ADL Plc

Charlton Court Nursing Home

Inspection report

477-479 Bradford Road
Pudsey
Leeds
West Yorkshire
LS28 8ED

Tel: 01274661242

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Charlton Court Nursing Home on 16 November 2016. The visit was unannounced. Our last inspection took place in July 2015 where we identified two breaches of legal requirements regarding staffing. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations and a clear time frame in which they would complete this. On this visit we checked and found improvements had been made in all of the required areas.

Charlton Court Nursing Home is a large, purpose built nursing home with accommodation for up to 60 people. It is located in a residential area of Leeds close to the boundary with Bradford. There are a number of communal areas including lounges, dining rooms and a garden.

At the time of our inspection the service had a manager who was going through the registered manager's process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service and their relatives told us the service was safe. The home looked well maintained, clean and tidy, and checks were carried out to make sure the premises and equipment was safe.

There were sufficient staff with the right skills and experience; several staff told us the staffing arrangements had improved. Appropriate checks were carried out before staff were employed and medicines were managed safely.

People who used the service and their relatives told us they were happy with the staff that provided care and support. Staff we spoke with said they felt well supported and understood their role as they received training that made sure they knew how to do their job well. Staff we spoke with understood their responsibilities around how they should support people with decision making. People enjoyed the food, and had plenty to eat and drink.

People told us they were well cared for and visiting relatives told us the service was caring. We observed staff supported people in a calm, compassionate and caring way. Staff were cheerful and friendly. When staff assisted people to move and transfer they explained what was happening and reassured them throughout. Systems were in place that ensured people accessed healthcare services.

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Staff responded to people's individual needs and delivered personalised care. People's care plans and other records showed their needs had been initially assessed and care was usually planned, although there was inconsistency with the level of detail within the care plans and we saw examples where care plans had not been followed. Care plans did not contain appropriate records to show people's capacity to make different

decisions had been assessed. The manager had identified care plans as an area for improvement and action was also being taken to improve activities in the home.

People told us they would talk to staff and management if they had any concerns and complaints had been responded to in a way which resolved the issue where possible to the person's satisfaction. Several written compliments had been received.

We received positive feedback from people about the manager. Resident and relative meetings and staff meetings were held. We saw from minutes of meetings that people had opportunities to discuss the service and were informed of planned events.

At the inspection we reviewed a wide range of audits which had been completed at the service which were used to monitor the quality and safety of service delivery.

We have identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection. 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.

Systems were in place to help keep people safe which included safeguarding them from abuse.

There was enough staff to keep people safe.

Medicines were managed safely. However, temperature was not consistently recorded and medication had been left unattended.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood how to support people with decision making, however capacity assessments was not always completed.

A range of professionals were involved to help ensure people stayed healthy.

Staff were trained to carry out their roles and responsibilities appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People were listened to and enabled to exercise preferences about how they were supported.

People said staff were kind and caring, treated them with dignity and respected their choices.

On the day of the inspection we found people were not always receiving person centred care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they knew how to make a complaint if they were unhappy and they were confident their complaint would be investigated by the manager and appropriate action taken.

The manager had identified care plans as an area for improvement and action was being taken to improve them.

People and their relatives told us activities were limited in the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager was going through the CQC registration process. The management team were open, supportive and were present and approachable throughout the home.

People who used the service, their relatives and staff members gave positive feedback about the manager.

The provider had systems in place to monitor and improve the quality of the service. However some audit action was not followed through.

Charlton Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 November 2016 and was unannounced.

At the time of our inspection there were 49 people using the service. During our visit we spoke or spent time with nine people who used the service and eight relatives. We spoke with nine staff members; including the manager, deputy manager, two nurses, four care staff and the cook. We spent time looking at documents and records related to people's care and the management of the service. We looked at four people's care plans and seven people's medication records.

The inspection was carried out by two adult social care inspectors 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.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications. Before the inspection providers are asked to complete 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 contacted the local authority and Healthwatch. We were not made aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2015, we found that people had not been safely protected because the provider did not always ensure sufficient numbers of suitably qualified staff were deployed in the home. At this inspection we found the provider had taken appropriate action and was now meeting that part of the legal requirement.

