Charnley House Limited

Charnley House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on the 16 and 17 February 2017. Our visit on the 16 February 2017 was unannounced.

Charnley House is situated in the Hyde area of Tameside and provides care, support and accommodation for up to 40 people who require personal care without nursing. At the time of our inspection there were 28 people living at Charnley House. The home is a three storey detached building, which provides accommodation in 38 single rooms and one double room. Communal bathrooms and toilet facilities are available throughout the home. There is one large lounge, one quiet lounge and a reminiscence room. There is a separate dining room which leads to a conservatory. The kitchen, which is attached to the dining room, has a hatch area where meals are served directly from the kitchen.

We last inspected Charnley House on the 8 and 9 September 2016 when we rated the home inadequate overall and placed it into special measures. At that inspection we identified multiple breaches of the regulations. We asked the provider to make improvements to the service and they provided us with action plans of how they would do this. At this inspection although we found some improvements had been made we found on-going and multiple breaches of the regulations. We are currently considering our options in relation to enforcement and will update the section at the back of this report once any enforcement action has concluded.

The service had a registered manager in place who was registered with CQC in October 2010. 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.

During our inspection we observed there to be sufficient numbers of appropriately trained staff to care for people. There was a programme of supervision in place to ensure staff received support and were given opportunities to discuss their performance. Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people.

Medicines were stored and administered safely. However we found that people who required medicines 'as and when' (PRN) did not have the necessary protocol in place.

Some areas of the home had recently been redecorated. We found some concerns around cleanliness and infection control. Servicing and maintenance of equipment was up-to-date. However, the appropriate monitoring of the risk of Legionella was not in place.

The provider was not always working within the principles of the Mental Capacity Act (2005), as we could not find evidence to show best interest meetings had been held when people lacked capacity to give their

consent to care and treatment. People who were receiving their medication covertly did not have the correct authorisation in place.

Risks to peoples' health were not always managed correctly. A person who was using bed rails did not have a risk assessment to show that they were safe to do so.

People we spoke with were happy with the choice of food on offer.

People were complimentary about the staff and told us they were kind and caring. We saw that peoples' dignity and privacy were respected. Care plans were detailed and person-centred. However, some care plans we reviewed did not reflect the person's current needs.

People were supported to maintain good health and where needed specialist healthcare professionals, such as dieticians and district nurses were involved with their care. However, we identified one instance when a person had not been referred to the district nursing service when they should have been. This put the person at risk of deteriorating health. Families were kept informed of any changes to their relative's health.

The service had a complaints procedure in place and people we spoke with felt that any complaints would be dealt with appropriately.

Although quality assurance processes, such as audits were in place to monitor the standard of service delivered, they had not identified the concerns we found during this inspection.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Arrangements were in place to safeguard people from harm and abuse. Recruitment processes were sufficiently robust to protect people who used the service from the risk of unsuitable staff.

Staffing levels during our inspection were sufficient to meet the needs of people using the service.

We identified a concern around the administration of medicines.

Although people had risk assessments in place, we identified failings in the management of risk to peoples' health.

We found concerns around cleanliness and infection control. There were insufficient checks around the prevention of legionella bacteria.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training on a variety of topics which enabled them to carry out their roles effectively.

A programme of supervision was in place which enabled staff to discuss their progress at work and identify any learning and development needs they might have.

The home was not working fully within the principles of the Mental Capacity Act (2005).

People had access to a range of healthcare professionals. However, we found one instance where a person had been put at risk as the appropriate referral to the District Nursing Service had not been made.

The food was of good quality.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People we spoke with were complimentary about the caring nature of the staff.

We observed that staff were kind and patient in their interactions with people.

Staff did not always follow the correct guidance provided by healthcare professionals or complete appropriate risk assessments.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had care records which were detailed and person-centred. However, we found several examples where care plans did not correctly reflect the person's current needs.

A range of activities were provided for people to take part in.

There were systems in place to enable people to make a complaint about the service.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Quality assurance systems were in place to monitor the quality and safety of the service. However these had not identified the issues we found during this inspection.

People using the service and their families were provided with opportunities to express their opinion of the service through an annual survey.

