HC-One Limited

Carr Gate

Inspection report

Lawns Lane
Carr Gate
Wakefield
West Yorkshire
WF2 0QU

Tel: 01924828105
Website: www.hc-one.co.uk/homes/carr-gate/

Date of inspection visit:
26 April 2016

Date of publication:
04 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Carr Gate Nursing Home took place on 26 April 2016 and was unannounced. The previous inspection, which had taken place during July 2015, had found the service was in breach of specific regulations. We had issued warning notices to the registered provider which meant they were required to take immediate action with regard to people's privacy and dignity, risks associated with medicines management, audit and quality assurance systems and staffing levels. We had issued requirement notices and received action plans from the registered provider to show how they would address other breaches we found with regard to providing meaningful activities, acting in accordance with the Mental Capacity Act 2005, meeting nutritional and hydration needs and suitability of premises.

This inspection found improvements had been made in each of these areas. However, there was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered manager had not reported a safeguarding incident in line with safeguarding procedures and a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always protected from assessed risks.

Carr Gate Nursing Home provides accommodation and nursing care for up to 65 people, some of whom are living with dementia. The home is on two floors and there are three units; Cherry (nursing care), Cliffe (residential care) and Holly (dementia care). At the time of the inspection 13 people were living on Holly, 14 people were living on Cliffe and 11 people were living on Cherry.

There was a registered manager, who had been registered with the Care Quality Commission to manage the service since July 2015. 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.

Most people told us they felt safe living at Carr Gate and the family members we spoke with on the day of the inspection also told us they felt their relatives were safe. One person, however, indicated they did not feel safe.

Staff had received training in relation to safeguarding people and staff were aware of relevant procedures to help keep people safe. However, on the day of the inspection, we identified a safeguarding concern that had not been reported and investigated.

Staff were recruited safely. Staffing numbers were determined by the use of a dependency tool and staff and people told us they felt staffing levels across the home were adequate. Whilst there were enough staff to meet people's needs, we observed sometimes the deployment of staff was not effective.

Staff received appropriate induction, training, supervision and support to enable them to perform their role

effectively.

People were provided with care and support in line with the principles of the Mental Capacity Act (2005) and staff demonstrated knowledge and understanding of the relevance of this when providing effective care to people.

People across the home were supported to have their nutrition and hydration needs met. However, the lunchtime experience on the Holly unit was not as well organised as other units, resulting in people having to wait longer for assistance.

Support was provided to people by caring staff. We observed many positive, caring interactions between staff and people.

Care plans were person centred and included people's choices and preferences, although one care plan we sampled contained contradictory information. Care plans were were reviewed regularly.

Although we observed some activities taking place, we felt there was a lack of meaningful activities. However, a new activities coordinator had been appointed and was due to start employment at the home during the week following the inspection.

The registered manager held regular meetings with people, staff and relatives and engaged with other agencies. Audits had improved since the last inspection but required further development. Strong teamwork was evident and people, staff and relatives had confidence in the registered manager.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

An incident of a person who was admitted to the home with bruising was not investigated or reported in line with safeguarding reporting procedures.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

People were not always protected from assessed risks.

Medicines were well managed and administered by staff that had been trained to do so.

Is the service effective?

Good

The service was effective.

Staff had received training and support to enable them to provide effective care and support to people.

Staff received appropriate supervision and support.

Staff were trained in, and had an understanding of, the requirements of the Mental Capacity Act 2005 and the principles of the Act were upheld.

People received support to access health care services.

Is the service caring?

Good

The service was caring.

We observed reassuring, positive and caring interactions between staff and people.

People's privacy and dignity was respected.

People's end of life wishes were considered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Personalised care plans reflected individual choice and need and these were reviewed regularly.

A care plan we sampled contained contradictory information.

Some people were not given choices, in terms of their choice of drink.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, staff and relatives had confidence in the registered manager.

Improved audits were in place to drive improvements at the home, although these were not always effective.

The registered manager engaged well with external organisations in order to improve service and had developed and continually updated action plans.

Carr Gate

Detailed findings

Background to this inspection

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

The inspection of Carr Gate took place on 26 April 2016 and was unannounced. The inspection team consisted of four adult social care inspectors.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority and the clinical commissioning group as well as information we received through statutory notifications.

We used a number of different methods to help us to understand the experiences of people who lived at the home, including speaking with people, making observations and inspecting records. We spoke with nine people who lived at the home, eight relatives of people who lived at the home, four care staff, a unit manager, the registered manager and the operations director.