People spoken with told us they felt safe. Some of the comments were, "Before I came here I kept falling at home. Just being here I feel safe." "Oh yes they are always careful. They know what they are doing. No problem here." "They are always patient and gentle. I am safe here."

A relative of a person told us, sometimes people wandered into their room but had no concerns about this as there had never been any incidents of aggression. One person said, "I feel safe and my door is closed on an evening." Another person said, "I walk with my frame and staff know I sometime fall if I am in a rush or distracted, they would help and support me."

During this inspection we saw staff were visible around the home and responded to calls for support/help within an acceptable time.

However, a relative said they did not think there was enough staff to meet people's needs and gave us an example of where support was not available. They said the family had become worried because their relative was losing weight and needed more help at meal times. They said there was not enough staff on duty and their relative was left to "Fend for themselves," with staff, "Putting a spoonful of food in their mouth when passing." The family said they now took it in turns to come at mealtimes to assist their relative. This information was relayed back to the manager who told us this concern was expressed to them some time ago and they now ensured enough staff were available at mealtimes but the relatives still continue to come around that time.

Other people said, "If I press the buzzer the staff come pretty quick." Another person said, "Generally there is enough staff but if they are short they bring someone down from upstairs." The person went on to say, "They work very hard, sometimes I have to wait to be changed but they always pop in and tell me when they are dealing with someone else and will get to me when they can."

The manager told us they had had eleven staff working on the day we inspected. This included a nurse, two unit managers and eight care staff. In addition there was a housekeeper, two domestic staff, a chef and a kitchen assistant. The manager told us this was the regular daily staffing total for six days each week. At night the manager told us five staff were on duty including one nurse. The staff rota we looked at confirmed this.

We saw there were sufficient numbers of staff available to keep people safe. The manager told us staffing levels were determined by the number of people and their care and support needs. Staff told us they felt there were enough staff to ensure the service was safe. One member of staff we spoke with told us,

"Generally we have enough staff but on occasion we can be very busy." Another staff member said, "There is always something to do, we are busy but have enough staff."

We looked at the recruitment records of four staff members. We found recruitment practices were safe. Relevant checks had been completed before staff worked unsupervised at the home which included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

In the PIR the provider told us, 'Our Policies and procedures are in place to protect residents, staff and visitors from potential harm or abuse. Staff are trained on how to recognise signs of abuse and how to report as well as what actions may be taken. Any safeguarding alerts are dealt with and lessons learned.'

We asked people if they felt safe in the home. All said they had never been harmed and stated that staff were kind and gentle when providing personal care and were competent when using lifting equipment. We observed staff using the hoist and supporting people to move and saw this to be carried out safely and competently with no signs of distress in the person. We saw staff hoisting a person into their chair, then made sure they were comfortable, while explaining what they were doing and chatting during the process.

Staff we spoke with told us people were safe. They said they had received training around keeping people safe and protecting people from abuse. Staff understood they had a responsibility to report any concerns to management who they said would deal with things appropriately. Staff told us the provider had a whistleblowing procedure. Whistleblowing' is when a worker reports suspected wrongdoing at work.

In the PIR the provider told us 'Staff who administer medication are qualified to do so and competency assessments are undertaken. These are done at least annually or more regular if concerns were raised or identified through regular medication audits. All residents have a medication overview sheet attached to their MAR sheet as well as a picture to identify them.'

We looked at how medicines were managed and observed a nurse during the morning medicines round. The nurse was calm and efficient and followed good practices to ensure medicines were administered safely. Some medicines were prescribed with special instructions about how they should be taken in relation to food. We saw there were arrangements in place to make sure these instructions were followed. We found records in general were all accurate. This meant all people in the home had received their medicines as prescribed.

We looked at nine random medication administration records (MAR) sheets. These were checked and administration was found to be accurate in terms of stock held. All but two MARs had a photograph of the person for identification purposes. The manager said this would be addressed. Any incidents of non-administration or refusals were noted on the MAR sheets.

As and when required (PRN) drugs were in place at the home. It was noted that there were protocol sheets with the MAR records indicating the rationale as to when they could be given and why. This meant there was guidance in place for staff to follow.