Charnley House

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 was carried out on the 16 and 17 February 2017. Our visit on the 16 February 2017 was unannounced. The inspection team on both days consisted of two adult social care inspectors.

Before the inspection we reviewed information we held about the service. This included the inspection report from our inspection on the 8 and 9 September 2016 and the action plans the provider had subsequently submitted to the Care Quality Commission (CQC) which told us how they planned to improve the service following our findings at that inspection. We also reviewed notifications the CQC had received from the provider. Notifications are changes, events and incidents that the provider is legally obliged to send to us without delay. We used this information to help us plan our inspection.

During our inspection we spoke with the registered manager, the assistant manager, three care staff, the cook and four friends or relatives who were visiting the home. We looked around the building and observed how staff cared for and supported people.

As part of the inspection we reviewed the care records of four people living in the home. The records included their care plans and risk assessments. We reviewed other information about the service, including records of training and supervision, two staff personnel files, maintenance and servicing records and quality assurance documents.

We spent time observing a lunchtime meal and watched the administration of medication to check that it was carried out safely.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt Charnley House was a safe place in which to live. One visitor said '' As soon as (the relative) was here they were a different person: safe and happy''.

Two people we spoke with gave conflicting comments about staffing levels. One person told us ''There always seem to be plenty of staff'', while another person said ''There are not enough staff knocking about''. The registered manager told us that she never used agency staff as regular staff covered for sickness and absence. From our observations we saw that there were enough staff to care and support people during our inspection.

During our inspection in September 2016 we identified that the provider had not always carried out all the necessary recruitment checks to ensure that staff employed at the service were suitable to work with vulnerable people. This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that this concern had been rectified and the requirements of the regulation were being met. We reviewed two staff personnel files and found that they contained evidence that all required pre-employment checks had been completed. This included two references checks and confirmation of identification. Staff had Disclosure and Barring (DBS) criminal record checks in place. These help the service provider to make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

During our last inspection we looked at how the service identified and managed risks that were specific to peoples' individual care needs and found that risk assessments were not always complete or did not reflect peoples' current care needs. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again found concerns in relation to risk management. In particular, where risks had been identified the appropriate action had not always been taken to attempt to mitigate the risk. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we identified that a person who had been found to have a discolouration to their sacrum, which indicated the beginnings of a pressure sore, had not been referred to the district nursing service until a week later. We could not find evidence in their records that action had been taken by staff to monitor their skin or steps taken to provide pressure relief when this person was sitting, such as the use of a pressure relieving cushion. This person had previously been identified as being a very high risk for pressure sore development. District nurses visited the day after they received the referral and prescribed a barrier cream in order to prevent further skin breakdown.

This person also had swallowing difficulties and a speech and language therapist (SALT) had recommended they receive a soft diet in order to minimise their risk of choking on food. We saw from their daily care records that on several occasions they had been given biscuits to eat, which would not be appropriate for a

person receiving a soft diet. This put them at risk of choking. We asked a senior carer about this and she told us ''I keep telling them (staff) not to''.

We identified one person who had bed rails in place. Guidance produced by the Health and Safety Executive (HSE) recommends that 'a risk assessment is carried out by a competent person taking into account the bed occupant, the bed, mattresses, bed rails and all associated equipment'. As this person did not have a bed rail risk assessment in place we could not be sure it was safe to use them. Subsequent to our inspection we received evidence that a bed rail assessment had been put in place for this person.

On the second day of our inspection we observed that a person had fallen during the night and sustained a graze to their head. The paramedics had attended and requested that the person be monitored to ensure they remained conscious and did not vomit. Vomiting and a lowered level of consciousness may indicate the person has sustained a head injury. We saw that staff had commenced a 24 hour observation chart, but this did not contain the relevant level of information about this person's conscious level. This meant that staff had failed to correctly monitor the person for a potential head injury. We saw that there were inconsistencies in documentation relating to this person's mobility risk. Two documents in their care file identified that they walked without a walking aid and information in their records following a physiotherapy appointment said 'not to use the frame, could cause more harm than good'. However, during our inspection we observed staff encouraging them to use their walking frame while mobilising. This put the person at risk, as staff were not following the advice which had been provided by a healthcare professional.