We looked at seven people's care records, three staff files, staff training records, as well as records relating to the management of the service and the maintenance of the home. We looked around the building and saw people's bedrooms, with their permission, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

Most people told us they felt safe living at Carr Gate. A person living on the Cliffe unit told us, "I feel safe enough. I'm happy and content." Another person, who lived on Cherry unit, said, "Yes I am safe here. They look after me. If I don't like it, I tell them." Another said, "Safe? Yes, certainly." However, one person told us, "They rough me about." We spoke with this person's relative who advised the person had a history of making these types of allegations and the relative was happy with the care provided. This was not recorded in the person's care plan however.

A family member of a person living on the Holly unit told us they felt their relative was, "Definitely safe here. Never had any safety issues."

Staff had received training in relation to safeguarding. The registered manager told us they checked weekly whether staff training was up to date in relation to safeguarding and this was raised in supervision. We found a member of staff had not updated their training when this was due to be refreshed and the registered manager had identified this and had addressed this with the member of staff. We saw this was discussed in the staff member's supervision to ensure they refreshed their training.

The staff we spoke with were able to outline the actions they would take and the reporting procedures if they suspected anyone was at risk of harm or being abused. One staff member told us the signs that may indicate a person was at risk of harm or being abused, for example, changes to a person's mood or physical appearance. This staff member was clear about safeguarding reporting procedures. Another member of staff we spoke with was clear about whistleblowing and told us they would escalate any issues if they felt the management of the home did not take any concerns seriously. Noticeboards displayed information, highlighting action that should be taken should anyone suspect abuse, with contact details for who to report this to. The whistleblowing policy was also displayed which helped to ensure staff knew what to do if they needed to report any concerns. This helped to ensure people were protected from the risks of harm or abuse because staff knew what action to take.

During our inspection, however, we saw a person had some bruising. Records showed the bruising had been recorded upon admission to the home but no enquiries or investigation had taken place to determine the cause. We raised this with the registered manager, who contacted the local authority safeguarding team on the day of the inspection. We also shared our findings with the local authority safeguarding team following our inspection. The fact that this had not been reported, prior to the inspection, showed that not all potential safeguarding incidents had been reported and investigated. This meant the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 13(2), because systems and processes were not established and operated effectively in line with safeguarding reporting procedures.

The registered manager told us risk was managed by assessing risks and putting measures in place to reduce risks, whilst also trying to ensure people maintained their independence. We saw risk assessments were in place within individual care files, such as in relation to falls, choking and moving and handling.

These contained information specific to the person being assessed. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

A staff member we spoke with told us they felt risk was managed well. They said, "There should be a falls risk assessment for those not steady on their feet. We get chance to read them, every time they're updated." The staff we asked were able to identify other risks to people such as risk of choking, weight loss and pressure care. Staff outlined the measures that were in place to reduce risks. This helped to reduce risks to people because they had been assessed and staff were aware of the measures in place to reduce risk.

Care plans contained moving and handing assessments, to provide staff with information so that people could be assisted to move safely. However, we found some information to be lacking. For example, one person's moving and handling assessment stated, 'hoist used for all transfers' but did not indicate instructions on how to use the hoist or what sling type should be used. This could put the person, and staff, at risk of injury during moving and handling processes.

We saw a notice displayed in a person's room which highlighted that aerosols must not be used in the person's room, because this caused breathing difficulties for the person. This was also reflected in the person's care plan which stated, 'No aerosol sprays to be used near [Name] as this induces prolonged coughing episodes.' This showed measures had been taken to reduce the risk of the person experiencing breathing difficulties.

We found individual personal emergency evacuation plans had been developed and these took into account the physical needs of each individual. We found, however, detail to be lacking in relation to people's cognition and this could be relevant in an emergency evacuation. There was an emergency 'grab bag' near to the main exit of the building. This bag contained items that could be used in an emergency such as a high-visability vest, jackets, torches, spare batteries, name wrist bands and information relating to individual emergency evacuation plans and fire plans for the building. This demonstrated the registered manager had procedures in place to help keep people safe in the event of an emergency.

Fire alarm testing took place weekly and regular practical fire drills took place. Emergency lighting and other safety checks took place regularly such as room temperature checks. Notices were displayed showing the action to take on discovering a fire. This further helped to ensure people's safety.

There had been a recent inspection of lifting equipment and the lift had been recently serviced. A fire risk assessment had been completed during February 2016. Weighing scales had been recently calibrated. Portable appliance testing (PAT) had taken place and was valid until April 2017. This showed steps had been taken to ensure the premises were safe and equipment was in good working order.

