Care UK Community Partnerships Ltd

Charlotte House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 28 June 2016 and was unannounced.

The last inspection took place on 15 February 2016 when we found two breaches of Regulations relating to consent to care and treatment and person centred care. The provider sent us an action plan telling us they would have made the necessary improvements by 30 June 2016.

Charlotte House is a nursing home for up to 56 older people, some people are receiving support at the end of their lives and some people are living with the experience of dementia. At the time of our inspection 35 people were living at the home. The home was managed by Care UK, a national organisation who provided care and support.

The registered manager had left the organisation since the last inspection. The provider had recruited a new manager and they were in the process of applying to be registered. 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 and associated Regulations about how the service is run.

People living at the service were happy there and felt their needs were being met. The relatives of people were also happy with the care at the service. People's preferences and wishes were taken into account when providing care and they were asked for their opinion about the care they received and the service. People received a choice of freshly prepared nutritious meals. Their health and wellbeing were monitored by the staff who worked closely with other healthcare professionals.

The staff were appropriately supported and trained. They were recruited in a way to ensure they were suitable to work with vulnerable people. There were regular team meetings and staff received the information they needed to care for people. People said that the staff were kind, caring and polite. However the staffing levels and deployment at the service meant that sometimes the staff could not spend time delivering quality care and people were unhappy about this. For example, during busy times of the day the staff did not always have time to offer people the support they wanted and there were not enough staff to deal with unexpected situations.

The service was well managed. The new manager had been in post for three weeks and was supported by the provider's operational support manager and regional clinical lead who had worked full time at the service since December 2015. They had helped to improve the service and introduce quality monitoring systems. These senior managers told us they would continue to support the new manager until they had established themselves. People using the service, their relatives and staff felt that they were given opportunities to comment about the service and were listened to.

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

Some aspects of the service were not safe.

The provider told us that their staffing ratios were appropriate to meet the needs of people who lived at the service. However, they did not always ensure that people were given the time and support to receive care in a way which reflected their preferences.

The staff moved people safely using hoists, but new staff felt unsure about guidance around the sizes of slings people needed to use. In addition there were not always enough slings to meet people's needs.

The risks to people's safety and wellbeing were assessed and people were supported to stay safe.

The environment was safely maintained.

Staff were recruited in a way to make sure they were suitable to work with people.

Is the service effective?

Good

The service was effective.

People were asked to consent to their care and treatment. Where people did not have capacity to consent, the provider had acted in accordance with the law and ensured that care was planned and provided in their best interests. Where people's liberty and freedoms were restricted the provider had obtained appropriate authorisation for this.

People were cared for by the staff who had the training and support they needed.

People's nutritional needs were met.

People received the support they needed to stay healthy.

Is the service caring?

Good

The service was caring.

The staff were kind, polite and caring towards people. They treated people with respect and had positive relationships with the people who they were caring for. They spoke fondly about people at the service.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and planned for in a way which reflected their preferences and choices. People received care which met their needs.

People were supported to take part in a range of different activities which reflected their needs and interests.

People knew how to make a complaint and felt these were appropriately responded to.

Is the service well-led?

Good

The service was well-led.

There was a positive culture and people using the service, their representatives and staff were happy with the service and though this was well managed. They were able to contribute their views and felt listened to.

The provider had systems for auditing the service and plans for continuous improvements.

Whilst there was no registered manager at the time of the inspection, the new manager was in the process of applying for registration with the Care Quality Commission.

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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 checked whether the provider was 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 28 June 2016 and was unannounced

The inspection team consisted of one inspector, one nurse specialist advisor 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. The expert-by-experience supporting this inspection had personal experience of caring for an older relative.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and safeguarding alerts, the previous inspection report and the provider's action plan.

During the inspection we spoke with five people who lived at the service, seven visiting relatives and friends and two visiting professionals. We also spoke with the staff on duty, who included care workers, nurses, the activities coordinator, the manager and the operations manager. A member of the provider's clinical governance team and the regional director also visited the service during the inspection and met with us to receive feedback about our findings. We looked at records used by the provider to manage the service. These included the care records for 10 people who used the service, the staff recruitment records for five members of staff, records of staff training and supervisions, records of complaints and the provider's audits. We looked at how medicines were administered, stored and recorded. We looked at the environment. We observed how people were being cared for and supported, including how they were supported at mealtimes.

