choice", "The food is very good. You can have what you want, as long as they have it in", "The food is very good", "Some of the food is good; breakfast. We are trying to change the menu to accommodate diabetics. We get too many potatoes", "The food used to be terrible but it has improved in choices", "They ask what you want to eat", "We get two choices, all of it is enjoyable" and "Food is generally good and good puddings."

During the lunch time meal service on the first day of our inspection we undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime period. A SOFI is a specific way of observing care to help us understand the experience of people who used the service who could not talk with us. We saw tables were nicely laid with cutlery, napkins, table cloths and condiments. Jugs of juice were also on the table for people to help themselves to.

There was a friendly atmosphere in the dining room with people chatting amongst themselves whilst they were awaiting their food. There were adequate numbers of staff to serve people their meals and to support people with eating their meals. Those people being supported to eat by staff members, were supported sensitively. We observed staff members speaking with people throughout the meal and asking if they wanted more or if they had had enough. We observed portion sizes of food appeared adequate, with what



looked like little waste. People were given the option to have more if they wanted.

We checked the food stocks within the kitchen and found ample supplies of food. The cook told us they were not given a budget and could purchase any food items within reason. We found the kitchen was clean and tidy. The service had received a 'Good' rating from the national food hygiene rating scheme which meant they generally followed safe food storage and preparation practices.

Prior to anyone moving into the service a pre-admission assessment was undertaken by the interim manager or deputy manager to ensure their needs could be met. The pre-admission assessments we looked at were in-depth and covered all aspects of people's needs. The information collated during this assessment was used to develop care plans.

We looked at how people were supported with their healthcare needs. People told us, "They would get the district nurse or the doctor for you if you are not well", "I want to use my legs and the staff encourage me to do that", "The doctor was called when I was unwell. Treated me brilliantly", "I was in pain and staff called the doctor" and "When I had a fall the doctor was called."

People's care records included information about their medical history and any needs or risks related to their health. We saw evidence that appropriate referrals were made to a variety of healthcare organisations including GPs, dieticians, speech and language therapists, occupational therapists, dentists and opticians.

The interim manager told us they used the 'Tele-med' system within the service. This was a system by which if someone was unwell in the service a staff member could access a laptop, contact a Tele-med operator, take the laptop to the person who was unwell and a diagnosis was done over telecommunication providing clinical healthcare from a distance. This saved having to call GPs out to the service and meant a diagnosis could be gained quickly. The interim manager told us the system had been very effective.

We considered how people's needs were met by the design and decoration of the home. All the people we spoke with were happy with their bedrooms and communal areas. We observed all corridors and doors were wide to accommodate wheelchairs. There were many communal areas giving people the option to be in quiet areas. Whilst the layout of the building was not particularly dementia friendly, the interim manager was actively thinking of ways to make the spaces stimulating. On the dementia unit we noted re-decoration was being undertaken to allow for themed corridors [one as a beach and one as a garden], memory boxes were in place outside people's bedrooms and there were plans to have an activities café which would include activity aprons [these are aprons specifically designed to provide stimulation to those people living with dementia], such as gardening ones with tools in. Signage was suitable to support people living with dementia to be as independent as possible.

We looked at how the service worked with other organisations when people were transitioning from one service to another or being referred. We saw pre-admission assessments were completed to ensure the service could meet the needs of people. The interim manager told us, "We do pre-assessments, we invite people in to spend time in the service. They could come in for a coffee morning, a meal or come and spend the night here. People are inducted into the care home environment during a four week period when they are assessed collaboratively with social services to see if they are meeting the requirements of residential care or nursing care. We have an open door policy for visitors and are happy to answer any questions." We also noted that the service had 'welcome packs'; these provided people and their family members with useful information about the service.

## Is the service caring?

### Our findings

People who used the service told us staff were kind and they liked living at Addison Court Care Home. Comments we received included, "Staff are kind", "My family seem to be happy with how I am being looked after", "It's alright here", "It's not bad here, there are a lot of places worse. Staff use their manners when they are supporting me", "I like it here, I like the company. The staff are very good", "Staff are good. We can have a laugh with them", "Staff are respectful. We have a laugh and a joke which is what it is about", "I get a good response from staff; they are very kind and show respect", "Staff deal with all requests", "Staff are brilliant" and "Staff are definitely nice."

