RochCare (UK) Ltd

Coniston House Care Home

Inspection report

Coniston Road, Chorley,
Lancashire, PR7 2JA
Tel: 01257 265715
Website: www.rochcare.com

Date of inspection visit: 10 February 2015
Date of publication: 05/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 10 February 2015 and was unannounced.

The last inspection of Coniston House took place on 19 March 2014. At that time we found inconsistencies in care planning and suitable arrangements were not in place to safeguard people against the risk of abuse. We deemed this to have a minor impact on people. We asked the provider to take action to make improvements in care planning and safeguarding procedures. We received an action plan, in which the provider said they would meet the relevant legal requirements by May 2014 . This action has been completed.

Coniston House is arranged over two floors, with each floor having bedrooms, bathrooms and a communal lounge and dining room. All bedrooms have en-suite facilities consisting of toilet and washbasin, with some also having a shower. There are gardens and a patio area with seating. The home is registered to accommodate 43 people. At the time of our inspection 39 people lived at the home.

The home is required to 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

Summary of findings

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.

At our last inspection on19 March 2014 no registered manager was in place. In July 2014 a new manager was employed. This person's application was accepted and a certificate issued on 24 December 2014.

People we spoke with all told us that they received their medication when they should. Staff administered medicines in a safe, kind and patient way. We saw that medicines were stored safely in medicine trolleys within a locked medicine storage room. However we had concerns over the access to this room. Some medication had gone missing. We also found gaps in some medicine administration records and the instructions for when people received 'as required medicines'.

People we spoke with and their relatives told us that they felt safe and in a protected environment. Staff had received training in the protection of adults and policies and procedures in line with local guidelines were in place.

Robust systems were in place in terms of recruitment. A full range of background checks including references and Disclosure and Barring Service (DBS) checks had been completed. The DBS checks to see if there is any criminal or other reason why a person should not be employed to work with vulnerable people.

People who lived at the home and relatives we spoke with all told us they thought there were enough staff to meet people's needs and keep them safe from harm. Staff rotas and our own observations confirmed this.

People we spoke with who lived at Coniston House told us they felt that staff knew them well and were able to access health and medical support as they needed it. Staff we spoke with were knowledgeable about the people they supported.

Staff had been supported to undertake a range of induction and basic training such as moving and handling, food hygiene and infection control. However staff we spoke with had not received training on the Mental Capacity Act 2005 (MCA) and the deprivation of Liberty Safeguards (DoLS). Whilst staff were witnessed to put the principles of the MCA into practice, their knowledge of what they were doing and why was limited.

Care plans we looked at showed people had been involved in planning their care and had given valid consent. Where people were unable to do so, we saw that their relatives had been involved in these discussions. We saw that all aspects of the recording and filing of DoLS applications and subsequent authorisations was good.

Staff we spoke with gave us mixed messages about staff supervision. We were unable to see any records that staff had received regular one to one supervision and appraisal during our time at the home. However we were provided with records which showed many people had received such support.

People who lived at Coniston House told us that they enjoyed the food in the home and that there was sufficient choice of nutritious food. We found the atmosphere in the dining room was calm and relaxed. Where people needed assistance this was done in a kind and unhurried manner.

People who lived at Coniston House and their relatives spoke well of the staff at Coniston House. Interaction between people who lived at the home and members of staff were seen by us to be respectful, kind and caring. People were treated with dignity and respect.

We found pre-admission assessments for people were of a good quality and consistent. Care plans we looked at contained details of personal information including people's history and background. We found them to be personalised to each individual. Each care plan contained a range of risk assessments which explained the risk how staff should monitor and deal with each risk.

There was no restriction on visiting and contact with friends and relatives. We saw no organised activities during our inspection and the activities coordinator had recently left. However the home was actively recruiting someone to fill this post. We observed that staff had little knowledge on how to engage or interact with people who lived there to entertain them.

The home had policies and procedures in place to handle and deal with any complaints. There was information available to people on how to complain if necessary and people we spoke with knew how to make a complaint.

Summary of findings

People who lived at Coniston House and their relatives were aware that there had been a number of changes in staff, both at management level and staff on the floor. They told us the new manager was approachable and supported the changes which had been made.

Staff we spoke with told us they felt happier and that there was now a better atmosphere. Staff told us they attended handover meetings at the start of every shift and regular staff meetings were held.

Regular audits and checks were carried out by the registered manager and other members of the management team for the home. We saw a system in place for the registered manager to monitor the response times when people used their call bells and a new medication audit tool had just been introduced.