Topical medication administration records (TMAR) were used to record the administration of creams and ointment. These had information about how often a cream was to be applied and to which parts of the body by using a body map.

We looked at medication storage and saw the medication room was well-lit and spacious enough for the amount of medicines required. All medicines were stored securely. However, although daily temperature records confirmed that medicines were stored within the recommended temperature ranges to ensure their safety and effectiveness. The temperature was not consistently recorded. The manager said they would ensure staff keeps this record up-to-date. The storage and recording of controlled drug medicines which require extra security was managed safely.

We looked at staff medication competencies which were in place and up to date. This showed staff who were giving out medicines were competent to do so.

Medicines for return to the pharmacy were sent through as required. This medication was recorded in a specific book for the purpose. Any remaining medication and clinical waste was collected and signed for by a specialist contractor.

We asked people if they had any issues regarding their medication and how staff reacted if they were in pain or unwell One relative told us there were times that tablets were left on the table with no water to wash them down. A few times they had seen tablets left on the table when they visited and one day they had found one on the floor. The manager told us this concern had not been brought to their attention. Other people told us that the nurse stayed with them until their medication had been taken and that medicines were given out around the same time each day.

People also told us they were kept comfortable and free from pain and were given paracetamol if needed or the doctor was called if they felt ill. Some comments were: "Tablets. They always stop with you when they give you them." "If you're in pain they will give you something. I fell and hurt my hip and they sent for the doctor straight away and didn't touch me in case they did some damage." "I get my inhaler twice a day, never any problem it's always on time." One visitor said their relative needed insulin injections and they had always received their medication on time with no problems.

Care plans contained a generic risk screening tool. This was a tick-box form which showed which risks were known to be associated with each person's care and support, and where there was risk identified actions taken to minimise these had also been selected. Areas in which risk could be identified included falls, nutrition, pressure ulcers, infection and contractures. Care plans contained information which would alert staff to risk, however we found the guidance was not always detailed. For example, we saw from one person's risk screening tool they were at risk of developing pressure ulcers. In the 'How to keep me safe' section of their care plan we saw this risk highlighted, however the guidance showing staff how to provide safe care did not provide information on how to help maintain the person's skin integrity or state what monitoring should be done. We spoke with the manager about this. They told us they had identified this as an area for improvement.

Requires Improvement

Is the service effective?

Our findings

In the PIR the provider said, 'Every resident has a care plan in place, this identifies their likes, dislikes, personal preference and highlights any risks. Care plans are used by staff to ensure residents' personal and preferred daily routines are met. Care plans are person centred and residents and relatives are asked to input as much as possible. Also where possible residents are encouraged to choose their own rooms and decorate them with personal items. On admission residents are allocated a key worker who amongst other things can help with ensuring their room is filled with personal items to make it feel more homely.'

People told us they thought the staff were competent when providing care and support. Examples we were given demonstrated that staff were sensitive to people's individual needs and enabled them to keep their independence. "I can manage to dress myself on my own so I don't want them to help but they come and check me to make sure I am alright." Another person said, "I'm afraid of the hoist and staff have accommodated this by not insisting and enabled me to stay in bed whilst I recovered, which is what I wanted."

Relatives told us they felt involved in their loved one's care and had participated in needs assessments and care planning. Staff were described as open and approachable and kept family informed of any concerns. One relative said: "I live down South so ring three times a week; they are always cheerful and responsible, keep me updated and if they are busy always ring me back." A visitor whose relative had only been in the home for just a few weeks said they had been involved in discussions about their needs and that this was an on going conversation each time they visited. Another visitor told us they had discussed their relatives care needs. They said, "They explain everything, what they are doing and why. We thought mum should stay in bed more but they explained that they had to get her up to prevent bed sores."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care plans did not contain appropriate records to show people's capacity to make different decisions had been assessed. Assessments of capacity should state what decision the person is being asked to make. We saw capacity assessments showing whether people could consent to living at Charlton Court had been carried out by external assessors as a part of the DoLS authorisation process. One person's care plan

contained a capacity assessment which did not state what decision was being considered. Although it was stated on the assessment that the person lacked capacity, and we saw this was referred to throughout their care plan. Another care plan contained no capacity assessments; however reference was made to the person lacking capacity. This meant people may not always be supported to make decisions in the appropriate way.