Requires Improvement

Is the service safe?

Our findings

Some of the comments from people who lived at the service and their relatives were, "I have never come across any problems about safety here", "Everybody is very friendly and I've never lost any property", ''I have felt perfectly safe", ''[My relative] is very safe here'', ''I have always felt safe'' and ''The safeguarding issues have got a lot better since the last inspection.''

Since the last inspection the provider had reduced the staffing ratios at the service. The service was not full and the provider told us the staffing ratios reflected the needs of people who lived there and were in line with the normal staffing ratios of their organisation. One person who lived at the service said, "I think there are enough staff." However the majority of people told us they felt there were not always enough staff. Some of their comments included, ''Sometimes they are short staffed, when they are busy", "There are days when they are under pressure", "There are definitely not enough staff on duty, especially at weekends", "There aren't enough staff up here", "They could do with more staff" "I don't think there are enough staff, especially in the morning" and "I get frustrated asking for assistance, there are only a few staff about." However, people told us that call bells were answered promptly and that if they requested assistance they received this. One person said, "I use the bell at night and they respond very quickly.'' Another person told us, "They aim to answer the call bell in three minutes but sometimes explain they need to come back."

The staff told us they did not think there were enough of them at certain times of the day. They said that during the morning it was sometimes difficult to make sure everyone had the care they needed to get out of bed and to have breakfast. They also said that it was difficult to support everyone at mealtimes. They told us that the staffing levels had been reduced since the last inspection but that the number of people who lived at the service had increased slightly.

We observed that people's needs were met during our visit. When people required attention they received this. However, there were times of the day when the care staff did not have any capacity to deal with unexpected situations. For example, the nurses told us that they regularly had to stop medicine administration rounds to support the care workers to deal with emergency situations. In addition there were two members of staff on each floor supporting people to get out of bed in the morning leaving only one care worker to support everyone who was in communal rooms and eating breakfast. At lunch time the activities coordinator and a number of visiting relatives supported people. Without this additional support some people would have waited a long time to be served and supported with their meals.

The majority of people who lived at the service required the support of two members of staff to move from beds to chairs and at least one member of staff to move around the building. With the exception of assigned individual support, which was separately funded for two people, there were only three care workers working on each floor during the day. Therefore it was difficult for them to support everyone at the time they wanted and give them enough time to make experiences such as getting washed and dressed relaxed and pleasant rather than just functional.

The staff received training to make sure they knew how to use equipment to move people safely. Some of

the experienced staff were qualified to train others and to assess their competency. However, some of the staff we spoke with did not demonstrate a good knowledge of the use of hoists and slings. For example, they told us that they did not know which sling was supposed to be used for each person. They said, ''We always use this particular sling with this hoist [pointing to one sling and one hoist] whoever we are moving.'' They told us that they would like clearer information about the slings and the support each individual needed. Another member of staff told us, ''We have been told to hold the sling up against someone and see if this is the right size.'' The provider told us that the staff had been given more precise information about the use of slings. However, they acknowledged that our conversations with these staff indicated they needed further guidance and training. They also told us the slings were colour coded. Most, but not all care plans, recorded the size of sling the person required, however, the staff told us they referred to colour codes and not sizes, therefore the care plans would be clearer if they used the colours to help identify sling sizes. Two of the care plans we examined did not refer to any sling size or colour coding for the person.

Slings were used for multiple people and were not washed between uses. This presented a risk of cross contamination from infections and slings becoming worn. In addition there were not always enough slings available for the staff to use. For example, the staff on the first floor told us there was only one sling of a certain size on the floor. During the inspection they had to retrieve the sling from another part of the building when they needed to support one person who had to wait for their care because of this. The staff told us this was a regular problem. The regional director told us they would look at this issue and consider purchasing slings for individual people.

There were comprehensive and up to date risk assessments where people were considered at risk. For example, if there were risks associated with their mental or physical health, with moving them safely and with equipment they used. The risk assessments included actions for staff to support people to minimise the risks of harm. The assessments and plans reflected individual people's needs and how to care for them. The staff demonstrated a good knowledge of risk and individual risk management plans. They were aware of how to keep people safe and spoke about how they delivered safe care and ensured the environment was hazard free.