Relatives also spoken with were very complimentary about staff members. Comments we received included, "Every time I visit the staff are very friendly", "He has been very happy here. Staff are very friendly and helpful", "All staff I have seen are lovely and kind", "[Relative] looks lovely today, her finger nails have been clipped, wearing clean glasses and clean slippers" and "Staff are very understanding."

We observed interactions from staff that that were kind, sensitive and caring. Staff spoke kindly and sensitively with people when supporting them with their needs. We observed staff dealing sensitively with a person whose behaviour was challenging; we saw the staff member walking and talking with the person to alleviate anxiety and reduce the impact on other people.

We asked the interim manager how they ensured people who used the service felt they mattered and that staff listened to them. They told us, "We have a quality walk round; this involves talking to service users and asking if they like it here, what they think of activities and the dining experience. I am in the process of appointing dignity champions; I have had quite a lot of interest in this role. A lot of the staff have had creative minds training. This is two day training on dementia, looking at what it may feel like to be diagnosed and live with this condition."

People were supported to maintain contact with relatives and friends. We observed relatives visiting throughout the days of our inspection and noted they were offered refreshments. The relatives spoken with told us they were made welcome in the home.

People's privacy and dignity was respected. People told us they could spend time alone if they wished. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality within the home. We observed throughout our inspection that staff ensured doors were closed when supporting people with personal care.

Records we looked at showed staff had received equality and diversity training. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences. All the staff we spoke with understood what equality meant and how to apply the principles of this in their roles.

We saw people were not involved in developing and reviewing their care plans to ensure their views were listened to and respected. The process of reviewing care plans helps people to express their views and be involved in decisions about their care. We discussed this with the registered manager who was aware that part of being person centred was supporting people to be involved in the development and review of their care and treatment plans. They told us this was an area of priority going forward.

We had one negative comment from a person who used the service; they told us they did not like it when staff members from different ethnic backgrounds spoke around them in a language they could not understand. This can be confusing and anxiety provoking for people and does not promote effective communication.

There were a number of notice boards throughout the service which included information on daily activities, when the podiatrist was visiting and a forthcoming clothes show. We also saw notice boards that informed people of the date, day, season and weather and menu boards to inform people what the meals choices for the day were.

All the people we spoke with told us they were encouraged to remain as independent as possible. One person told us, "I like to do things myself but if I need staff I only need to press my buzzer. We are not short of help." One staff member we spoke with told us, "I am very conscious of people being independent and allowing them to do things for themselves." We observed staff members encouraging people to be as independent as possible throughout our inspection.

We noted that that care records were held securely; this helped to maintain the confidentiality of people who used the service.

## Is the service responsive?

### Our findings

We asked people if they had been involved in the development and review of their care plans; none of the people we spoke with had been involved nor had they seen care plans. Comments we received included, "No I have not had a discussion about care plans", "Not sure I have seen a care plan", "I have not really been involved in decision making or care plans" and "I would prefer it if my views were heard."

We looked at five care records. We saw care plans were in place in relation to needs such as eating and drinking, personal hygiene, elimination and continence, medicines, skin integrity, breathing and circulation and sleep. We saw care plans were very detailed and contained clear and concise information about people's health care support needs. However, we found these were not person centred; whilst reviews were being undertaken on a regular basis, there was no evidence to show the person or their relative had been involved in the process. The interim manager confirmed they were aware the care plans were not person centred and assured us this would be looked at as a matter of priority.

We also found some of the handwriting within care records so poor it could not be read. It is important that all documents are legible and in a format that the reader can understand; we brought this to the attention of the interim manager for them to look into.

Training records we looked at showed that staff had access to end of life training in order to be able to support people at the end of their life. Records we looked at showed that end of life care plans were in place, although no one using the service was currently receiving end of life care and support. These were detailed but did not evidence any family involvement or the involvement of the person. It is important that people and their families are involved in planning for the end of their life to ensure that their needs and wishes are met.

We received mixed views about the activities available within the home. People told us, "There is not really any activities but I don't like doing them", "There is not a lot of activities for me to do. When they can, one of the staff take me down to the club for a drink and we might go out in the minibus for a run", "I watch television at night. I just rest during the day. We had a male singer yesterday and that was good. I read books and newspapers", "I enjoy watching television; it's not boring", "I listen to music, do word search and go out", "Watching television and shifting from one position to another" and "There are activities. There are children coming in today to do things."