We identified a full length glass door leading from the dementia unit. There was a sign on the door but this was above head height. We considered this may pose a risk so highlighted this to the registered manager and operations director on the day of the inspection. The registered manager contacted us following the inspection to confirm action had been taken to rectify this.

Analysis of accidents and incidents took place. For example, a falls analysis which highlighted the location, time of fall, cause of fall and level of harm was used in order to identify any potential trends. Action had been taken such as infra-red motion sensors being installed to alert staff to any potential falls. Specific falls team meetings took place and items such as the environment, falls reduction measures and use of walking aids was discussed. There was a dedicated falls team which consisted of designated staff who met to consider any trends and falls by individuals and to look at measures which could reduce falls. We saw a

record that a person had walked into a 'wet floor' sign. Lessons were learned from this and staff were instructed to, 'make sure all the floor is dry then the safety sign to be removed.' This was also recorded on the person's review, reminding staff to remove all obstacles. This showed measures were in place and actions were taken to reduce the number of accidents and falls. People were observed to have their walking aids such as zimmer frames and walking sticks within reach. This would reduce the risk of people falling, trying to reach for their aids.

When we looked at records of accidents and incidents on the Cliffe unit we found a person had sustained a skin tear due to 'Injury caused by footplate. Foot put behind so when carer tried to turn the wheelchair [person]'s foot got caught and skin tear resulted.' This was recorded and the registered manager provided evidence to show this had been addressed and staff were advised to remind the person to keep their feet on the footplate when the wheelchair was in motion.

The previous inspection found staffing levels to be unsafe. We found improvements at this inspection. The registered manager used a dependency tool to help determine staff numbers. 'Resident risk assessment scores' which took into account people's needs were evaluated each month and this was used to determine staffing levels.

A relative told us, in relation to staff numbers on the Cliffe unit, "There used to be two staff on but now it's three, that's much better. They've so much to do with making beds, doing tablets and helping folk out." A staff member on this unit also told us they felt staffing numbers were adequate. We were told by a staff member, "Every day, every unit is now fully staffed."

A person we spoke with on the Cherry unit told us they felt there were enough staff. A relative also echoed this. A member of staff told us, "There are enough staff for each shift and they do all work as a team."

Although staff numbers had increased, we found staff were not always visible on the Holly unit and there were periods of time where we observed no carers to be present in communal areas, such as the lounge. For example, during the morning we observed a person walking around the Holly unit, inappropriately dressed when there were no staff in the lounge.

During the inspection, a person fell and hit their head on the wall as they fell. The nurse came and checked the person and, with the assistance of a carer, used hoisting equipment to help the person. An inspector, who had witnessed the fall, highlighted to staff the person had hit their head. As no staff member witnessed the fall, this would not have been apparent to the nurse. Upon checking the records, we saw this person had also experienced a fall during January 2016 and, as a result, the person's falls risk assessment had been updated to reflect they required close supervision. However, on the day of the inspection the person fell over a yellow floor sign which had been left in the area and the fall was unwitnessed by staff. We shared our observations with the registered manager and operations director who agreed to consider this further. This meant the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(b), because staff did not follow plans to keep people safe according to assessed risks.

We looked at three staff files and found safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

The previous inspection had found risks to people were not safely managed in relation to the administration

of medicines. During this inspection we found improved practices. Staff who were responsible for managing and administering medicines had received appropriate training. Furthermore, knowledge testing and competency testing took place following staff training to ensure staff were competent.

Medication records contained a photograph of the person to whom the information related. This helped to reduce the risk of people being administered the wrong medicine. The person's name, date of birth and any allergies were also recorded.

We checked a random sample of medication administration records (MARs) and found there were some where medicine had been administered but staff had not signed the chart. The records showed where people had been offered but had refused medicine. We observed the registered manager ask a member of staff for the MARs, in order to undertaken a spot check of medicines. We checked a random sample of medicines and they reconciled with the records.

Medicines were stored safely. Storage temperature checks were completed daily and the storage temperature was within appropriate limits.

We observed the nurse administering medicine to a person who was susceptible to sudden jerky movements. The nurse was mindful of this and assisted the person in an appropriate, patient manner.

We found improvements had been made since the last inspection in relation to infection prevention and control. Premises were visibly much cleaner and free from odours. There was a dedicated member of domestic staff allocated to each unit. A recent infection prevention and control audit had resulted in an action plan, which included a recommendation that alcohol hand gels should be mounted throughout the building. We saw this action had been completed. Anti-bacterial gels were available throughout the home. Soap and paper towels were available in bathrooms. We observed staff washing their hands and following good infection prevention and control practice. Personal protective equipment (PPE) was accessible for staff to use and we observed staff to use this. This helped to reduce the risk of the spread of infection. There were new carpets and décor since the last inspection, resulting in a more pleasant environment.