Care plans did not contain records which showed how consent for areas of people's support such as living at Charlton Court, administration of medicines and sharing of information had been obtained. People who had capacity had not signed documents in their care plans, and we did not see records of best interests decisions made for people who lacked capacity. We saw one person's room had an additional restriction in place. We asked about consent for this, and the manager told us the person's family had requested it. The person lacked capacity to consent to this, and we saw records stating a family member had Lasting Power of Attorney for health and well-being matters; however there was no record of a best interest's decision having been made. There was a hand-written amendment on the person's care plan. The manager told us this would be addressed.

This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eleven people had an approved DoLS in place, and the provider recognised when an application was required were and making these applications in a timely way. Two records we looked at showed the DoLS had additional conditions which the provider was expected to meet. We did not see records which showed what the provider had done to comply with the conditions. For example, one condition stated, "[Name of person] should be supported to have walks within the unit and outside as well. [Name of person] should be accompanied by staff off the unit." There was no plan in place to show how this need would be met, and there was no record of the condition on the person's DoLS in the care plan. We spoke with the manager about the conditions on people's DoLS, and what was in place to ensure these were met. They told us, "There's nothing written down, and for some of them the conditions aren't things we could do now. There have been changes in risk and mobility that mean they couldn't achieve what is being asked for." The manager told us they would contact the authorising authority to discuss the conditions.

Staff we spoke with said they had received training about the MCA and the training record we reviewed confirmed this. Staff had good knowledge around when they should support people with decision making and when people had the right to make decisions even though these might be unwise.

Staff said they received a good induction which had prepared them well for their role. We saw the provider had introduced the Care Certificate for new staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. There was also a comprehensive induction programme in place which gave staff plenty of opportunity to discuss their role and receive feedback on their performance.

The manager confirmed following induction training all new staff completed a programme of mandatory training which covered topics as dementia awareness, infection control, emergency first aid and health and safety. Staff spoken with told us training was discussed during their one to one supervision meetings. The training matrix showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date.

The staff team confirmed they received regular supervision and yearly appraisals. Staff told us this was a two way process. They felt comfortable to talk with the manager about anything and feel supported.

We saw visits by health and social care professionals were recorded in people's care plans, together with notes relating to advice or instructions given. We saw people had access to a range of visiting professionals including GPs, opticians, psychiatric services, memory teams, safeguarding teams and dieticians.

All care plans we looked at indicated people had a level of nutritional risk, and we saw a malnutrition universal screening tool (MUST) had been used to record people's weights, and calculate the level of risk. We did not always see guidance in the care plan was being followed. For example, one care plan stated the person's intake should be recorded in a food diary. This was not being done. Another care plan stated the person should be weighed weekly. We saw their weight had last been recorded on 16 October 2016, and the previous weight was recorded on 1 September 2016. This meant measures put in place to minimise risks of malnutrition might not always have been effective. The manager said staff would be reminded to follow what is agreed.

People told us they got plenty to eat and drink and we noted that there were jugs of water available in all the rooms we entered except one. A cooked breakfast was offered to people in the morning and a hot meal at lunch and tea-time.

People told us they enjoyed the food and were given choices about what they had to eat. Responses were positive and we got some good comments about the cook who seems to have gone out of their way to ensure people were encouraged to eat. Some comments were: - "The food is quite good. The cook checks I'm eating and if not she will bring me something else. One day I didn't like it and she made me some egg and chips." "The food is right nice. You get a choice if you want something else to eat." And "The food is alright, we get options but my family bring me things to eat." One person's daughter said, "mum wasn't eating at first so the staff encouraged me to stay for lunch which I did a few times and found the food excellent."

We observed the lunch time meal and saw that the food looked nutritious and appetising. There was enough staff on duty and some people were given appropriate support to enjoy their food but we noted two people were struggling to cope. We saw staff came to assist those people. The meal served was in large chunks and they were struggling to fit the food onto the spoons and into their mouths. Staff came and cut up the food and supported those people.