These issues show there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Mitigation of risk.

We reviewed the procedures and systems the home had in place for the safe storage and administration of medicines. At our inspection in September 2016 we identified concerns in this area; in particular in relation to the accuracy of the Medication Administration Records (MARs), storage of medicines and lack of medicines audits. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that some improvements had been made.

Medicines were stored safely and twice daily checks had been made to ensure that the temperature of medicines storage was within the correct range. Medicines should be stored at the correct temperature to ensure they maintain their efficacy.

We observed the lunchtime medication round and saw medicines were administered safely. The person administering medicines wore a 'do not disturb' tabard to remind people that she should not be interrupted. This helped to minimise the risk of medicine errors. We looked at the MARs and saw that they had been completed correctly. Each MAR contained information about the person's allergies and their photograph, which helped to minimise the risk of the medication being given to the wrong person. One person was taking a heart medication and needed to have their pulse rate monitored before receiving it. We saw that this had been done. Regular audits were carried out to check on the accuracy of the MARs and the recording of medicines storage temperatures.

We reviewed the use of medicines that are given 'as and when required' (PRN), such as painkillers and laxatives. Where PRN medicines are given there needs to be a protocol in place. This should explain the reason for the medicine, how staff would know the person needs the medicine, what effect the medicine should have and any circumstances where staff needed to consult the prescriber of the medicine to review its use, for instance if the person had not required the medicine for a period of time or the medicine was not

having the desired effect. We found there were no protocols in place for people who required PRN medicines. This meant staff did not have sufficient information to ensure people were given these medicines safely and consistently.

These issues show there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Management of medicines.

We looked around all areas of the home to check on the standard of maintenance and cleanliness. During our inspection in September 2016 we identified concerns around the cleanliness, maintenance and safety of some parts of the building, and of equipment which demonstrated there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, although we found there had been some improvements, we again found some issues with cleanliness, infection control and safety of the premises which demonstrated there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw completed cleaning schedules for the rooms and equipment. However there was a malodour in the main corridor. One person we spoke with commented that their relative's bedroom had a malodour. We were told there was a programme in place to replace the carpets, starting with the carpet in the main corridor.

In one of the upstairs toilets we found a used sanitary product left on the windowsill, and in the laundry we found a soiled item of clothing discarded on the floor. We saw that one person's walking frame was dirty. Outside in the yard we saw that the bins were overflowing with rubbish bags and broken furniture was piled in a corner. This provided an unsightly environment which could be seen by people who use the service sitting in the conservatory.

We found that some improvements had been made since our last inspection in the prevention and control of infection. There were adequate supplies of liquid soap, paper towels and alcohol hand gel available and we saw that staff wore the correct personal protective equipment (PPE), such as disposable vinyl gloves and plastic aprons, when supporting people. However we found two foot-operated bins did not work, which meant people risked contaminating their hands when disposing of soiled items. In the laundry, in addition to liquid soap we saw a bar of soap available for handwashing. Bar soap can harbour microorganisms which could cause infection. NHS Professionals Standard Infection Control Precautions states 'Bar soap should not be used by staff for hand hygiene in a clinical or care setting'.

Toilets and bathrooms displayed posters advising people to wash their hands. However they did not show the recommended method for correct hand washing. We brought this to the attention of the registered manager, who immediately produced a poster for display in the toilets and bathrooms which showed details of the recommended handwashing technique.

During our last inspection we found that people who required assistance using a hoist did not have their own personal sling and that slings were 'shared' between people. This practice meant there was a risk of cross infection. At this inspection we found that all people who required to be moved by a hoist had been assessed and allocated the correct size sling. This prevented cross infection and also ensured safe moving and handling. Staff had received recent training in infection control and those we spoke with told us that they felt infection prevention and control had improved in the home since our last inspection.

During our tour of the building we identified two radiators in the main downstairs corridor that were not covered and were very hot to touch. This meant there was a risk that people could burn themselves if they

leant or fell against them. We brought this matter to the attention of the registered manager, who immediately turned the radiators off. Subsequent to our inspection we were informed that covers had been fitted to prevent people from injuring themselves if they touched or fell against the radiators when they were hot.

