Centenary Care Homes Limited

Centenary House

Inspection report

70 Charlton Road
Shepton Mallet
Somerset
BA4 5PD

Tel: 01749342727
Website: www.centenarycare.co.uk

Date of inspection visit:
20 December 2017
21 December 2017

Date of publication:
20 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 December 2017, the first day of the inspection was unannounced.

We last inspected Centenary House in September 2016, during this inspection we found people's medicines were not consistency managed safely, there was a lack of meaningful activities for people, the governance systems were not fully effective and the provider had failed to notify the Care Quality Commission of events and incidents in line with their legal responsibilities.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive and well led to at least good. During this inspection we found that improvements had been made in some areas, however we found further concerns which resulted in breaches in the regulations.

Centenary House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Centenary House is registered to provide personal care and accommodation to up to 13 people. The home is an older style building with accommodation for people arranged on the ground floor. The home specialises in the care of older people. At the time of the inspection there were 12 people living at the home.

There was a manager in post and they were going through the process to apply to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not consistently protected from the risks associated with burning themselves on hot radiators. Not all of the radiators were covered and one person had part of their bed pushed up against an uncovered radiator that was on. Water temperatures were not being tested to ensure they remained in a safe range and risks to legionella bacteria in the water systems were not being managed consistently.

Medicines were administered safely to people and people were happy with how staff administered their medicines. Some improvements were still required with medicines management. Medicines stored in the fridge were not stored securely. The fridge temperature was not taken consistently to ensure it remained within a safe range.

The home was not consistently clean, including the kitchen and there were areas of the home that needed improving. The provider had a refurbishment plan in place for the home identifying areas for improvement.

Timely action was not always taken when risks were identified in the home. Some bedroom doors were propped open which would prevent them closing and providing protection in the event of a fire in the home. This had been identified by the fire service in January 2017 and they had not all been fitted at the time of the inspection.

The systems for assessing, monitoring and improving the quality and safety of the service provided were not fully effective.

We received mixed feedback relating to the staffing levels in the home, the provider had recently agreed for another staff member to be available in the afternoons. Recruitment procedures were in place to ensure staff employed were suitable for their role.

Incidents and accidents did not occurred often in the home, when they did they were recorded by staff. When an incident had occurred any learning from it was shared with the staff team.

People felt safe at the home and with the staff who supported them. Staff were aware of the correct action to take if they suspected someone was being abused.

Staff monitored people's health and well-being and made sure they had access to other healthcare professionals according to their individual needs.

People commented positively about the food, people had access to a choice of food and received adequate nutrition and hydration.

Staff told us they received supervision and felt supported in their role. Staff received a range of training to meet people's needs.

People were supported by staff who were kind and caring. Staff treated people with respect and dignity.

There were organised activities and people were able to choose to socialise or spend time alone. People and relatives felt able to raise concerns with staff and the manager.

Staff felt well supported by the manager and felt there was an open door policy to raise concerns. People and relatives were complimentary about the manager and staff.

There were systems in place to share information and seek people's and relatives views about the care and the running of the home.

We found breaches in three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, two of these were repeated breaches. You can
see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not fully protected from the risks associated with being burned on hot radiators, hot water and the risk of fire doors being propped open.

People were not living in a consistently clean environment.

People's medicines were not always stored securely. People's medicines were administered safely.

Risks to people relating to their care needs were assessed and planned for.

People sometimes had to wait for staff support, staffing had been increased in the afternoons to meet people's needs.

Where people were involved in incidents and accidents, lessons were learned.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training relevant to their role.

People's rights were protected because the principles of the Mental Capacity Act 2005 were being followed.

People were supported to have enough food and fluids.

People were supported by staff who felt supported in their role.

People's healthcare needs were supported and met. The home worked within and across other healthcare services to deliver effective care to people.

Areas of the home were in need of refurbishment, the provider had an action plan in place to address this.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported in line with their preferences.

People were supported by staff that treated them with kindness, respect and compassion.

Is the service responsive?

Good

The service was responsive.

People were able to make choices about their day to day lives.

People were able to take part in organised activities or choose to occupy their time in their preferred way.

People said they would be comfortable to speak with a member of staff if they had any complaints about their care or support.

Is the service well-led?

Requires Improvement

The service was not fully effective.