There were records to show that equipment, such as bedrails and safety mats were regularly checked and that the staff checked each person regularly, making sure they were safe, comfortable and had changed position if they were at risk of developing pressure areas.

People told us that the home was clean and they had all the equipment they needed. They liked the environment they lived in and their rooms. Some of their comments were, "It's always a nice clean place", ''The home is very clean, they do my room daily", "It's a clean Home. My room is kept clean and tidy", ''There is a programme of re-decoration" and ''There is a good cleaner and there is going to be some re-decoration."

The home was clean and smelt fresh on the day of our visit. Communal areas were hazard free and bathrooms, toilets and corridors were equipped with hand rails. There were specially adapted shower rooms making these easier to access. All rooms had a call bell. These were accessible and placed close to people who were left in their rooms so they could call staff if needed. There were assessments for each person to determine whether they were able to use the call bell and understood what this was for. Plans to keep people safe when they did not understand how to use these included regular checks by the staff. We saw that these took place.

All windows were secured with restricting devices to prevent them from opening widely. Window restrictors, call bells and other safety equipment were regularly checked to make sure these were working and safe. The

provider had a procedure for fire safety. This included an up to date fie risk assessment, individual evacuation plans for each person, regular checks on fire safety equipment and staff training and information.

The provider employed full time housekeeping and maintenance staff who worked at the service each day. There were schedules for cleaning and we saw housekeeping staff cleaning communal areas and bedrooms throughout the visit. The maintenance staff undertook regular checks on the building and electricity, gas and water safety. There were certificates to show that all equipment, including the lift and hoists had been regularly checked and serviced.

People told us they received their medicines when they needed them and they were happy with the support they received around this. Some of their comments were, "I get my medication, no problems", "The staff watch me take [my medicines]", ''They give me my medication, they trust me to take it" and "Yes, I get my medication when I should.''

People received their medicines as prescribed. Medicines were stored securely and the medicine rooms were well organised and appropriately stocked. We observed people being administered their medicines. They were given the information they needed, were able to take their time and make a choice about their medicines. The staff administering medicines were appropriately trained and had been assessed as competent.

Medicine administration records were accurate, up to date and clear. There were protocols in place for managing pain and for ''as required'' (PRN) medicines.

The local Clinical Commissioning Group (CCG) pharmacist regularly visited the service to meet with the staff and GP to review and discuss medicines. They also carried out audits of medicine management. We met the CCG pharmacist and they said that they thought medicines were well managed at the service. The provider also carried out their own audits regarding medicines. These were recorded and included any actions for improvement.

The provider had a procedure for safeguarding adults and information about this was available for the staff. All of the staff had received training in safeguarding adults. The staff were all able to tell us what to do if they suspected someone was being abused. They knew they should speak with the manager and local safeguarding teams. We saw that safeguarding was discussed during team meetings and individual supervisions. There were posters of information about what to do about suspected abuse on display for people using the service, visitors and staff. The provider had responded appropriately to allegations of abuse. They had worked with the local authority to investigate concerns and take action to keep people safe. They had reported concerns and kept the Care Quality Commission informed of safeguarding alerts and the action taken regarding these.

The provider had appropriate procedures for the recruitment of staff. These included inviting potential staff for an interview at the service. The provider undertook checks on their suitability which included checks on their criminal records, references from previous employers, checks on their identity, eligibility to work in the United Kingdom and registration with the Nursing and Midwifery Council for the nursing staff. The potential staff were asked to complete application forms with details of their full employment history. We saw records of these checks in the selection of staff files we viewed for the staff employed since the last inspection.

Good

Is the service effective?

Our findings

At the inspection of 15 February 2016 we found that people had not always been asked to consent to their care and treatment. The provider had not always assessed their capacity to make decisions and they had not been involved in planning and agreeing to their care. In addition some decisions about future care and treatment, for example the decision not to be resuscitated in the event of their heart stopping, had been made without their knowledge and without their consent. The provider supplied us with an action plan describing how they would make improvements in this area.