Relatives we spoke with told us the service organised social events to keep people entertained.

We observed on the morning of the first day of our inspection, the activities co-ordinator was undertaking activities with people on the dementia unit. In the afternoon a singer had come into the service and many people attended this; we saw people were dancing with staff and singing along to the music. People looked to be enjoying themselves. We also observed a quiz being undertaken and a small group of children had come in from a local school with their teacher to sit and do activities with people. We were told by the activities co-ordinator that quite a few people enjoyed the children coming in. The service also had talking

books that service users could access.

We spoke with the activities co-ordinator to enquire about their role and the activities provided for people. They told us, "My role is to provide meaningful and person centred activities. I produce a monthly programme and do a monthly events planer. The programme goes into residents' rooms for them to read. We have a school coming in every week and it is me that arranges the hairdresser and podiatrist."

Whilst there was a programme of activities in place, the activities co-ordinator told us it was not rigid and could be changed to meet people's wishes. Activities were also available for people on a one to one basis such as hand massage, nail care, shopping, or just to sit and talk. The activities co-ordinator told us, "I would like to be able to set aside a whole day for one to one's but I don't always seem to have the time and I cannot be on all the floors at the same time. In an ideal world it would be good to have a permanent person doing activities on the top floor; the staff on there are very good and will do activities with people when I am not there."

The activities co-ordinator told us there was a budget in place for activities and it was dependent upon how many people were using the service; they also undertook fundraising events within the service on occasions with the money going towards more expensive activities. Fundraising events were also undertaken to raise money for dementia awareness and cancer research.

Technology was used to support people to receive care and support. The service used a call bell system, which enabled people to alert staff that they were needed. We saw that people had their call bells within reach. Sensor mats had been placed in bedrooms, where people were assessed as having a high risk of falls. The home also had Wi-Fi available throughout the building and staff had access to a tele-medicines system. This enabled staff to speak with a healthcare professional at a hospital via a computer link. Staff had access to the provider learning academy where they could undertake online training. All the registered nurses had an email address so they could receive policies and procedure updates and a newsletter informing them what was happening across the organisation. Two laptops were available; one that could be used by staff for training and one for people who used the service.

We asked people who used the service if they were able to make their own choices. Comments we received included, "If we don't like anything we just tell them. They don't have any choice but to listen to us and they do sort things" and "We can do whatever we want." Throughout our inspection we observed staff members giving people choices such as, what they wanted to wear, what they wanted to eat and if they wanted to join in activities.

Most people we spoke with knew how to make a complaint. They told us, "If you are worried about anything you can send for the manager to discuss your concerns and she will sort it out", "I would complain to the manager if I needed to. She would listen", "If I was unhappy I know who to go to yes, the boss" and "If I have a concern I usually do tell the staff." Other comments we received included, "I don't know who I would tell if I was not happy", "I don't know how to complain" and "They don't have time to listen to complaints."

Relatives we spoke with told us, "I did raise a complaint to the manager and was satisfied with the outcome" and "I have not raised any complaints but I know how to if I need to."

The home had an up to date complaint policy and procedure in place. This would ensure both people who used the service and staff had the relevant information to support them in acting on and dealing with complaints. The complaints procedure had details relating to who to contact and as well as how the provider dealt with any complaints.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We looked at how the provider shared information with people to support their rights and help them with decisions and choices.

We asked the interim manager how they were meeting the requirements of this standard. They told us they knew about the standard and had many ways of ensuring information was given to people in a format they could understand. For example, things could be printed off in larger fonts, easy read documents could be given out to people and documentation in different languages could be accessed.

## Is the service well-led?

### Our findings

We asked people who used the service if they knew who the manager was. They told us, "I am not aware of who the manager is", "I know who the manager is", "There are a few bosses here", "I have met the manager" and "We are on our third manager in a matter of months. She checks we are ok."

The service did not have a registered manager in place. 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.

Until such time as a new registered manager was appointed an interim manager was in place. The interim manager had been working in the service since April 2018 since the previous registered manager left the post. The interim manager had begun to identify a number of issues within the service and had commenced making positive changes which were evident during our inspection. However, there remained some concerns which we have discussed in other domains through this report.