Systems were in place to monitor and improve the quality of the service for people. The systems were not fully effective at identifying all of the shortfalls in the service and ensuring improvements were made.

People were supported by staff who felt able to approach their managers.

There were systems in place to ensure people and their relatives had an opportunity to provide feedback on the service and be involved in any changes.

Centenary 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 took place on 20 and 21 December 2017 and the first day was unannounced. This inspection was carried out by two inspectors and an expert-by-experience on the first day and one inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel the service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with nine people and three visitors including people's relatives, about their views on the quality of the care and support being provided. We spoke with the manager and six members of staff including the cook. We also spoke with two visiting health professionals.

We viewed the premises and observed care practices and interactions in communal areas. We observed lunch being served. We looked at a selection of records which related to individual care and the running of the home. These included five people's care records, medication administration records, five staff personnel files and training records and records relating to the management of the service, including quality audits, staffing rotas, policies, incident and accident records and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 6 and 7 September 2016 we found people were at risk of not receiving their medicines and some medicines had been given to people when they should have been discarded because they were out of date. There were errors in how records had been kept and changes in medicines were not always recorded with a clear record of when and who had made the decision. At this inspection we found some improvements had been made to the management of medicines, however there were still some areas of concern found.

People had individual Medicine Administration Records (MARs) that included an accurate record of the medicines people took. When people had changes to their medicines this was documented on their MARs, including details of who had made the decision. However, one person who had recently moved into the home had handwritten entries by staff on their MARs. We found these records were not signed or countersigned by two staff. This is recognised good practice to ensure people received the correct medicines and this also reduced the risk of errors occurring. We discussed this with the manager who told us they would ensure these entries on the MARs would be signed and counter signed by two staff.

Most of the medicines were stored safely and securely in the home, however we observed on the first day of our inspection the medicines fridge was not locked and there was a note stating the lock was broken. We also noted there were gaps in the recording of the fridge temperatures to ensure it remained in a safe storage range. Over a period of 19 days the temperature was not taken on 10 of these days, we noted however on the days the temperature was taken it was within a safe range. Medicines stored in the fridge included eye drops which were no longer in use and unopened antibiotics. We discussed this with the deputy manager who managed to lock the fridge and told us they would ensure the fridge temperature would be taken and recorded daily. The manager told us they would dispose the eye drops and antibiotics.

Risks relating to the exposure to hot surfaces were not being consistently managed safely. For example, we saw four people had radiators in their bedrooms that were turned on and these were not covered with radiator covers. We also observed there was an uncovered radiator in one of the toilets. One person had the bottom half of their bed pushed up against a radiator, which meant there was a risk they could be burnt whilst they were in bed. Two people were at risk of falling and had uncovered radiators in their bedrooms they could have fallen on. Whilst the manager was able to describe some measures that were in place to prevent these people falling onto their radiators, such as movement sensors in the bedrooms to alert staff when they got up, there was no formal risk assessment in place identifying these risk management measures.

The manager put immediate safety measures in place to prevent the likelihood of these people being burn on the radiators. Following our inspection they made arrangements for the radiators to be covered. The manager confirmed there had been no incidents of people burning themselves on uncovered radiators.

We tested the water temperatures and in three bedrooms and a communal bathroom and the temperatures were over 44°C. High water temperatures (particularly temperatures over 44°C) can potentially create a

scalding risk to vulnerable people. We discussed this with the manager who confirmed two of the people did not use their taps independently and the third did use theirs on occasions. However there was no risk assessment in place to prevent the risk of the person scalding themselves. The manager confirmed there were no thermostatic mixer valves in the water system to regulate the water temperature. They also confirmed there had been no incidents of people scalding themselves on hot water.

Following the inspection the manager confirmed they had reduced the water temperatures to below 43°C and they had arranged for a company to visit to install thermostatic mixer valves to regulate the water temperatures. They had also tested all of the water temperatures in the home and they confirmed they would arrange to complete this as part of the homes regular checks.