During our inspection in September 2016 we had concerns about the safety of the steep stairs leading from the main corridor to the first floor, where there was a large unlocked wrought iron gate. At that time we saw people attempting to climb the stairs and being brought down by staff. Since then the provider had put a small barrier in place at the bottom of the stairs to prevent people from climbing them unsupervised, although this was due to be replaced with a more substantial barrier. The registered manager told us that during an inspection by the fire service in November 2016 they had been told that the wrought iron gate should be secured by the use of a 'bungee' cord in order to prevent people opening it and inadvertently falling down the stairs. On the first day of our inspection we saw that the bungee cord was not securing the gate. This put people at risk of harm. We brought this to the attention of the registered manager, who secured it.

There were systems in place to protect staff and people who used the service from the risk of fire. Records showed that regular checks had been made on the firefighting equipment and fire doors and that a weekly fire alarm test was carried out. However, one staff member was unable to tell us how to open the first floor fire door. At our inspection in September 2016 we found that people did not have a personal evacuation escape plan (PEEP). A PEEP explains how each person would be evacuated from the building in the event of an emergency and includes information about their mobility and any communication difficulties. At this inspection we found that this concern had been rectified and everyone living at the home had a PEEP, which was stored in their care records and in a file in the reception area, where it was easily accessible in the event of an emergency.

We saw that servicing of equipment, such as hoists and lifts, gas and electricity appliances were up-to-date. We asked the registered manager what precautions were taken to minimise the risk of Legionella in the water supply. Legionella is a bacteria that can result in serious illnesses, to which people living in care home can be particularly susceptible. We were told that regular flushing of the water system was carried out by the maintenance person to prevent water stagnation. However, there was no up-to-date legionella risk assessment for the home in line with the Health and Safety Executive guidance on reducing the risk of legionella in care homes.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

A 'Food Standards Agency' inspection had been carried out in January 2016 and the home had been awarded the highest rating of 5.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) in relation to training and supervision of staff. At this inspection, we found improvements had been made and the requirements of the regulation were being met.

During our inspection in September 2016 we found that although staff told us they felt supported in their roles we were unable to find evidence that they had received regular formal supervision. Supervision and appraisal meetings support and help staff to discuss their progress at work and identify any learning and development needs they might have. At this inspection we found that a programme of supervision had started and all but two members of staff had received supervision in January 2017. Supervision meetings were planned to take place four times a year and the registered manager was in the process of holding an annual appraisal for all staff.

We looked at the training available for staff who worked at the home and saw that this had improved since our last inspection. The provider had signed up to a private company which provided health and social care training in a number of different formats, such as face-to-face, workbooks and e-learning and we saw from the training matrix that staff had recently undertaken a variety of training. The registered manager was due to attend a 'train the trainer' course for moving and handling, which would enable her to deliver the moving and handling training for staff. She had already undertaken a 'train the trainer' course to enable her to deliver training in 'dignity in care'.

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 made in their best interests and as least restrictive as possible. During our inspection we saw that staff generally sought peoples' consent before undertaking any care or support task. However, we saw one instance where a carer moved a person who was sitting in their wheelchair by the dining table away from the table without first asking her consent to do so.

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 are called the Deprivation of Liberty Safeguards (DoLS).The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the appropriate DoLS authorisations were in place and that the registered manager kept an up-to-date record of when DoLS authorisations were due to expire so that re-applications could be made in time.

During our inspection in September 2016 we found that the provider had not carried out mental capacity assessments for those people who lacked the capacity to give their consent to care and treatment. In addition, where relatives had given their consent, for example by signing care plans on a person's behalf, they did not have the legal right to do so, as they had not been granted Lasting Power of Attorney (LPA) for

health and welfare needs for that person. We also saw no evidence that best interest meetings had been held to ensure people's rights were protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had started to take steps to address this issue. However, further improvements were needed and we found a continued breach of this regulation. We could not find evidence of mental capacity assessments or best interest meetings where people did not have capacity to consent to care and treatment. In one instance we saw that an 'advance care plan', which set out a person's hopes and wishes for their future care in the home had been signed by the person's son, although they did not have the legal right to give their consent. At this inspection we found that the provider had sent letters to all relatives asking for information about whether or not they had obtained LPA for health and welfare needs and/or finances. The provider was still awaiting some responses to their enquiries. Where people had responded and needed advice about the application process, this was provided by the registered manager.