At our inspection of 5 and 6 February 2017 we found the provider had failed to ensure systems and processes were operated effectively. We checked this again during this inspection. Whilst improvements had been made since our last comprehensive inspection we found despite quality assurance and audit systems being in place these were not effective. This was because the management of medicines was noted to be unsafe and care plans were not person centred. Further improvements to the quality monitoring process must be made to ensure there is a clear overview of practice within the service and therefore well led.

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating both within the service and on their website. This was to inform people of the outcome of our last inspection. In preparation for the inspection, we checked the records we held about the service. We found that the interim manager had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken to ensure people were kept safe.

We asked the interim manager how they promoted transparency and an open culture for staff. They told us, "I am a firm believer in not having a blame culture; things are allowed to go wrong without repercussion. I am very much about lessons learnt. I would rather staff came to me with issues than not. In terms of transparency I am very much an over reporter; I would rather air on the side of caution. I have an open door policy." Throughout our inspection we noted the interim manager was visible throughout the service and their office door was kept open so staff could speak to them if needed. The interim manager confirmed they spent a lot of time in communal areas and started work before the night staff went home so they could do a 'walk round' with them. They told us they attended handover meetings three times a week so they were kept up to date on what was happening in the service.

All the staff we spoke with told us the interim manager was approachable and they felt supported in their

roles.

Records we looked at showed a number of quality audits were undertaken within the service such as, risk assessments, care plans, medicines, tissue viability, accidents and incidents and kitchen. We saw out of hours visits were conducted and the interim manager undertook 'quality walk rounds'. Whilst improvements had been made since the interim manager came into post and these audits highlighted issues and actions taken to address them, they were not always effective. We found concerns in relation to medicines management, high use of agency staff and care plans.

We asked people if they were involved in meetings about the service. One person told us "I go to the residents' meetings. They ask us if we want to change the menu or any activities we want to do." Other people we spoke with told us they had not been involved in any meetings or had been asked to complete a survey. However, we spoke with the activities co-ordinator who told us, "Part of my role is to do the resident and relative meetings. They are monthly at the moment, just so we can keep people informed of what is going on, but it is usually three monthly."

Records we looked at showed that governance meetings were held by the interim manager with the deputy manager, a registered nurse, activities co-ordinator and admin. The meeting of 22 May 2018 showed discussions took place around safeguarding, themes and lessons learned from falls management information, continence management, pressure area care and choking management. Staffing levels were discussed noting the high use of agency staff; it was noted that agency staff were to join in with 'flash' meetings held on a daily basis. It was noted that newly recruited staff members were discussed. A discussion around complaints showed that this linked with lessons learned and showed improvements had been made. Staff we spoke with and records we looked at showed staff meetings were held and regular daily handover meetings occurred to ensure that staff were knowledgeable about people who used the service and organisational information was shared.

We asked the interim manager what the key achievements of the service were. They told us, "I think the documentation now from where we were three months ago is a huge achievement. We still have a way to go on being person centred and we are looking at this going forward. We are at a point where I am just the home manager and free to do more. There is an awful lot of systems set up around governance, they are not perfect but they are getting better, such as much more robust induction for agency nurses." We also asked what the key challenges had been; the interim manager told us, "Some of it has been around the staff warming to me. The transition has been easier in one way as I was supporting the previous manager in a quality capacity which is a very different role. I have built a relationship with the nurses and care staff and we get on well, there is a nice atmosphere. Recruitment has been a challenge in terms of registered nurses. There is a nice steady stream of staff waiting to start now and we have got seniors now which will help with the pressure of nursing staff. We are also building relationships with family members; building bridges with families that have been unhappy in the past."

The interim manager told us how they ensured improvements were made within the service and how they drove this. They told us, "I am a part of it. I do not ask people to do anything I am not prepared to do myself. It is about motivating people, having a blameless culture and lessons learned. I tend to find that staff who can be quite resistive, if you give them key tasks and responsibilities it works really well."

We were shown an 'accelerated plan, standard operating procedure'. This was an organisation wide document, however, the interim manager had devised specific aspects for Addison Court Care Home. For example, what to do if staff identified a wound, how to apply specific pain relief patches, managing an enquiry and a fluid intake procedure. The interim manager told us it was a good way to ensure everyone was



doing the same thing. They were going to introduce one for capacity assessments and best interests.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>Medicines were not being managed safely.</b>
Treatment of disease, disorder or injury	