We noted that people were waiting at the dining tables for lunch at least 45 minutes before the food was served. We saw one or two people became a bit agitated at the long wait and one person kept asking if they were going to get any food. We relayed our findings back to the manager who told us they would ensure people's experiences at meal times are better and ensure people were taken to the dining room when meals ready to be served.

Requires Improvement

Is the service caring?

Our findings

In their PIR the provider told us 'Staff treat residents with dignity and respect, they knock on doors before entering and offer choices at all interventions. Staff are aware which residents are unable to initiate conversations. Staff are aware of the importance of confidentiality and the importance of storing records securely. Residents are listened to if they have any concerns.'

People told us the staff were kind and caring and the comments about the standards of care were generally complimentary. However two relatives told us of incidents where staff had not been as responsive to people needs and we also experienced a situation where someone who was in pain and discomfort was ignored by the staff. These incidents occurred on the first floor where people had higher level needs and consequently were a lot more demanding. The manager was told of this by the inspectors and agreed this would be addressed.

One relative spoken with said things had improved at the home over the last few months since the new Unit Manager had been recruited. They said that [name person] provides stronger leadership and direction to the staff and they are now better organised.

We found care plans lacked information relating to aspects of peoples lives including their likes, dislikes, hobbies, interests and social networks. This information would help staff form relationships with the people they support, and promote person-centred care. We saw the manager had begun to gather information from people and their families in order to address this. We did not see evidence people were involved in the writing of their care plans. People or their representatives did not sign care plans.

We observed during the day that staff were clearly visible and supported people in a calm, compassionate and caring way. Times for people to get up were flexible. Staff were cheerful and friendly. When they walked by people they would acknowledge them and checked if they were fine. When staff assisted people to move and transfer they explained what was happening and reassured them throughout. People looked well cared for and consideration had been given to people's dress, their clothing was clean and footwear was appropriate.

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence; for example, by encouraging them to make choices about how they spent their time at the home and always asking them for their consent before assisting with their personal care needs. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people and people were provided with the opportunity to make decisions about their daily lives.

We noted that staff treated people with dignity and respect, addressed people by their first names and knocked on doors when entering rooms. One person said, "They always treat me with respect. Shut the door and close the curtains when they are doing something." They went on to say at first they felt uncomfortable about a male carer washing them but said he always asks first and they feel ok about it now. A relative said

their father had at first felt embarrassed when being provided with personal care but the staff had put him at ease and he was comfortable with it now.

When we looked around the service we saw there was information displayed in communal areas to help people understand procedures and keep them informed. There were notice boards which had minutes of resident and relative meetings. The provider had displayed the report following the last CQC inspection. Information around advocacy and safeguarding people from abuse which informed people about what action they should take when they had any concerns was also displayed.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider told us 'Care, treatment and support is consistent. Residents are given choices around their care and these are respected. A pre-admission assessment is done to ensure we can support them in the home and meet their needs. Care plans identify how an individual likes to spend their time and how they like to be supported, it also identifies that staff have had discussions with families to indicate what may cause anxieties and how to avoid this from happening.'

Care plans contained an assessment of people's care and support needs carried out before they began to use the service. This meant the provider had checked to make sure they could meet people's needs. From this assessment risk was assessed and a series of care plans written.

We saw care plans were reviewed monthly, with notes to explain what if anything had changed or why the care plan should remain unchanged. Whilst this was evidenced, the detail within the care plans was not always adequate and up-to-date. The care plans were reliant on the initial assessment made when the person was admitted to the home and did not always refer to currient lifestyle changes or capture all physical and/or mental impairments. We did not see evidence of people's involvement in this process. An annual review was carried out with people, their families or representatives. This recorded details of any concerns raised and changes to the care plan made as a result. People involved in the annual reviews signed the document.

Care plans contained records to show what activities people had participated in. These records did not evidence people had access to a varied and regular programme of activities. The manager told us, "I had recruited someone to lead activities, but they left with no notice. I am trying to recruit someone else, but it has to be the right person."