At the inspection of 28 June 2016 we found that improvements had been made. For example, the provider had a system of reviewing each person's care once a month which included speaking with the person about their care plan and the care they received and involving their relatives and representatives. This system known as ''Resident of the day'' was designed to review all aspects of the person's care, including how they felt about social activities, food and their bedroom. The review was designed to ensure key staff from each department spent time with the person discussing their preferences. However, we noted that these reviews did not always happen each month for everybody and sometimes people using the service and their representatives had not been involved in the review.

We looked at the care plans for a selection of people who were assessed as having capacity to make decisions about their care. We saw that these included evidence of discussion with the person and their wishes regarding end of life care and resuscitation had been recorded. For people who did not have capacity, there was evidence of discussions with their family, powers of attorney or other representatives to make sure decisions were made in their best interests.

People had signed consent to the use of photographs, but not to other aspects of their care and record keeping. However, the staff had recorded how and when people had consented to the care which was being delivered. We saw the staff offering people choices and asking for their permission to care for them, for example when supporting someone to move using a hoist. The care plans included information about how people gave consent and communicated their feeling if they were unable to express this verbally. The daily care notes recorded that consent was obtained from people and showed how people had felt about their care, including when they had refused care or were unhappy with an aspect of this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had made applications for DoLS where people lacked capacity and were in the process of reviewing these and making sure they were up to date and relevant.

The provider had held a training session for all the senior staff at the service to refresh their knowledge about assessing capacity, the MCA and DoLS. The staff we spoke with had a good understanding of the MCA and how to ensure people consented to their care.

People told us they thought the staff were well trained and did a good job. Some of the things people who lived at the home and their visitors said about the staff were, "The staff are able and good at their jobs", "I think they are pretty good at doing what they should", "The majority of staff are well trained. The newer ones need more training", "The permanent staff are well trained but they bring in agency staff and they don't know the residents", "Some staff are better than others, but all are good at their jobs.''

The staff told us they had the support they needed. They had regular team and individual meetings with their line manager, and annual appraisals of their work. These meetings were recorded and we could see that they took place regularly and discussions around various procedures and practices took place. The staff had opportunities to contribute their opinions and ideas. The provider had a system of recognising and rewarding good work called the GEM (Going the Extra Mile) Award scheme. People living at the home, visitors or other staff could recommend people who they felt had carried out an exceptional piece of work or were consistently exceptional.

New staff took part in a range of classroom and computer based training. They also shadowed experienced members of staff when they started at the service. Their competency was assessed by senior staff. We spoke with three members of staff who had been recruited since the last inspection. They explained that their induction and training had covered the areas they needed to know about the service. The staff were provided with information through handbooks and had access to the provider's computer system and internal website which listed policies, procedures and other information to support them in their role.

Over the last year there had been some refurbishment and improvements of the environment. The regional director told us that a large amount of funding had been authorised for further improvements which would include redecorating and new furniture for communal rooms and bedrooms. They told us that consideration would be given to how to make the service more ''dementia friendly'' by providing way finding clues and looking at lighting and colour schemes. They also told us there would be more interactive environments for people spending time in communal rooms, such as tactile objects and more available resources for people to use themselves.

There were large notice boards on each floor with photographs of activities and information about planned activities. Menus were pictorial. However, there was not a photographic board to help identify the staff on duty. The majority of staff, but not all, were wearing name badges on the day of our visit.

Some of the comments about food and mealtimes were, "The food is good, it's nicely presented and portions are big enough and I'm more than contented with them", "There's enough to drink", "On the whole the meals are pretty good and varied", "As far as I know you can ask for an alternative", "They top my water jug up when I ask", "The choice and variety of the food is not to my liking but the cook will do an alternative for me", "Sometimes the family will bring a meal in for me and the staff will heat it up for me", "The food is okay but sometimes what's on the menu, is not what is served up", ''I enjoyed today's meal", "I do think they would do something different, if I asked", "The food's alright, very good actually", "[My relative] gets fluids all day" and "The food is quite nice."