We saw records of fire equipment, emergency lighting, water temperatures and the electrical system being checked. The home was also subject to internal inspections and audits by the family members of Rochcare (the parent organisation for the home), for instance the regional manager visited the home on a frequent basis.

We found that [the registered person had not protected people against the risk of people receiving their medication in a safe manner. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Summary of findings

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.

People we spoke with and their relatives all told us they felt it to be a safe place and people were well cared for. Staff had received training in the protection of vulnerable adults and policies and procedures were in place.

We found people were at risk of receiving their medication in an unsafe manner. There were shortfalls in the recording, storage and information about when people should receive their medication. We have asked the provider to address this issue.

We found there were sufficient numbers of suitably qualified staff on duty to keep people safe. Incidents were well recorded and analysed and people had personal evacuation plans in place to deal with any foreseen emergency.

Is the service effective?

Requires Improvement 

The service was not always effective.

People we spoke with and their relatives told us that staff knew them well and had sufficient knowledge to provide their care and support. However we did find that some training had not yet been completed by some staff.

Policies and procedures were in place in respect of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Where DoLS applications had been made and authorised there was good recording, oversight and audit of this process. However we found quite a number of staff had not yet completed training in the MCA and DoLS. This training has now been sourced.

People were supported to receive suitable food and nutrition. People's health was monitored and people we spoke with told us they were able to receive on going healthcare whilst at Coniston House.

Is the service caring?

Good 

The service was caring.

All of the people we spoke with and their relatives told us that staff were kind and caring. Our own observations confirmed this.

Care plans we looked at contained details of personal information including people's history and background. We found them to be personalised to each individual. There was evidence that people or their relatives had been involved in the care planning process.

Staff were able to demonstrate a good knowledge of the people they cared for and we saw staff treated people with dignity and respect.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Pre-admission assessments for people were of a good quality and consistent. Care plans contained a range of risk assessments with clear instructions for staff on how people's risks should be managed.

There was no restriction on visiting and contact with friends and relatives was encouraged. However we saw no organised activities during our inspection and the activities coordinator had recently left. The post had been advertised.

Policies and procedure were in place which gave clear instructions on dealing with complaints. People we spoke with had received information and knew how to make a formal complaint.

Is the service well-led?

Good 

The service was well-led.

People who lived at Coniston House and their relatives were aware that there had been changes in management and care staff. Staff we spoke told us they felt happier and that there was now a better atmosphere.

Regular audits and checks were carried out by the registered manager and other members of the management team for the home.

We saw records of fire equipment, emergency lighting, water temperatures and the electrical system being checked. The home was also subject to internal inspections and audits by the family members of Rochcare (the parent organisation for the home).

Coniston House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 February 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, a pharmacist and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had supported a number of friends and relatives in or moving into nursing care and advocating on their behalf with issues concerning their care.

Before the inspection we looked at information and intelligence held on our own systems. This included notifications sent to us by the provider and any whistleblowing or safeguarding information provided to us. We had not requested a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information from external sources such as various websites where people can make comments or leave reviews about services.

During this inspection we spoke with five people who lived at the home and four relatives. We spoke with five care staff, the deputy manager and senior care staff. The registered manager was not available at the time of our inspection but we spoke with her on the telephone. We also spoke with commissioners from local authorities who commissioned services from the home and health and social care professionals who visited the home to seek their views.

We observed care provided throughout our inspection, looked at a sample of three care plans during the inspection as well as three additional records relating to the Deprivation of Liberty Safeguards and 30 of the 39 medicine administration records. We used a system of pathway tracking. Pathway tracking looks at the support people receive at each stage of their care.

The registered manager was not available on the day of our inspection and the deputy manager had only been in post three weeks. As such the deputy manager was unable to locate some records such as supervision and training records on the day. We asked the provider to send these to us after the inspection to confirm what we had been told, which they did.

Requires Improvement

Is the service safe?

Our findings

During our last inspection of Coniston House on 19 March 2014 we found short falls regarding procedures for keeping people safe. A significant number of staff had not received any training in the safeguarding of vulnerable people. Policies regarding safeguarding although detailed, did not reflect locally agreed multi agency procedures. This lack of staff training and inappropriate written guidance meant that staff were not fully equipped to identify the possibility of abuse or to respond appropriately to any allegations and amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We deemed this to have had a minor impact on people. We received an action plan from the provider in which we were informed how they intended to meet the legal requirements by May 2014.