We saw first aid kits were placed around the home and these were checked monthly. This meant that provisions were in place to provide emergency first aid to people if required.

Good

Is the service effective?

Our findings

A relative we spoke with said, "There have been positive changes, in every way. My [name] can be really awkward but they do really look after [name]. It's lovely."

A person we spoke with, who lived on the Cliffe unit, said, "You see, it's alright. I've got what I need. The staff help me with whatever I ask them to. They're kind and good lasses. If I had any complaints I'd tell them straight."

A relative of a person on the Cherry unit told us, in relation to staff, "Never had any complaints. One or two are exceptional." This relative told us they felt staff handled any incidents effectively and they were impressed with how staff distracted people if they sensed any stressful situations arising or escalating.

A relative told us they felt supervision of staff on the Cherry unit was poor. They said, "People are left in the lounge on their own and staff in the dining room on phones."

A family member of a person who lived on the Holly unit told us they felt their relative's care was, "Very good."

A member of staff we spoke with told us they had a full induction prior to commencing work and this included shadowing other, more experienced, members of staff and training in areas such as moving and handling, safeguarding and fire evacuation. This staff member told us their training was refreshed annually.

Staff had received specific dementia training, following a nationally recognised programme. A staff member was able to provide examples of how this training had enhanced their knowledge and skills when supporting people living with dementia, for example, by using picture cards and by understanding the importance of being patient and giving the person time to make choices and decisions. This helped to ensure people were provided with effective care and support.

Staff had undertaken training in areas such as safeguarding, equality and diversity, infection control, health and safety and emergency procedures. Some staff training was completed on-line. The registered manager told us they were aware that some staff may not be as confident with on-line training as others. Therefore, some champions for training had been identified to offer support to those staff who required this. This meant the registered manager had taken steps to ensure staff had up to date skills to enable them to provide effective care and support to people.

The registered manager showed us a tool-kit called 'my home life'. This toolkit was developed from research and piloted with care home managers. The tool-kit was designed to enable the registered manager to interact positively with staff and to open up conversations about living, dying, visiting and working in care homes, with prompts to help staff reflect and consider best practice in care homes.

We saw evidence that regular staff supervisions took place. Items discussed included staff knowledge of the

Mental Capacity Act 2005, staff training and any issues regarding performance. We saw action plans resulted from some supervisions and staff were given guidance to improve their working practice. The registered manager had identified, on one unit, that a member of senior staff had not completed supervisions with staff in accordance with the schedule. This had been addressed, with an action plan and deadline for completion. This helped to ensure staff received appropriate, regular support and supervision.

The registered manager had attended a workshop in relation to effective appraisals for staff. This was a new process, whereby staff would review their progress and performance and this would form the basis of discussion with their supervisor or manager about their annual appraisal. This showed staff received regular support and management supervision to monitor their performance and development needs.

Five nursing assistants had been appointed throughout the home. One of these staff members had been a senior carer and had progressed to the role of nursing assistant. This opportunity provided these staff with a 16-week training programme to enable staff to be competent in administering medication, use simple dressings and raise any issues that the nurses needed to deal with. This enabled the nurses to concentrate on nursing.

Some staff were designated 'Dementia Friends', which is an Alzheimer's Society initiative. Staff had received additional training in order to understand what it is like to live with dementia. A member of staff was a 'Dementia Friends Champion'. A Dementia Friends Champion is a person who encourages others to make a positive difference to people living with dementia. This showed the registered manager and staff recognised and followed good practice guidelines in relation to providing care for people living with dementia.

We found a staff member to have limited English language skills. We raised this with the registered manager and operations director because we were concerned what the impact of this could be on the people to whom care and support was being provided. The registered manager had not recognised this prior to the inspection. However, the registered manager contacted us following the inspection to confirm the person had been offered, and had accepted, support to develop their English language skills further. This showed the registered manager had been responsive to our feedback and findings and the staff member was to receive additional support.

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

People can only be deprived of their liberty 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). Two applications had been approved and the registered manager had informed the Care Quality Commission of these, in line with their responsibilities. Other applications, for people who were assessed as lacking capacity and who were being deprived of their liberty in order to receive care and treatment, had been submitted to the 'Supervisory Body'. The registered manager was awaiting the decision from the local authority regarding these applications.