People were offered a choice of main meals at mealtimes and a selection of alternatives was available. Menus with photographs were displayed on the tables and the staff offered people choices and asked what they wanted. The chef met with people when they moved to the service to assess their likes, dislikes and

food preferences. They had clear individual records in the kitchen and knew about allergies and specialist dietary requirements. Food was freshly prepared each day and the kitchen was well stocked. There was hot food, drinks, milkshakes and snacks available throughout the day and night. The provider had asked people about their preferred mealtimes. People on one floor had chosen to eat an earlier lunch than those on the other floor. The operations support manager told us this would be changed again if people wanted a change of times.

People were offered drinks throughout the day and jugs of cold drinks were available in bedrooms and communal rooms.

The staff assessed people's nutritional needs and risks associated with their weight, appetite and related health conditions. There were clear care plans relating to these and people were regularly weighed. Where people were at risk of malnutrition they were given a calorie rich diet and we saw that for some people who were low weight, this was increasing. The staff referred people to dietitians and other healthcare professionals to ensure they received the right advice about how to support individuals. These referrals and information from the professionals were recorded.

People told us that they were supported to stay healthy. They said they could see their doctor and other healthcare professionals when they needed. Some of the things people living at the home and their relatives told us were, "They organise a visit from the chiropodist", "If I was unwell, they would call the doctor", "They organise physiotherapy for me twice a week", "If I was not well they would call the doctor to see me", "The podiatrist visited me yesterday and the optician comes in. I see the hairdresser from time to time", "We tell the staff when [our relative] needs a chiropodist or a hairdresser", "The chiropodist visits because [my relative] is diabetic and the optician also visits as does the hairdresser" and "The chiropodist visits every six weeks" and "They come to check her eyesight, teeth and my sister does her hair."

People's healthcare needs had been assessed, including specific nursing care needs such as wound care, use of oxygen and other specialist care. There was clear information on each person's health conditions and how the staff should support the person. Care plans were detailed and centred around the individual person's needs. The provider employed nursing staff who carried out healthcare checks. There were records to show that people's health and wellbeing was checked regularly and evidence the staff liaised with the doctors and other healthcare professionals when needed.

Good

Is the service caring?

Our findings

People living at the service and their relatives told us that they had good relationships with the staff. They said the staff were kind, caring and polite. Some of their comments included, "The staff are very caring, kind and attentive", "I've never needed to use the call bell because they are always here if I need them", "I get on well with the staff", "They are all very nice", "The staff are kind with me and others", "Their attitude towards me is lovely", "They are the same with everyone – always very kind", "The staff are kind", "If they are busy elsewhere, they will tell you and they come back", "The laundry and cleaning staff are very good also", "The carers are definitely kind towards me, I can't find fault", "The staff are kind and attentive, not rude", "The staff are very good, very polite" and "The staff are quite good. Most of them are very caring."

We saw that the staff treated people with respect and kindness. They were gentle when they approached people, spoke with them positively and showed genuine affection. The staff made eye contact and smiled when talking with and supporting people. They explained what they were doing when they provided care and asked people's permission to support them. We saw that people were offered choices and when they told the staff they did not want something the staff respected this. The staff were focused on the people who they were supporting and did not leave them to attend to other tasks. When the staff were distracted by another person, they apologised to the people who they were caring for. They also apologised when people had to wait for care. One person became unwell during the visit and the staff offered comfort and reassurance making sure the person felt safe and had the care they needed. The staff were also attentive when supporting someone to change their clothes because they had spilled their drink on these.

The staff supported people to have positive mealtime experiences. They offered people choices, allowed people to take their time and encouraged people. They spoke positively about the food and drinks offered and asked people about their enjoyment.

The managers talked about examples of specific care given by some of the staff working at the service. They spoke about how one care worker had taken time to work with an individual who had been resistant to care. They had provided reassurance and opportunities for the person to express their choices and this had helped them to accept care and support.

The staff respected people's privacy, offering to care for them in bedrooms and behind closed doors. They spoke discretely about the care being offered. They used people's preferred names when speaking with the person and with each other. Some of the things people told us were, ''They knock before coming in, I do think we get respect as they are private and confidential when talking to me", "Oh yes, they do treat me with dignity", "They are very respectful towards me and I love them all" and "Yes, they respect me when dealing with me personally."