During this inspection we found that staff had received training in the protection of adults. Staff we spoke with told us they had received training in the protection of vulnerable adults and were able to tell us how they would respond to any incidents they witnessed or were told about. Training records we viewed confirmed this and we also saw sight of the certificates gained. Policies and procedures were in place for safeguarding and whistleblowing. These reflected local procedures. The deputy manager was able to show us a safeguarding log where all incidents reported to the local authority were recorded along with an audit trail and record of notifications sent to the Care Quality Commission (CQC) as required.

People we spoke with and their relatives told us that they felt safe and in a protected environment.

People who lived at Coniston House told us: “I feel safe and content here”. “I’m comfortable and happy here; it’s a very safe place”. And: “It’s a safe place to be for me”.

Relatives we spoke with said: “We have found it very good. The environment is safe and secure”. “The security is good here, dad is in a safe place”. And: “I’m so happy Dad is in here. I know he is safe and well cared for”.

People who lived at Coniston House we spoke with all told us that they received their medication when they should.

People told us: “I’m on sleeping tablets and they give them to me at 10.00 pm as I usually go to bed after that”. “I have to take inhalers and some small tablets for my nerves; they give them to me morning and afternoon”.

We looked at medication procedures within the home and saw that medicines were stored safely in medicine trolleys within a locked medicine storage room. However some medicines in the room were not locked away and the medicine refrigerator was not locked. We noted that the key to the medicine room was a master key which unlocked bedrooms as well, which meant staff not authorised to handle medicines might also have access.

We spoke with the registered manager about this who confirmed that it was the same key. This meant in the event a senior member of staff gave the medicine room key to care staff to get a person into a locked bedroom if needed, then for a period of time, however short, unauthorised staff would have access to the medicines room. The registered manager told us that the medicine room locks would be changed as soon as possible.

The cabinet for storing medicines that are controlled drugs met legal requirements. Medicines were stored at the right temperatures; however, the temperature of the medicine refrigerator was not monitored in the right way. We saw that regular readings were taken and recorded, however best practice and current ‘NICE’ guidelines state that a minimum and maximum temperature should be recorded.

Our pharmacist inspector looked at the current medicine administration record (MAR) charts for 30 of the 39 people who lived at the home at the time of our inspection. The administration of medicines (or why a medicine wasn’t taken) was mostly recorded but there were ‘gaps’ in the early morning and evening on three people’s records. We found one discrepancy between the administration record and the quantity of medicine available. This meant the record was wrong.

We watched some people being given their medicines after lunch. The member of staff administered medicines in a safe, kind and patient way. We saw that one person was prescribed a pain-killer up to four times a day if needed, but they were not asked if they were in pain. The member of staff told us that this person couldn’t tell them they were in pain so staff decided if they needed the pain-killer by

Is the service safe?

observing them. There was no written guidance on when to give medicines prescribed 'when required' for this person, or others in the home. This meant people might not receive these medicines in the way their doctor intended.

Records were kept for medicines received and disposed of, and the amount of any medicine 'carried forward' from the previous month was written on a person's medicine chart. This was so that all medicines could be accounted for.

The cabinet for storing medicines that are controlled drugs met legal requirements. Our pharmacist inspector checked the home's stock of controlled drugs (CDs) against the CD register. Controlled drugs are those which are controlled by law under the Misuse of Drugs legislation. Two CD injections that were prescribed for people but never needed had not been disposed of, and were not recorded in the register. A small quantity of another medicine was missing and unaccounted for. Staff did not carry out and record regular checks of controlled drugs. This meant there was a possibility of mishandling or misuse.

The registered manager had very recently started a programme of audits to improve medicines safety and reduce medicine errors. This had at least enabled a timescale for the missing medicine to be established and the Police informed.

These shortfalls constituted a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were aware prior to this inspection that there had been a large number of safeguarding alerts regarding this home. The majority of these related to incidents with staff recruited prior to the current manager taking up post. We had been informed and saw evidence which showed the new manager had taken a firm grip of things. CQC and the local authority safeguarding team have seen evidence of a gradual turn around. Several staff have been disciplined and subsequently dismissed. Referrals had been made to the Disclosure and Barring Service (DBS) in respect of these staff. Relatives we spoke with during this inspection were supportive of the registered manager and approved of the action taken.

The home had adapted a much more robust system in terms of recruitment. We looked at three staff files. We saw that all required checks, including DBS (criminal record background) check had been completed. Suitable references including those from previous employers had been obtained. All application, interview and identity check records had also been retained. We even noted a sign in the foyer of the home which gave instruction that ex members of staff were not to be admitted to the home.