The previous inspection found the registered provider was not acting in accordance with the MCA. We found staff knowledge had improved in this area. Information was displayed around the home, highlighting the principles of the MCA and the registered manager told us, and we saw evidence, they regularly checked staff knowledge in this area.

Staff and the registered manager acted in accordance with the principles of the MCA. Care plans reminded staff they must assume the person has capacity to make their own decisions. Care plans contained decision specific mental capacity assessments and, where people were found to be lacking capacity, decisions were made in their best interest. The person and their relatives had been involved in this process.

Consent was sought, for example, in relation to photographs being taken and used and whether people wanted their doors locking. We observed staff asking people for consent prior to providing care and support.

Staff we spoke with were clear about people's rights to make their own choices and decisions. A staff member told us, "I would refer to a person's care plan if I wasn't sure of their wishes and they could not communicate. I would offer different drinks. Show the person and let them pick. Or use picture cards." This showed the staff member respected the person's right to make their own choices.

During the previous inspection, we had found people were not receiving suitable nutritious food and hydration. During this inspection we found significant improvements were evident.

A relative we spoke with told us they felt the food quality had considerably improved and their family member enjoyed the meals and was gaining weight.

A person we spoke with said, "I enjoy the meals. Today I had salmon and it was beautiful. Nicely cooked."

A relative told us, "The chef goes to a lot of trouble to get the thing right."

A staff member we spoke with also told us they felt food had improved and told us, "The new chef makes a difference. They're aware of people's dietary needs."

A meal service checklist had been introduced which prompted staff to ensure, for example, that dining areas were clean and organised, people were greeted and acknowledged as they entered the dining area and people were given choice.

We saw resident feedback forms had been introduced since the last inspection. People were asked for their views in relation to the quality of food and this information was fed back to the chef.

During the meal time experience we saw people were offered choices of meals. People were shown different plates of food to assist them in choosing. Choices of drinks were also offered. Tables were set with tablecloths, placemats, condiments and napkins. The chef engaged with people and asked whether they had enjoyed their food. Some people asked for second helpings and this was provided. We observed plate guards were used to assist people where appropriate. Plate guards stop food falling from the plate onto the table. People on the Cliffe and Cherry units in particular received effective support from staff where necessary to eat their meals. This helped to ensure people had their nutrition and hydration needs met.

We observed, however, during the lunchtime period on the Holly unit, staff were struggling to provide the level of assistance that everyone required. We observed a person had sat for 30 minutes with their food in front of them, with no encouragement offered. Another person was trying to eat their meal but required assistance and there was no carer to assist because all available carers were supporting other people. A carer, who had left the dining area in order to assist someone to eat their meal in their room, returned to the lounge and began to clear dishes, without checking whether anyone else required support. Although we had not identified that any of the people we observed during this period were nutritionally at risk, people

were not offered appropriate support on this unit. We shared our observations about staff deployment on the Holly unit with the registered manager and operations director.

The design and environment of the home had improved since the last inspection. New homely break-out areas had been created which gave people the opportunity to have their own space or spend time socialising with others. There was a new hairdressing salon and we saw this in use on the day of the inspection. Appropriate pictures were displayed on the walls, from bygone years. We observed there to be ample coffee tables, within reach of people's armchairs. There were books on shelves and magazines on tables. Windowsills contained flowers, ornaments and plants. A relative of a person who lived on the Cliffe unit told us they felt the new lounge decorations were much better and said, "It's now very homely." Outside spaces were well maintained with bunting and flowers and pots on display. On the Holly unit we saw, as well as room numbers, picture frames were displayed on people's doors which could help people with dementia to identity their rooms more easily.

People had access to health care and we saw referrals were made to other health agencies or professionals. For example, we saw a referral had been made to the speech and language therapist team (SALT) for one person and a soft diet had been recommended. This had then been updated with follow up advice a month later. People also received regular chiropodist care and we saw referrals to memory services and district nurses. This showed people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

A person who resided on the Cherry unit told us, "I like it. I like the staff. I can joke with them. They are good. [Name of staff member] is very good."

A relative told us, "I have nothing but praise for the staff here. I'm going to book me a room here. All really excellent."

Another relative we spoke with said, "Oh these carers are brilliant. They know my [relative]."

Another family member of a person who lived on the Cherry unit told us, "The staff know the clients really well. We see the same staff when we come and they always tell us how [Name]'s been. [Name] is not the easiest to look after but they manage it really well." Another said, "They [staff] go well beyond."