Care plans included information about people's religious and cultural needs and preferences. This included making sure they had access to food, religious leaders and other items important for their faith. The staff had discussed people's wishes for the care they would like to receive at the end of their lives and where they wanted to be cared for. These discussions were recorded and included information from people's families

and others who were important to them.

Good

Is the service responsive?

Our findings

At the inspection of 15 February 2016 we found people's needs were not always being met because they were not always offered regular showers and baths. The provider supplied us with an action plan which said they would have made the necessary improvements by 30 June 2016.

At the inspection of 28 June 2016 we found that some improvements had been made. However, people felt that sometimes the staff were too busy to offer them baths and showers. The staff told us they did not always have time to do this and one member of staff who had been employed since the last inspection told us, ''I do not know why we have a bath here, no one ever has a bath.'' They went on to say, ''In my time here I have only ever given three people a shower, we just give people a wash most of the time, I do not think people have showers often.''

The staff kept records of the personal care offered and given to people. The provider required them to record people's preferences on these records, but we found that only one in eight records we looked at contained a recorded preference. The record stated this person preferred two showers a week and a wash the other days. The record of care given in May and June 2016 stated that during one week the person had two showers, another week they had been offered showers twice and refused these but they had not been offered any other showers. There had been no showers offered or given to the other seven people whose personal care records we looked at. As their preferences had not been recorded we could not tell whether this was their choice and reflected their needs. People appeared clean and well cared for. The visiting hairdresser washed people's hair and this appeared clean for everyone. People's nails were clean and they were dressed in clean and appropriate clothing. One person told us, "Yes, I do have a shower from time to time."

We saw evidence that the operations support manager and clinical lead had discussed recording and following people's preferences with regards to personal care at team meetings with all the staff. They had emphasised the importance of this. We discussed this with the provider who agreed that there was ongoing work to support the staff to understand how to offer people choices about showers and baths so they felt they had opportunities for these if this is what they wanted. The staff felt that there were not enough of them on duty to offer people the time for this kind of care.

At the inspection of 15 February 2016 we found that people's emotional, social and leisure needs were not always met in a person centred way. The care and nursing staff did not initiate social activities or ask people what they wanted to do with their leisure time. The provider sent us an action plan telling us they would make the necessary improvements by 30 June 2016.

At the inspection of 28 June 2016 we found improvements had been made. The provider employed a member of staff to coordinate and provide activities. They had also recruited a second activity coordinator who was due to start work at the service shortly after the inspection. The staff had started to create life stories with people using the service and their relatives to help them get to know individuals better. The activities coordinator spent time with individual people and in small groups entertaining them, supporting

them with activities and offering them alternatives things to do. They had a range of resources which included games, puzzles, reminiscence items, books and music. The activities coordinator was attentive towards people and made sure they interacted with everybody in their rooms and in communal areas. Other people were supported by the care staff, although there were times when people were not engaged in any activity and had fallen asleep in communal rooms. The staff were available and checked on people's wellbeing. They chatted to people and offered people newspapers and other things to do. We saw that a number of people spent time in their rooms. Some were watching televisions or reading. People told us they were happy in their rooms and had enough to do. The staff regularly checked that they were comfortable, safe and had all they needed.

People told us they liked the planned activities and sometimes enjoyed trips out of the home. They and their relatives told us they participated in meetings to discuss the service. Visitors told us there were no restrictions on visiting times and that they were able to support their relatives with aspects of their care, if this was what they both wanted. Visitors told us they were made welcome. Some of the things people said about the social activities were, ''There are enough (activities) to interest me", ''There is quite a lot to do but I choose what I want to do", "I had a visit from the church minister", "A local choir will visit next week", "I do take part in some activities and I choose what I do", "We take part in the religious services, when they happen.'' One relative told us, "[My relative] loves the music they play here." Another relative said, "They brought farm animals in, which [my relative] enjoyed"

The provider told us they planned to purchase more equipment and things for people to interact with around the environment.

There was a plan of organised events and entertainment. These were advertised on the notice boards around the home. They included visiting musicians, church services and pet therapy sessions. There were regular meetings for people who lived at the home and their relatives. We saw that people were invited to contribute their opinions during these and planned activities and people's preferences for these were discussed.