People who lived at the home and relatives we spoke with all told us they thought there were enough staff to meet people's needs and keep them safe from harm.

People who lived at the home said: "I think there are enough staff, some days they don't turn in and they are down but there's always staff walking past the door if you need anything". "I shout if I need anything if I'm in the lounge. In my room I use the buzzer and they come to me to help me to the toilet and such". And: "They are there if they are required".

Relatives told us: "There always seems to be staff about, I know there are lots of residents but usually we see three or four staff in the lounge when we visit if he is in there". And: "I know there have been some staff changes recently and I think this is for the best, I support the new manager in what she is doing".

On the day of our inspection we spoke with the new deputy manager as the registered manager was not available. Although we were able to speak with the registered manager by telephone on several occasions during the day.

The deputy manager had been in post for three weeks but appeared confident and un-phased by our unannounced visit. We asked about staffing levels on the day and were told, other than the deputy manager there was one team leader, two senior care staff and four care staff. Also working that day was one cook, one assistant cook, one person on domestic duty.

Our own observations confirmed that there was enough staff on duty to keep people safe and provide care. We saw a nice approach and interaction between staff and people who lived there.

We saw that call bells were answered promptly. As an example during one of our observations in the ground floor lounge it was noted that there were ten residents and one staff member at one point. People were sat in chairs, some around the walls and others in two rows facing a TV which

Requires Improvement

Is the service safe?

they were either watching or they were dozing. An alarm was activated in one person's room and the staff member left the lounge and responded to it after which the staff member returned to the lounge.

Requires Improvement

Is the service effective?

Our findings

People we spoke with who lived at Coniston House told us they felt that staff knew them well and were able to access health and medical support as they needed it. People told us: "If I don't feel so good and I want to see the doctor I ask [named] or [manager] to get the doctor for me and they always do so". And: "They keep my family up to date, they visit me regularly, but if anything happens in the meantime they ring either of my two daughters and let them know what's going on".

One relative we spoke with told us: "They are onto things fairly quickly here. They get the doctor if he needs it".

Staff we spoke with were knowledgeable about the people they supported. Staff described training received such as First Aid, Infection Control, Moving & Handling, Dementia Awareness, End of Life training, Administration of medicines, Managing Challenging Behaviour and said the quality of training was good. One staff member said: "The manager tries hard to get us training, especially new starters". Although one member of staff did say: "If I could improve something I would say training, more of it and in more depth".

We looked at staff files and saw the relevant training certificates on the staff files. Staff had been supported to undertake NVQ level three and four in care. The training matrix we were shown on the day indicated low compliance on training in some areas such as Food Safety, although staff engaged in this area such as kitchen staff had completed the training. The training matrix was confusing to read and after the inspection the registered manager provided us with a comprehensive list of staff and what training each person had completed. For example we could see that out of a total of 35 staff 35 had received full induction training.

One area of concern was training around the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Staff we spoke with had not received training on the MCA and DoLS. The deputy manager and senior staff had a good understanding of the MCA and DoLS. The training list we were provided with showed that only the registered manager had received any training on the MCA and DoLS. Care staff were only able to give us general answers about how they would obtain valid consent from people, for example asking them. We saw staff asking peoples permission to assist them and provide personal care. Whilst staff were witnessed to put the principles of the MCA into practice, their knowledge of what they were doing and why was limited. Any detailed knowledge of this subject was restricted to the senior management team.

Care plans we looked at showed people had been involved in planning their care. We saw evidence that people had given valid consent and where people were unable to do so then we saw that their relatives had been involved in discussions around the care plan as part of best interest decision making.

We had previously spoken with the registered manager prior to this inspection about training on the MCA and DoLS and we were aware that attempts had been made to source appropriate and relevant training but without success. The registered manager was aware that this training was an important aspect of staff development. We have since received confirmation that training in the MCA and DoLS has been booked. 41 places have been booked for staff commencing 18 April 2015 which means staff will soon have access to this training to improve their knowledge and understanding of this area.

We spoke with the deputy manager, who although she had only been in post some three weeks was able to access the current DoLS file. We saw that three DoLS applications had been granted by the local authority and one authorisation was pending.