We saw evidence that two people were receiving their medicines covertly. This means giving medicines in a disguised form, for example in food or drink, when a person refuses the treatment necessary for their physical or mental health. The use of covert medicine administration should only be considered where a person lacks capacity and is unable to make their own decisions about the treatment they receive and where a best interest decision has been made to show the reasons for the decision and why it is necessary. We saw letters from each person's doctor authorising the use of covert medicine. However, there were no best interest decisions in place for either person.

The above examples demonstrate a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people living in Charnley House had access to a range of healthcare professionals, including district nurses, opticians and dieticians and information about referrals to and visits from professionals were stored in people's care files. During our inspection, one person who was feeling unwell was immediately referred to their doctor. People we spoke with told us that when their relative needed to attend hospital appointments staff from the home accompanied them, which made the event less distressing for them. Relatives commented that they were kept informed about changes to a person's health. One person told us that their relative had been poorly recently and they were informed promptly. They told us ''Even with little things they are on the phone straightaway''.

During our inspection in September 2016 we identified that staff had failed to refer a person who was substantially underweight for specialist help. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found ongoing concerns around nutrition.

People we spoke with were generally happy with the quality of food and told us staff were aware of their relative's food likes and dislikes. A comment from the recent resident/family satisfaction survey said ''Food; extensive choice''. We observed a lunchtime meal and saw that there were sufficient staff to help those people who needed assistance with eating. There was a choice of main meal and dessert and the food looked hot and appetising. People were offered a second helping if they wished. Between meals people where offered a choice of hot drinks and biscuits.

We saw a dietician's nutrition care plan from December 2016 for a person who had lost 11% of their body weight during the period June to December 2016. At our previous inspection we raised a safeguarding alert with the local authority about this person, as the provider had failed to refer them for specialist dietary

advice because of weight loss. At this inspection we reviewed the dietician's plan which identified that the person did not always eat well and suggested a variety of ways in which staff could help the person to increase the calorific content of their diet, such as through fortifying food with cream, offering high calorie homemade milkshakes and high calorie snacks between meals. We asked staff to provide us with evidence that the person was offered fortified food, drinks and snacks but they were unable to do so, as they did not monitor this person's dietary intake in any formal way, such as through recording on a 'food chart'. During our inspection we did not see this person being offered high calorie snacks or drinks. The cook told us that she generally fortified food for everyone where she could, for example by adding cream to mashed potato. However, we did not see evidence that this person was given any special fortified food or snacks to try to boost their calorific intake. We raised a safeguarding alert with the local authority around our concerns about this person.

These examples demonstrate a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were complimentary about the staff at Charnley House and we received positive comments about their approach to people who lived at the home. One relative said ''The girls are lovely with (the person)'' and another told us ''Staff are unbelievable''. Comments we read from a recent survey included "All staff old and new are very caring and work hard'', ''All Charnley House staff are exceptional'' and ''All staff are very friendly and cooperative''.

At our last inspection we saw that people were not always treated with dignity and respect. We saw several instances where people were wearing clothes that they had spilled food or drink on and they had not been assisted to change, and some people wore shoes or slippers that were soiled. In addition we saw one incident were a person was not treated with dignity and respect during care delivery. This meant the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

At this inspection we found improvements had been made in this area and the requirements of the regulation were being met. We saw there had been recent training in this topic for those who were not previously up-to-date. This meant all staff had received the relevant training in this area and during our inspection we saw that staff treated people in a considerate way. A notice board in the main corridor displayed information in words and pictures about treating people with dignity and respect. We saw a positive comment around dignity in the recent survey, which said ''This is very important and it is to a high standard''.