People told us that their needs were met. They felt their preferences and wishes were considered. Some of the comments people living at the service and their visitors told us about their care were. "I do feel I get the care I need", "I don't mind who cares for me but they asked if I wanted a man or a woman care worker", "I definitely get the care I need", "I only have to ask and it's done", "I prefer the female carers and I get them'', "In general, I do think [my relative] gets the care he needs" and ''They care for me how I want and do everything I need.''

People's needs were recorded in clear and appropriately detailed care plans. These included how they would like care to be delivered and how they expressed their choices and communicated. The care plans were written in a way which was easy to understand with actions for the staff. They reflected people's specific needs and preferences and recorded actions focused on the person who was being cared for. The care plans were regularly reviewed and updated by the staff. They were accessible on the computerised system which all staff had access to and were also printed so the staff had access to paper copies. Individual health and care needs had been assessed and these assessments were updated each month and changes recorded in the care plans. The staff kept records of daily care provided and these were up to date and showed that care plans had been followed.

Some of the comments from people living at the service and their relatives about their care plans were, "I am not sure about a care plan but the staff talk to me about my care'', "I am aware of my care plan and it's updated regularly", "They do involve me in decisions about my care", "They involve me in changes to [my

relative's] care plan and I sign them off", "They involve me in things about [my relative's] care", "They ring me up if [my relative] is not well or if they need to pass on information", "They ask me if I'm happy with [my relative's] care plan", ''The staff involve me and my family in decisions about [our relative's] care" and "They are very thorough with records of her care."

For people who had a specific care need, such as risk of developing pressure areas, there were detailed plans which included actions for the staff to prevent injury and damage to the skin. The staff recorded checks on the condition of people's skin and regularly repositioned those who could not do this for themselves. This was also recorded. All wounds and injuries were assessed and plans to care for these were in place. The staff had recorded the progress of wounds and treatment given.

People knew how to make a complaint and felt that concerns and complaints were listened to and acted upon. Some of the comments from people living at the service and their relatives were, "I've never needed to make a complaint", "If there's a problem, I'd take it to the management", "The manager would sort out any concerns, I'm sure", "I've no complaints" and ''When we made a complaint, they dealt with it, I am happy to tell them if something is wrong.'' The provider's complaint procedure was on display and included information about who to contact if a person was not happy with the initial response to a concern. The provider recorded all complaints, the investigation of these, actions taken in response to the complaint and the response to the complainant. We saw that complaints had been investigated and responded to appropriately within reasonable timescales. The provider had assisted one person to raise their concerns with another organisation when they had a complaint about a service they had received elsewhere. The provider analysed information from complaints to identify any themes or areas of the service where problems were recurrent.

Good

Is the service well-led?

Our findings

People told us that they were happy with the managers who worked at the home. They said that they were approachable and they listened to their feedback. We observed the operations support manager spending time speaking with different people. They knew them well and had a good rapport with them. People felt comfortable speaking with them.

Some of the comments people made about the operations support manager and new manager were, ''I see (the manager) quite a bit'', ''I know who they are and she is always coming round to see us'', ''The managers who visit us here are very nice'', "I have met the new manager. I find her very pleasant, calm and she is approachable", "I know the new manager, she's nice" and "The under-manager is also very nice."

People living at the home and their visitors told us the managers listened to them and asked their opinions about the service. Some of their comments included, "They will listen if you want a moan about something", "I think they are a listening management", "I will pass my concerns on, if I have any, and they will deal with it", "I think when the new management settles in, they will be good listeners", "They are definitely a listening management", "If you complain, they follow it up quickly" and "If you make a suggestion, they try to sort it.''

The atmosphere at the service was calm and people appeared relaxed and comfortable. People told us they liked living at the service. One person said, "Yes, it's run well, very friendly and I'm entirely happy here.'' Another person told us, "It is good here, they try to make it as comfortable as possible.'' Relatives also liked the service. Some of their comments included, "In general, I am happy with [my relative's] care" and "This is a brilliant home with brilliant staff." However, both people who lived at the home and their visitors told us they would like more staff. One person said, "If I had a wish, I would say more staff.'' Another person told us, "My wish would be for more carers.''

People were asked for their views about the service through annual satisfaction surveys, regular resident and relative meetings and reviews of their own care. Minutes of meetings and the results of satisfaction surveys were displayed on notice boards around the home.