We looked at the paperwork and care plans for these people. We saw that all aspects of the recording and filing of DoLS applications and subsequent authorisations was good. We saw that where conditions had been placed on the home as part of a DoLS authorisation these had been

Is the service effective?

incorporated into the person's care plan. We also saw good records when the home had issued themselves with an urgent authorisation for a person, a standard request had been submitted to the local authority and there had been a delay in the assessment process. As an example, if they had not heard anything from the local authority by the end of seven days there was evidence of chase up, extension requests and weekly contact with the local authority DoLS team. In the meantime care plans were regularly reviewed to see if a least restrictive option could be put in place.

Care plans we looked at contained formal mental capacity assessments and tests where decisions around some aspects of care had to be made. We saw that these had only been completed where there was some suspicion that the person concerned may be unable to make the decision for themselves due to their cognitive level. Where people had been deemed to lack the capacity to make such decisions we saw best interest decisions had been made and recorded appropriately. We did not observe any other potential restrictions or deprivations of liberty during our visit.

During our time on site we received mixed messages around staff supervision. We looked at a sample of four staff files and were unable to see any records that staff had received regular one to one supervision and appraisal. The deputy manager was unable to assist in finding any such records. Staff we spoke with gave us mixed answers as to whether or not they had received this support. One senior member of staff told us that she had not had supervision since she started last May (2014). However when we spoke with the registered manager by telephone and later by email we were informed that this person had received supervision in November 2014 and we were sent a copy of the record. She could not understand why this person thought they had not received any.

Other staff members we spoke with told us they received regular formal supervision sessions with their manager, in addition to an annual appraisal. These meetings gave staff the opportunity to discuss their own personal and professional development as well as any concerns they may have.

We asked for further evidence after the site visit. We were subsequently shown records which showed 20 members of staff had received one to one supervisions within the 12 weeks prior to the inspection. We looked at a random sample of five records. We saw that suitable topics had been discussed. The manager told us that due to dealing with other issues with some staff who no longer worked at Coniston House that supervisions had not been as regular as they should have been. A new schedule of supervisions had been drawn up and now that a full management team was in place supervisions would be on a more regular basis.

We looked at nutrition to see if people at Coniston House were supported to receive sufficient food and drink to maintain a balanced diet. People who lived at Coniston House told us that they enjoyed the food in the home and that there was sufficient choice of nutritious food. People told us: "The food is very good, you get a choice of a hot or cold breakfast and they give you something else if you don't like what's on the menu". "I like the food here; it's excellent, if you inform them soon enough you can have what you like". "Generally the food is good here, if you don't like what's on you can ask for a sandwich. You get three meals a day and a snack at supper with a choice of hot drinks and either cake or biscuits". And: "The food is good with enough choice as far as I am concerned".

Relatives we spoke with told us: "From what I've seen the food is good, he has a cooked breakfast and can have his meals in his room if he wants". And: "The choices of food here is right for Dad. The dietician is going to assess him so that he doesn't lose weight. He will be on a weight management programme from next week".

We observed the lunchtime service in the main ground floor dining room. At 12:05pm there were eighteen residents sat at four tables, all the tables had table cloths and were set with cutlery at each chair.

Hot food was brought in a hot trolley from the kitchen and served in the dining room by one of the kitchen staff. The hot meal consisted of sausage and mash with mixed boiled vegetables and gravy. There was a vegetarian option which was a cheese and onion pasty which was offered to two people. People were offered small or large portions. Lemonade was given to each person already poured into a glass. Two staff were serving people their meal and during the next fifteen minutes four other people were walked or wheeled into the dining room and placed at a table. We did note that although there was a large board in the main dining area, in the small lounge downstairs, where some people chose to eat there was no board for food choices. The deputy manager assured us that this would be addressed.

Requires Improvement

Is the service effective?

We saw that only one person needed help with eating and was assisted by one staff member sitting alongside this person helping her eat with a spoon. This was done in a kind and unhurried manner. From time to time we saw people were encouraged by staff to eat the food in front of them. As an example, a member of staff noticed one person having trouble and offered to cut up his sausage, which was done. He had no further trouble eating. Two people who were slow eating were asked if they wanted an alternative sandwich, but they declined. One other person was slow in eating and was encouraged by staff to eat, but declined and the plate was removed. From time to time people were praised for continuing to eat their meal. Several people told us after they had enjoyed the meal and that it was tasty.

We saw a hot drink was offered to people from a pot. When the drink was poured we observed that milk had already been added and there were no milk jugs or sugar bowls on the tables. One person used his own sweetener to sweeten his tea and was handed a teaspoon to stir his tea which he then handed back, others drank it as it was served. This was mentioned to the deputy manager at the time, who seemed surprised at this but said she would look into this practice of adding milk directly into the pot.