We saw that people in the home looked cared for: their clothes and appearance were clean. A carer told us that since the last inspection she felt staff paid more attention now to the way people were dressed. One person, who was a regular visitor to the home told us ''I am always happy with the way they look''. However, two people we spoke with commented that they sometimes found their relative wearing clothes that did not belong to them and when we inspected the laundry we found that some recently washed clothes, which were ready to be taken to people's bedrooms were crumpled and had not been ironed.

We also identified instances during the inspection where peoples care needs had not always been met and risks appropriately assessed to ensure peoples safety. We have discussed this further in the Safe domain of this report.

We observed how staff interacted and spoke with people and found that they were patient and did not rush people who they were assisting. For example, we watched people being assisted with their food at lunchtime and this was done in an unhurried manner and we saw staff walking beside people, giving them a helping hand when they needed it. Staff spoke kindly and politely to people and smiled at them in a reassuring manner. We heard staff laughing and joking with people appropriately. One relative told us ''The staff have banter with (the person)''.

We were told that at the time of this inspection that nobody was receiving' End of Life' care. However, it was

a service the home would provide, supported by the district nursing service. Care files we reviewed contained 'advance care plans' which detailed information about the person's wishes for their care as they approached the end of their life.

People were free to visit the home at any time and we saw that staff had a friendly and relaxed relationship with visitors. We saw one visitor being offered a drink and the member of staff said ''Give me a shout if you need anything else''.

Requires Improvement

Is the service responsive?

Our findings

Prior to moving into the home a pre-admission assessment was carried out by two of the senior carers. This enabled people to make an informed choice as to whether or not the service was suitable for them and ensured the home was able to meet the person's needs.

We reviewed the care records of four people living at the home and saw that they contained a range of information which was used to plan the care and support each individual person needed. This included details about the person's medical and social history, an assessment of their nutrition, mobility, personal hygiene needs, continence and communication and a range of risk assessments, including malnutrition universal screening tool (MUST) and Waterlow scores. The Waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy. The MUST score helps to identify adults who are malnourished, at risk of malnutrition or obese. People's weights were recorded weekly. A body map to record and highlight any bruising or injuries sustained, for example following a fall was kept in the person's care record.

Care plans were detailed, personal and written in the first person and had been reviewed regularly. However, we saw several examples where changes to a person's health or care needs had not been adequately reflected in their care plans. One person had been identified as having the beginnings of a pressure sore but their skin integrity/pressure relief care plan did not contain any details about this, or how staff might prevent further deterioration through the use of a pressure relieving cushion.

One person had a mobility care plan dated 10/1/17. This stated 'I am unsteady on my feet. I walk about independently, but need supervision when doing so. I want you to supervise me from afar when I am walking around'. However, their moving and handling risk assessment dated 3/2/17 said '(person) cannot currently walk independently. Wheelchair to be used for going from A to B'. During the inspection we saw this person walking about using a walking frame.

These examples demonstrate a breach of Regulation 17 of the health and Social Care Act 2008 Regulated Activities Regulations 2014.

A calendar of activities taking place at the home was displayed in the reception area and in the main corridor a notice board of 'What's happening in February' displayed information about a Valentine's Day special event and up and coming birthdays. During our inspection we saw an outside entertainer, who was a regular visitor to the home and knew everyone's name, engage people in activities in the communal lounge area. This person brought their dog with them, and people appeared to enjoy seeing and getting close to it. One person we spoke with told us their relative had been taken on trips out to the theatre and to a local school for a carol service. They told us there was 'Always something happening in the week'.

During our inspection in September 2016 we saw that several areas in the home needed updating and redecorating. At this inspection we saw that some improvements had been made. The dining room had recently been refurbished and was light and attractively decorated. There was an ongoing programme to

redecorate bedrooms and those we saw had been personalised with photographs, paintings and other personal items. A photograph of each person was on their bedroom door. This helped those people with dementia recognise their own room.

During our last inspection in September 2016 we had concerns around communication between staff about peoples' care needs and that 'handover' meetings were brief and not thorough enough. At this inspection we found there had been an improvement in this area and staff we spoke with confirmed that communication was better. One carer told us that at the handover meetings information about all the people who lived at the home was shared and that this information was recorded in a designated book, which staff could refer to at a later time. In addition to handover meetings the registered manager had introduced 'flash meetings' which consisted of a daily team briefing for all key staff from the different departments, such as housekeeping, maintenance and catering. These meetings helped each department have a better understanding of what was happening throughout the home. Information discussed at the meeting was recorded on a sheet of paper and given to the registered manager. The registered manager did not attend these daily meetings herself and relied on the information being passed to her. We discussed this with her and suggested it would be more appropriate for her to attend in person.