The staff spoke positively about the culture at the home. They said that they had seen improvements to the way in which the service was managed and also how people using the service and staff felt. They told us that they felt the changes introduced had benefited people and they felt listened to and supported. One staff member told us, "I love working here, I wouldn't want to be anywhere else" and "I do get good support from the management." One staff member told us, "I love working here, I wouldn't want to be anywhere else" and "I do get good support from the management." The staff appeared relaxed around managers and we saw the operations support manager listening to them and asking their advice. However, many of the staff commented that they felt there were not enough of them on duty. The staffing levels had been reduced since the last inspection and the staff told us the current staffing levels did not reflect the needs of the people who lived there. They felt this impacted on the way they all worked and some staff said that it was, ''stressful'' and ''very hard to care for people the way we want.''

The registered manager left the service since the last inspection. The provider had employed a new manager who had worked at the service for three weeks at the time of our inspection. The new manager was appropriately experienced, having worked as a registered manager for another organisation managing a care home for older people for ten years. The manager had started the process of applying to be registered with the Care Quality Commission. They were still undertaking their induction into the role and told us this involved working with other managers and seeing how other Care UK homes were run.

The provider employed an operations support manager to work at the service from December 2015 because improvements were needed and they wanted this manager to oversee these improvements. The operations support manager told us they were continuing to work at the service and would do so until the new manager was established. The regional clinical lead had also worked at the service since December 2015 overseeing how care was provided and supporting staff to improve practice. The manager told us they were in the process of recruiting a clinical lead for the service. There was also a deputy manager.

The operations support manager told us they were training some of the experienced and competent staff to take on more senior roles at the service. This included training them to help with administration of medicines, giving them the qualifications to train other staff in moving people safely and providing them with the skills to lead a team of workers. They told us this would help give the nurses support in managing how the service operated each day.

Care UK is a national organisation providing care service throughout the country. The regional director and regional clinical governance team carried out regular checks and audits and visiting the service to provide support.

In November 2015 we found that the service was not safe or well-led. We had serious concerns and found breaches of seven Regulations which led to us issuing warning notices as well as requirements. Since this time the provider had taken considerable action to make improvements. They had reviewed all aspects of the service and have met all of the areas of the breaches. They had introduced systems to regularly audit and monitor the way in which care was delivered. In particular the concerns about safety were quickly addressed. In addition people's mealtime experience and the way in which staff cared for them and treated them had improved. Some of these improvements were noted at our inspection of February 2016 and we saw that in June 2016 these had continued. The operations support manager, manager and regional director had demonstrated a commitment to further improvements and told us about their plans for some of these. The managers were keen to praise the work and commitment of the staff at Charlotte House who had worked alongside them to make sure changes were meaningful for the people who lived there.

The provider's governance team carried out quarterly audits of the service which looked at whether the service was safe, effective, caring, responsive and well-led. The last audit had been in April 2016, although the provider had planned to carry out an audit on the day of the inspection also. The audit report gave a detailed analysis of each area of the service and actions required for improvement. The person who carried out the last audit told us they had seen improvements at the service since April 2016.

The staff at Charlotte House also carried out their own checks and audits. These included audits of care records, mealtime experience, nutrition, medicine management, safety and the environment. All audits were recorded and shared with the provider's senior managers. We saw that where concerns had been identified the staff had taken action to make improvements and these were monitored.

The manager reviewed and analysed all reports of accidents and incidents, complaints and safeguarding alerts. They assessed these to identify any trends and where improvements in the service were needed. The

manager shared a monthly report with the provider which looked at these areas along with infections, wounds, hospital admissions and other key indicators.

Records at the service were accurate, up to date and clear. Information was recorded in an accessible way. The provider had a computerised system for care plans, staff records and other information. This was appropriately secured and paper records were stored securely in staff offices.

The provider regularly liaised with the local authorities and local clinical commissioning groups who carried out their own audits and checks on the service. The provider had plans for improvements to the environment and had approved the finances for this. The manager told us they were speaking with other managers about how best to organise the refurbishments in a way to minimise disruption. The regional director told us the plans for refurbishment included looking at ways to make the home more dementia friendly.

Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.