Although all other comments from people and relatives regarding staff were positive, one relative did comment that, although they felt most staff were, 'nice', on one occasion they had overheard some staff make derogatory comments. Following the inspection, we shared this information with the registered manager so this could be addressed.

The registered manager knew people who lived at the home. We observed the registered manager speaking to people in caring tones. The registered manager knelt down to the person's level when speaking with them. This demonstrated a respectful approach and provided a good example for staff to follow.

At mealtime we observed a member of staff walked past a person and asked the person if they had enjoyed their dinner. The person replied but the member staff did not hear properly. The member of staff stopped, bent down and asked the person again, giving the person full attention. This demonstrated a caring and genuine manner towards the person from the staff member.

We observed a carer setting tables prior to a lunchtime meal. The carer encouraged a person to assist with the setting of the table. This showed the carer was enabling the person to maintain their life skills and independence and was therefore empowering the person.

We observed a member of staff assisting a person to eat their meal. The member of staff could be heard saying, "Are you enjoying it? Do you want some more broccoli? Do you want a drink [name]?" The member of staff was talking to the person in a caring way and enabling the person to be in control as much as possible, even though they needed assistance to eat their meal.

We observed a person being assisted to move from their wheelchair to a chair, with the use of some lifting equipment. Staff covered the person's legs which helped to maintain their dignity. Staff were reassuring and said to the person, "Going up [Name]. Let's get you in a comfy chair." This helped to put the person at ease at what could otherwise be a compromising situation.

The previous inspection found people's dignity and rights were not respected and the registered provider was issued with a warning notice in relation to this. At this inspection we found significant improvements.

The staff we asked told us they protected people's privacy and dignity, for example, by closing doors when providing personal care to people. We observed this in practice and we also saw staff knocked on people's doors, which showed their privacy was respected.

Throughout the inspection, we found people were involved in decisions and their human rights were upheld in a respectful manner. We observed on many occasions, people were given choices and encouragement and, as a result, were more empowered.

A member of staff saw a person had put their hands under their jumper and therefore asked if the person wanted a blanket. The member of staff brought the person a blanket. This showed staff were able to identify signs that a person may be in discomfort and staff took action to prevent this.

We observed a friendly atmosphere in the communal lounge areas. Staff asked people their choice of channel on the television and made the remote control accessible to people. We saw staff smiling at people and asking people if they were okay.

Throughout the inspection we observed and heard many respectful and positive interactions between staff and people who lived at Carr Gate. We did, on one occasion, hear a staff member say to another staff member, "I'm gonna start toileting soon." This term is not respectful of the people who required support. We had seen a positive change in the culture of the home, in terms of caring for people since the last inspection and, although this was an isolated incident we heard, we shared this with the registered manager.

We observed a person walk into another person's room. The nurse appropriately and gently escorted the person out of the room in a caring manner.

The registered manager told us end of life wishes were discussed with people upon admission to the home. Some people had a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) order in place. These were clearly indicated and placed at the front of care plans so people's wishes could be known. Furthermore, if a person did not have a DNACPR order in place, this was also indicated clearly at the front of the file. This helped to ensure people's wishes, at the end of their life, were considered and respected.

Requires Improvement

Is the service responsive?

Our findings

A relative told us, "Sometimes they have a singer and a chap with a ukulele. They've got a patio outside for the summer."

An online comment had been submitted to the home which stated, '[Name] enjoys the numerous activities and is much more involved with their peers than they were when living at home.'

Another relative told us they were happy with the care in general but, if they were not, they would, "Go straight to the manager."

The registered manager advised care plans were updated monthly and the registered manager completed care plan audits weekly. We saw evidence of this. Action plans resulting from the audit were logged and the person responsible for updating the care plan was identified and appropriate action taken, within a specified timescale. We found people, and their relatives where appropriate, had been involved in their care planning.

Despite care plan audits taking place, we found one of the care plans we sampled contained contradictory information. The care plan had recorded a person's weight loss using a malnutrition universal screening tool (MUST). However, there were discrepancies in the person's height recording and this would mean the assessment was not accurate.

Care plans were person-centred and contained important information pertaining to each individual. Plans included information relating to the person's life story, their family and friends, occupations, skills and interests. Each plan contained a photograph of the person with an individual profile highlighting, for example, 'What people like about me, important things about my life and things I enjoy during the day.'

We saw pre-admission assessments in the care plans which showed an assessment had taken place and information gathered prior to the person receiving care and support.