We found the atmosphere in the dining room was calm and relaxed with staff wandering amongst the tables chatting to people, but when staff were out of the room clearing away plates and glasses the room fell silent whilst they waited for desert, which took twelve minutes to arrive. Some people took this long gap between courses as a sign that the meal was over and began to rise and leave the table. When staff spotted this they asked people to sit and wait a little longer for the desert to arrive, which when it came was bananas and custard. This appeared to be eaten and enjoyed by all people.

At the end of the meal people were offered a second hot drink, which only one person accepted. People were escorted from the dining room to the first floor or ground floor lounges or to their rooms after lunch.

People we spoke with told us they had access to health and medical support as they needed it. We were told: “I’ve seen the doctor for my chest. I have to take inhalers. I have been a bit depressed after my stroke and I now take tablets for my nerves. And: “The physiotherapist trained me to use my Zimmer after I had my stroke”.

Relatives who we spoke with also commented: “He’s had access to the GP and the District Nurse, the Nurse visits every month to give him his injection”. “He [relative] has been to the dentist and recently he has seen the optician”. And: “The dietician is going to assess [relative] to make sure he doesn’t lose weight”.

We observed during our inspection that staff from an external healthcare organisation had been brought in and had set up in one lounge trimming and cutting peoples nails to keep them tidy and clean.

Visiting health and social care professionals we spoke with told us: “There have been two episodes of pressure damage but they have been caused by rapid change in patients condition on both accounts. I feel that the advice we give staff and service users regarding preventing pressure damage is being utilised”. And: “[The manager] and I communicate often and feel that the team she is building is proving to make significant changes for the good. As a [named team of nurses] we are happier in attending with the reduce worry of service users”.

Good

Is the service caring?

Our findings

People who lived at Coniston House and their relatives spoke well of the staff. People who lived there told us: "I get on ok with the staff. They have taken me out this morning for my cigs. To be totally honest, this is a good home, I can't fault the staff whatsoever, they have a lot to put up with but they still come in here and have a chat with you". "The staff do really well for us here, they are very nice". "Some of the staff have changed recently and it takes a while to get used to them but they seem very nice". And: "I think its brilliant here, the staff are so kind, you really feel like you are being looked after".

Relatives we spoke with said: "We visit regularly and we have found it excellent, considering his [their relative's] physical condition they could not do a lot more than they are already doing for him. I would say the staff are respectful to all the residents here". "I have a good impression of the home, the staff are respectful, courteous and professional". And: "I feel confident in the staff here, the atmosphere is good and the staff are wonderful with him".

Coniston House operated a 'key worker' system. This is where a member of staff takes on special responsibility for the particular needs of a small group of people who live at the home. People had regular one to one meetings with their key workers. This provided people the opportunity to, discuss their needs and express their wishes with an opportunity to feedback about the service or raise any concerns they had. It also provided a useful conduit for information to relatives. The deputy manager informed us that it was one way of trying to get the care staff more involved with people.

Relatives we spoke with were familiar with key working arrangements in the home and that these were currently limited to seeing to incidentals like toiletries, one said "I know that Dad has a key worker. She talks to me about getting things for him that he needs, soap and shampoo and suchlike". And: "They told me about Dad's key worker".

Care plans we looked at held information about people's lives and achievements. Each care plan had a person centred profile which contained such things as specific words people used. It was clear from evidence within those plans and from what people told us that people and/or their relatives had been involved in developing their own life history profile.

Staff we spoke with told us: "I read the new care files and check their preferences". "I do a room check when I arrive, some might wish to get up at 6am, others between 8am & 11:30am. Breakfast is available 8am till 11am and I get them a drink before that if they want it". "It's about time they get something back". "I let them do as much as they can". And: "It is really good care".

During the three periods of observation, when people who lived at the home and staff were together the interaction was seen to be respectful, kind and caring with many staff holding hands or touching people to communicate, calm and reassure them. However, there were periods when human engagement was absent because staff and people who lived at the home were not together and most people were unable to converse due to their cognitive impairment.

During our last inspection of Coniston House on 19 March 2014 we had some concerns that people's privacy and dignity may have been compromised by the CCTV (closed circuit television) system in place at that time. Cameras monitored a number of exits, including the main door and fire exits. We were told that this was for security purposes. However, filming also captured activity in some corridors and part of the seating area in the main entrance. This could compromise the privacy of people who lived at the home.