The service had a complaints procedure which was displayed in the reception area of the home and people were given a copy of the procedure when they received their contract of admission. The registered manager told us that what were classed as 'minor' complaints were dealt with as and when they happened. Other more serious complaints were formally logged and investigated within 28 days and a formal written response given to the complainant. People we spoke with knew of the complaints procedure, although they had not had to make a complaint. One person told us ''I've nothing to complain about at the moment''.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. The registered manager was also the home owner, and had worked at Charnley House since 1985. This meant they were familiar with the building, its environment and the day-to-day workings of the home. The manager had been registered with the Care Quality Commission (CQC) since October 2010.

At our last inspection in September 2016 we found short falls in the management and governance of the home and rated the 'well-led' domain of our report 'inadequate'. We identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered manager did not have sufficient systems in place to monitor the quality and standard of the service. At that inspection we identified concerns in relation to training and supervision, medicines management, cleanliness and infection control, risk assessments, lack of quality monitoring and general oversight of the management of the home.

At this inspection although we found some improvements, we found ongoing concerns in a number of areas and identified breaches of five of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to managing risk, PRN medicines, cleanliness and infection control, premises and equipment safety, consent, meeting nutritional and hydration needs, referrals to health professionals, accurate, complete and contemporaneous care plans. These breaches have been discussed in detail in the relevant sections of this report.

The governance systems and auditing processes in place were not robust and effective and had not identified the concerns we found during this inspection.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Since our last inspection in September 2016 the registered manager had received support in implementing the necessary changes through employing, for a limited time, a consultant from a private organisation which provides quality assurance support to healthcare providers. In addition, she had employed another member of staff to work as an assistant manager. During our inspection we found the registered manager and assistant manager helpful and cooperative and they provided us with the necessary information we required.

At our last inspection we identified that the registered manager was not aware of their obligations to provide their service within the fundamental standards of the CQC which form part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Since then the registered manager, assistant manager and senior carers had attended a CQC compliance workshop which provided them with training around meeting the fundamental standards.

Staff we spoke with told us they felt standards had improved at the home since the last inspection and that

everyone had tried hard in order to implement the changes needed. One person told us they had received direction and guidance from the management team and staff reported that the management team were more 'visible' than before. The registered manager was in the process of moving their office from the lower ground floor to the ground floor to enable them to be less isolated from the rest of the staff. However, during our inspection the registered manager spent the majority of their time in the lower ground floor office away from staff and people who used the service. One relative we spoke with told us ''I don't see the management a lot'' and another person said ''I've never met the manager; never seen her''.

People living at the home and their relatives were provided with an opportunity to comment on the service through an annual survey. The most recent survey had been conducted in December 2016 and there had been a response rate of 66%. We saw that feedback from the survey was generally positive, and included the following comments: ''All staff worked hard to ensure (the person) was well looked after during their stay'' and ''All staff old and new are very caring and work hard''.

We saw that mandatory staff meetings were held approximately four times a year. These meetings enabled important information about the home to be discussed with staff. We looked at the minutes for the last meeting and saw that the topics discussed were the previous CQC inspection and training and supervision schedules. The registered manager told us that if there was other vital information that needed to be cascaded to staff she put this information in memos which were given out with staff wage slips.

Under the terms of their registration with the Care Quality Commission (CQC), providers and registered managers have a legal obligation to notify us of certain incidents, events or changes to the service. During our inspection in September 2016 we found that several safeguarding incidents at Charnley House had not been reported to the CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations, 2009. At this inspection we found that appropriate notifications had been submitted to the CQC and the requirements of this regulation were now being met.

Since 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. Charnley House was last inspected by the CQC in September 2016 and awarded the overall rating of 'Inadequate'. During this inspection we saw that the rating was displayed in the entrance hall, as required.