Care plans contained information regarding the support each person required in relation to, for example, their routine on waking, personal hygiene, continence needs, eating and drinking, daily activities and medication. Plans contained information which was person-centred and some plans gave staff a good understanding of how to support the person. For example, one plan stated, '[Name] will often look for [name of spouse]. They respond well when you remind them that they have a problem with their memory and that [name of spouse] passed away many years ago. Distraction techniques tend to frustrate [name].' This provided staff with appropriate detail and information to support the person effectively.

We saw that preferences, in terms of whether the person would prefer a bath or a shower, were detailed in care plans as well as how often the person wished to bathe or shower and what time of day was their preference. People's preferred time to retire to bed and rise in a morning were also recorded. This showed plans were personalised to the individual, recording their own choices.

Another care plan we sampled stated, 'Does not like large groups. Enjoys one to one and likes to look through photo albums and books about the Royal family. We observed this taking place. This showed that staff were providing support in accordance with the person's care plan.

The previous inspection had found there were not sufficient meaningful activities for people. We found improvements, although we continued to find meaningful activities were limited. However, a new activities coordinator was due to commence working at the home during the week following the inspection. In the meantime, an existing member of staff was acting part time as an activities coordinator. Having a dedicated activities coordinator means that care staff are able to continue to provide care whilst people participate in activities.

The registered manager told us they felt activities had improved since the last inspection. People participated in activities such as planting pots in the outside area, visits to the local garden centre and public house. We observed a carer bring a person some knitting and the carer chatted with the person about their chosen pastime. We saw a person having their nails painted, a carer reading a newspaper with a person, someone playing dominoes with a carer and we observed a carer spending time with someone, reminiscing about their life.

Each unit had an activities board. On the activities board we saw an annual summer fayre was being advertised. A singing entertainer had provided entertainment a few days prior to the inspection. Dates showing Holy Communion and faith services were also displayed.

On the Holly unit, there were memory boxes outside people's doors. This contributed towards creating a personalised environment for individuals, as well as assisting people who live with dementia to recognise their room. Rooms were personalised with photos and items of sentimental value were on display.

We observed people being given choices throughout the day and people were supported to make choices and decisions where they required assistance. However, as a tea-trolley came around on the Cliffe unit with drinks and biscuits, we observed staff pouring drinks for people. The staff member told us, "We know what everybody likes." However, the staff member did not ask people what they would like. Some people asked for what they wanted and the staff member accommodated their choice but other people were not given a choice.

We looked at the complaints policy and complaints received. We saw, when complaints were received, these were dealt with in a timely manner. Apologies were given and actions resulted where this was appropriate. For example, staffing levels had been reviewed and a new chef had been appointed, following complaints received. A family member we spoke with told us they would know how to complain if they needed to. This showed that people were aware of how to make a complaint and complaints were listened to and dealt with appropriately.

However, another relative we spoke with told us they did not feel their relative was well catered for. We were told, "[Name] would like some sweet potatoes instead of potatoes but I've asked and they've not done anything about it. But, other than that, I've no complaints. [Name]'s happy."

Information was shared between staff, both verbally and written, when shifts changed. A member of staff told us information in relation to any concerns or appointments would be shared. A relative we spoke with, however, told us they felt communication between staff could be improved. For example, they felt changes to their family member's diet were not always effectively shared.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since July 2015.

A person we spoke with told us the registered manager spoke with them and knew their name.

A family member told us they knew the registered manager and they felt the registered manager was, "Good and easy to talk to." Another relative told us, "[Name of registered manager] comes around and always speaks." A further relative said, "[Name of registered manager] has made a difference but when [Name of registered manager]'s not here, things slip."

All of the staff we asked spoke positively of the registered manager and of the management of the home. A staff member working on the Cliffe unit told us they felt the home was well run and they felt supported in their role. They told us, "Staff look out for each other and give each other support."

Another staff member, who worked on the Cherry Unit, told us they felt the home had, "A nice atmosphere." This staff member told us, "It used to be a bit of a muddle, but there's continuity now."

Another staff member we spoke with on the Cherry unit said, "I love it here. Staff are good and enthusiastic." This member of staff told us general administration and organisation had improved and that improved systems were in place.

On the Holly unit, a member of staff told us they were aware of the previous inspection report findings and they felt the home was, "A lot better."

We noted a compliment had been submitted electronically through a website which stated, 'This is a great care home. We struggled to find somewhere we liked until we found Carr Gate Care Home. We've not regretted our decision. First class service all round, couldn't be more pleased. My thanks to all the staff.'

The registered manager told us, "I love every day that I'm here. I feel supported from top management."

A member of staff we spoke with told us they would be happy for one of their own family members to live at the home.