On the day of our inspection, we noted people spent their time either sleeping or watching television. Other than this there was no other form of stimulation on offer. This in particular was commented about by one of the relatives we spoke with. They said, "Occasionally they will take some people downstairs if there is something on but otherwise there's nothing for them to do". They told us about one person who occupied themself by dusting but the cloth had been taken away from them by staff. Another person enjoyed colouring but again the crayons had been taken away by staff.

The people on the ground floor said there were occasional events such as exercises and quizzes and a singer was also mentioned. There had also been parties for D Day and Halloween. However we did not see anything to suggest a structured and organised programme of events that people could look forward to. There was no planned programme observed although one relative told us information was sometimes put on the notice board. Another relative told us that there was 'not much going on at the moment' as the previous organiser had left.

The manager agreed this is an area for development in the home once they have the resource in place which would help to improve the quality of life of the people. We concluded that activities did not regulary take

place at the home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had complaints procedures in place. We looked at the records of complaints and concerns raised about the service and saw these were investigated appropriately. We saw records relating to any investigation or communication which had taken place and could see any actions which had been taken as a result. Two of the relatives whose family members had moved into the home recently said the complaints procedure had been explained to them.

We saw the provider had received a number of written compliments from people or their relatives. Comments included, 'I cannot thank you enough for the care and compassion shown to [name of person] whilst they were with you.' 'We wanted to thank you and your staff for looking after [name of person] over the last years of their life. You looked after them well and we always felt they were in safe, caring hands,' and 'Thank you to all at Charlton Court for making [name of person]' 102nd birthday such a special day.'

Requires Improvement

Is the service well-led?

Our findings

In the PIR the provider told us 'The manager operates an open and transparent culture and is responsible and accountable for running the home. They operate an open door policy where staff are encouraged to bring concerns regarding care or treatment of residents or staff behaviours to their attention immediately, they are also aware who to contact in the manager's absence. They challenge poor practice and unacceptable behaviour with the support of the company director where necessary. Relatives are encouraged to raise any concerns they have at any time.'

The service had a manager who was going through the registration process with the CQC. We received positive feedback about the manager. Comments from relatives included, "[Name of the manager] is brilliant, always welcoming and always takes time to speak to us. We would definitely recommend this home. "The place is clean and does not smell. They are very welcoming. One member of staff said, "The service has really improved. [Name of manager is very good. She is a strong leader and I can speak to her about anything." Another member of staff said, "The manager is very approachable." Throughout the inspection the manager was receptive when areas for improvement were identified; they said they were keen to develop the service and wanted to make continual improvement.

The manager and provider conducted a series of audits to monitor, measure and improve quality in the service. These covered areas such as infection control, medicines, catering, premises and dignity and respect. We saw these were completed regularly and where issues had been found actions had been identified to show how improvements should be made. These were used to create an action plan for the manager to work from. However there were issues in relation to care plans, meaning the provider had not robustly checked the quality of the care planning in the service. There were a lack of activities for people in the home.

We saw records of accidents and incidents were analysed monthly, to show when and where incidents had occurred. We did not see any analysis of this data to show whether it had been used to identify any trends which may indicate further action was required.

Staff we spoke with said communication and support within the service was good. We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home. Staff said the manager and senior management team maintained a visible presence in the home and often spent time with them and people who used the service. One staff member said, "[Name of manager] is out and about all the time, chats to everyone and find out what's going on around the home."

We saw there were regular 'relative/'residents' meetings where people were encouraged to contribute and discuss matters. Topics discussed were staff changes, how to raise concerns and menus. Dates for future meetings were displayed. A relative told us about a monthly residents meeting but had not attended any of these.

The home used survey questionnaires to seek people's views and opinions of the care and support they

received. Information provided was collated and an action plan formulated to address any concerns or suggestions made. The results was displayed in the reception area. We looked at a number of completed questionnaires from people who lived in the home and their relatives. The comments received were positive and people were pleased with the standard of care and facilities provided. Comments included "Completely satisfied with the care and condition of the home, and general helpfulness of friendly staff" and "Good general and personal care."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Evidence of consent was not always available as well appropriate records to show people's capacity.