During this inspection we noted that cameras had been adjusted. They now only covered that main entrance door, and emergency exits and fire escapes. No communal areas were covered. Policies and procedures were in place. Recordings were kept on a computer hard disc drive (HDD) for a period of three months before automatically being deleted. Access was password protected for the management team only. It was only ever viewed as and when required, such as after any incident.

People's privacy and dignity was respected. One person told us the staff respected their privacy and said: "They always knock before they come into my room; I prefer to lock my door as some people will come into your room, the staff have a key to open it, but they knock and shout before they come in".

People choose whether to be in communal areas or have time alone in their room. We saw that many people had

Good

Is the service caring?

keys to their own rooms. These decisions were respected by staff. We saw there was quiet space available if people wanted private conversations or time alone with visitors in an area other than their bedroom.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection of Coniston House on 19 March 2014 we found short falls regarding pre admission assessments that had been carried out before people were admitted to the home. The quality and quantity of this information varied. Risk assessments addressed areas such as; falls, mobility, skin integrity and personal safety. However we noted some risk assessments conflicted with the information in the corresponding care plan, regarding falls and pressure care. This amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We deemed this to have had a minor impact on people. We received an action plan from the provider in which we were informed how they intended to meet the legal requirements by May 2014.

During this inspection we found pre-admission assessments were of a good quality and consistent. There was sufficient information to show a person's needs and if the home was in a position to meet those needs. We also saw that the pre-admission assessment fed into the initial support plan and covering key areas of need.

Care plans we looked at contained details of personal information including people's history and background. Plans were personalised to each individual and not just a description of tasks to be completed. We saw from records that care plans and other records were reviewed on a regular basis or when changes occurred which meant staff had the most up to date information available to help them support people. We saw evidence that people had been involved in their care plans and reviews where possible and where not we could see people important to them had been consulted. Where people were unable to make some decisions for themselves and there was no family to consult with, people were able to access advocacy services to ensure they had someone to support them.

We saw from care records we looked at that risk assessments were in place and gave good detail of the risk around particular areas and how staff should monitor and deal with the risk. As an example we saw detailed recording around the risk to one particular person, the subject of a DoLS authorisation, around how risks of this person attempts to leave to home should be managed. Risk assessments were reflected in people's care plans and each contained an overall summary which gave a good overview for staff to look at and see at a glance, people's needs and requirements.

We looked at what activities were available for people to take part in. Most people were sat in chairs in the upstairs lounge, some around the walls and others in two rows facing a TV which they were either watching or they were dozing. We saw during periods of observations in the lounges the only activity that was available was batting a balloon around in the first floor lounge. This was undertaken with the TV still on and not everyone was able or wanted to join in.

We were informed by the deputy manager that the activities coordinator had left and there was a staff vacancy for this post of twenty-five hours a week which was due to be advertised. This would help to organise structured activities. However we were concerned that people who lived at Coniston House were self-interacting and staff appeared to have little knowledge or skill on how to interact.

By way of example, we saw one person leave the lounge and was then approached by a staff member in the corridor. The remaining staff member in the lounge left to retrieve a person's spectacles from his room, leaving the lounge without staff. The person in the corridor was approached by three other staff members who begin a conversation with him. At this point there were four staff in the corridor conversing with one person and no staff in the lounge with ten people. This situation persists for several minutes. The staff member who had left returned to the lounge gave the person his spectacles, placing them on his face. The conversation in the corridor ended and one staff member entered the lounge and started to converse with the staff member already there. This staff member then left and returned minutes later with a cup of tea for one person, after which the staff member sat down next to another person and started to converse.

There were no organised activities in the ground floor lounge except for watching TV. There did not appear to be any activities which either focussed on the care plan objectives of the individual person or were designed to enrich people's experience of living at the home. Two other members of staff were observed either speaking to people

Requires Improvement

Is the service responsive?

individually and some people were having their finger nails trimmed. We saw no other activities and no evidence of community engagement or use of relatives/ volunteers to assist in activities.

Staff we spoke with did say to us: "The best thing here is the banter you can have with the residents". And: "If I could improve anything it would be activities. Sometimes they get bored".

There was no restriction on visiting and contact with friends and relatives. People we spoke with reported that they could choose what to do when to go to bed and when to rise in the morning. One said: "I decide when to go to bed and if I want a lie in in the morning that's OK". "I decide when I go to bed and if I want another half hour in the morning they let me sleep in". Two people told us: "My daughter and grandchildren can come any time". And: "People can visit any time".