The previous inspection report was displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

Since the last inspection, the registered manager had provided regular updates and action plans to CQC and had attended meetings and engaged with the local authority. The Clinical Commissioning Group (CCG) had asked a vanguard team to offer support to the home and this had been accepted and the registered

manager had been working with a vanguard. The aim of the vanguard includes standardising assessments and care planning, which is more proactive, enabling a shift from reactive to planned care. Holistic tools are provided for care planning as well as building skills and confidence of care home staff by providing training and education to support the workforce.

Following the last inspection, the registered manager had held a meeting with staff, people who lived at the home and their relatives to discuss the findings of the previous inspection and to outline how the home intended to address the issues. We saw a meeting had been held with relatives during March 2016, in order to provide an update on progress and the actions taken. This showed the registered manager was engaging with people and their relatives.

The registered manager told us links with the local community were increasing. For example, a faith leader attended the home monthly, children from the local school attended the home to sing and a local councillor had recently visited an event at the home. Students from a local college had attended the home to deliver activities and chat to people.

We observed there to be a lack of overall direction and scrutiny on the dementia unit, with the nurse looking to carers for guidance, for example in relation to reporting of accidents and incidents, assisting people to move with the use of equipment as well as people's choices and preferences. We shared these findings with the registered manager at the inspection and they agreed to address this, although they highlighted the nurse on duty on the day of the inspection was an agency nurse.

The last inspection had found audits were not robust and systems for monitoring the quality of care provision were poor. We found audits were well organised and planned on a calendar. Some action plans resulted from audits and we could see actions were taken. Although we found significant improvements had been made since the last inspection, audits were not yet robust enough to identify some areas which required improvement such as the accuracy of care plans, safeguarding reporting and staff direction and deployment.

We saw, at least once a month, audits took place by the operations director, human resources or senior service quality inspector. These included an audit of resident care, signage, dining experience, medication management and resident feedback. Actions required were then highlighted for the registered manager to complete. We also found the registered manager had completed out-of-hours and weekend quality assurance audits. Medication audits regularly took place and considered stock control, storage, administration and how controlled drugs were being managed.

The registered manager undertook daily walkarounds within the home and looked at areas such as resident care, infection prevention and control, dining experience and feedback from people. If actions were required as a result, these were logged and monitored to ensure action was taken. For example, the registered manager had identified that a member of staff had not completed some charts and documentation appropriately and fully. The registered manager therefore met with staff to share with them some examples of good practice and the importance of keeping accurate records. This was recorded in supervision and highlighted further learning for staff with an action plan.

The operations director said of the registered manager, "[Name]'s been here on weekends, evenings, nights. They've put their nurse uniform on and showed staff what to do. There's been a cultural change and you can see it."

The registered manager had identified that a manager of a particular unit had not completed one to one

supervisions with staff. The registered manager discussed this with the staff member and action was taken and a target date set for supervisions to have been completed. This showed the registered manager was monitoring progress and taking action to address shortfalls in different areas of practice.

A monthly weight analysis took place. This provided the registered manager with a summary of people who had gained or lost weight over the month. We saw actions had been identified such as referrals to a dietician and supplements being prescribed where people had lost weight. The registered manager had undertaken a monthly quality assurance check to ensure people were being weighed and appropriate actions taken.

We saw surveys had been sent to people and their relatives and they asked questions such as, 'Do you like living in our care centre?' and, 'Do you feel you are well cared for?' and, 'Would you like to be more involved in decision making?' Results from a recent survey suggested that people and their relatives were not sure of the responsibilities of all staff members, for example, who to complain to. In order to address this, photographs and roles of staff were displayed. This showed the registered manager had sought feedback from people and their relatives and taken action to address their needs and wishes in order to improve the quality of service.

We viewed some questionnaires which had been sent to relatives during the month of the inspection. 17 had been returned and all 17 stated they felt their relative was safe and secure within the home. One relative had stated, 'Over the last 12 months I have seen sure and steady improvements within all aspects within the home, both in management and administration.'

Flash meetings and daily briefings were held with heads of departments. These included discussions of housekeeping, catering, maintenance, administration and activities.

Notices were displayed throughout the home, highlighting meetings that were taking place and how people and relatives could be involved. We saw staff meetings took place monthly. Items discussed included progress, actions, and reminders to staff to complete appropriate documentation, infection prevention and control for example. Holding these meetings is an important part of the registered manager's responsibility in monitoring the service and coming to an informed view regarding the standard of care and treatment for people living at the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not follow plans to keep people safe according to assessed risks. Regulation 12(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13(2).