Relatives we spoke with confirmed that they could visit without restriction. We were told: "We can come at different times and on different days of the week, we are always made welcome". "I can visit at any time". And: "I can come any time and they ring me at home if anything happens they think I should know about".

The home had policies and procedures in place to handle and deal with any complaints. There was information available to people on how to complain if necessary.

People who lived at Coniston House and relatives had no complaints about the home and those that had any concerns felt able to approach the staff in the office to seek a resolution. People told us: "It's a well-run home and I have no complaints, but if I did I would talk to [named] the manager. I was in the office the other day, we talk regularly about things". "The new manager said to me 'If you have any trouble, come to me'. She comes round and talks to you and you can tell her what you think".

Relatives we spoke with said: "If things aren't satisfactory you can talk to the staff. We have been worried about him [their relative] losing weight, but the staff are very approachable and they listened to what we said and keep an eye on what he is eating more now". "You can speak to them openly and frankly about what is going on. The staff seem to in good control of things when you mention anything to them".

Good

Is the service well-led?

Our findings

People who lived at Coniston House were aware that there had been some changes in the staffing arrangements, both at management level and staff on the floor. We were told: "The new manager is very nice. She comes round and talks to you". "Since the new manager came we have meetings in the office and they tell us what they are doing". And: "The staff have changed and it takes a while to get used to them".

One relative said "I'm content with the staff changes and I support what the new manager is doing".

Since our last inspection on 19 March 2014 there had been a change in the management situation at the home. The previous manager who had not registered with the CQC had left and a new person appointed. This person had registered with CQC as the registered manager and had implemented many changes. This had included a number of disciplinary hearings regarding unsuitable staff. A number had been dismissed over a period of time and new staff employed. A deputy manager had also been employed and we were able to speak with this person during our inspection.

People who lived at Coniston House commented that they thought the new manager was approachable. We were told: "The new manager said to me 'If you have any trouble come to me' she is always showing her face". And: "If I was worried about anything I would talk to the manager".

Staff we spoke told us they felt happier and that there was now a better atmosphere. They were supportive of the new registered manager and had a good understanding of their roles and responsibilities. Staff said they felt supported by management. Staff we spoke with told us: "I think the registered manager is brilliant". "We are getting better. I'm happy here". "The manager is very supportive. She will talk me through my problems". "The deputy is on the ball. That's what we need". And: "There is a really good team here".

Some staff mentioned the overall improvement and effect some of the changes had on the staff team: "It has been hard with staff. Respect has to be earned. We are working together now." "Some are finding it hard to accept the changes".

Staff told us they attended handover meetings at the start of every shift and regular staff meetings were held. We were informed by management and staff we spoke with that one was scheduled for the Thursday of the week we inspected (12 February 2015). This kept staff informed of any developments or changes within the service. Staff told us things had improved at the home and they felt their views were considered and they felt more supported in their roles. The deputy manager informed us there was a senior staff meeting every two weeks. However she did say that meetings for people who lived at the home had not occurred recently. This would be addressed.

We were shown minutes from several 'resident and relative' meetings which had taken place along with a selection of comments from past satisfaction surveys. All of the comments we looked at were positive about the service provided. The registered manager did tell us after our visit that they would be conducting another survey soon but staff changes and sorting out some of the past concerns had taken priority to make sure people received safe and effective care.

The service had provided us with a current statement of purpose. Clear lines of responsibility and accountability were in place throughout the home.

Regular audits and checks were carried out by the registered manager and other members of the management team for the home. Staff we spoke with also informed us that a new care plan audit was being prepared which would be used by the registered manager, deputy & team leader. These helped to ensure that high standards were maintained. We also saw that there was a system in place for the registered manager to monitor the response times when people used their call bells and a new medication audit tool had just been introduced. Regular daily, weekly and monthly audits were completed on, accidents and incidents along with staffing requirements and many other aspects of the home.

Records we looked at evidenced that safety checks took place. We saw records of fire equipment, emergency lighting, water temperatures and the electrical system being checked. Risk assessments addressed the potential risks of using certain equipment at the home as well as making sure that the correct environment was maintained for the diverse needs of people who stayed at the service.

Good

Is the service well-led?

The home was also subject to internal inspections and audits by the family members of Rochcare (the parent organisation for the home), for instance the regional manager visited the home on a frequent basis.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with the administration of their medicine. There were concerns over access to medicines. Some medication was missing. There were gaps in recording and instructions for 'as required' medicines. Temperatures of the medicine refrigerator were not monitored in the correct way. Regulation 12 (1)(g).