Due to the lack of water temperatures being taken, this meant the risk of legionella bacteria in the water was not being managed effectively. Legionella can cause serious lung infections. The Health and Safety Executive (HSE) states "Health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures are in place to control the risks". Although we saw a water sample had been sent to an external water testing company in August 2017 and the company had confirmed legionella was not detected, there was no risk assessment in place detailing the frequency of ongoing checks required to ensure the water remained safe.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system, personal emergency evacuation plans and regular servicing and checks on equipment. We saw some people had their bedroom doors propped open with various items, which meant in the event of a fire the door would not close and act as a fire barrier. The manager told us these people chose to have their bedroom doors open to avoid them becoming isolated. However, there were no risk assessments in place detailing measures in place to reduce the risk of harm if a fire occurred in the home. The manager told us there were arrangements for the doors to be fitted with self-closing devices, records confirmed this had been advised by the fire service 11 months prior to the inspection in January 2017. Following our inspection the manager confirmed they had put risk assessments in place and the date for the door closures to be fitted was in January 2018.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We completed a tour of the building and noted there were areas that were not clean. For example, in the kitchen the microwave was dirty and food stained, the vegetable fridge was dirty, the skirting boards were dirty and the floor lino and wall tiles were greasy. Inside the kitchen units were also greasy. The kitchen window and fly screen were dirty and there were cobwebs in the ceiling corners. The milk dispenser had a layer of dust on the top of it.

On the first day of the inspection we observed the shower room was not clean, there was an area where the toilet had been leaking resulting in discolouration of the floor. There were worn clothes left behind the door. A set of weighing scales were dirty and there was hair was present in the sink plug hole. In the main lounge the carpet was stained and dirty in areas and some of the chairs were stained.

Although there were cleaning schedules in place detailing the cleaning tasks that should be completed, this was not fully effective. We discussed this with the manager who demonstrated they were in the process of discussing cleaning expectations with the cleaning staff. Following the inspection the manager confirmed they had employed an additional cleaner, arranged for a deep clean to be carried out and revised their cleaning schedule. They also confirmed they would be completing and recording regular checks on the

home to ensure the cleaning met the required standards.

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

People were supported by staff who tried to prevent the spread of infection when supporting them with intimate care. Staff had access to protective equipment such as gloves and aprons and they were used.

People told us they were happy with the way staff supported them with their medicines and they confirmed they received these on time. One person told us, "I take medicines. The staff give them to me, usually on time." Other comments included; "Medicines, yes they give them to me every four hours" and "Medicines, yes tablets, the staff give them to me, mostly on time". One relative commented on how the manager had been proactive in supporting their family member to have a medicines review and change their medicines. They described the impact this had on the person as "Helping them no end" and as "Having [the person] back."

When people chose to manage some of their own medicines we saw there were systems in place to ensure this was completed safely. We observed staff administering medicines and ensuring people had swallowed them by observing them to ensure the medicines were taken.

There were systems in place to ensure medicines were in date and safe to use. Medicines were supplied by a pharmacy on a monthly basis; a record was kept of all medicines received at the home and those returned. Suitable arrangements were in place for medicines, which needed additional security. We checked the stock of four medicines against the records and found they were accurate. We observed the medicines trolley was locked at all times when staff were not present. This meant unauthorised people were unable to access other people's medicines.

When there had been one medication error, we saw action was taken to ensure the person had not come to any harm and the staff member received additional support and training. Where people required medicines 'as required' for example, for pain relief, there were protocols in place detailing when the medicines should be offered and the maximum amount a person should have within 24 hours to prevent an overdose and inconsistent administration.

We received mixed comments from people regarding the staffing levels in the home. Comments included; "Not enough staff, we are told they are trying to cut back", "Enough staff, they could do with a couple more, especially mornings when everybody needs to be seen to", "Yes, enough staff" and "They are a bit short at the moment. You have to wait a while before you can get help." People had access to a call system in their rooms which when we asked people said were responded to, "Fairly quickly."

We discussed the feedback from people about the staffing levels with the manager and they told us the staffing arrangements were based on people's preferences and that most people chose to get up after 9.30am. The manager also told us staffing levels had previously been reduced in the afternoon which was not successful and the day before the inspection they had increased the level to ensure people's needs were met. This also included an additional staff member for six hours each week to undertake the laundry duties.

The manager told us staffing levels were based on people's individual needs, although they were not currently using a specific tool to assess and review staffing levels. They reviewed the staffing levels with the deputy manager on a weekly basis and said if additional staffing was required for example if someone was ill, they would arrange for this to be put in place. They gave an example where this had happened recently

because one person was unsettled at night. The manager told us they were planning on using a dependency tool to determine staffing levels in the new year.

Staff told us staffing levels had recently improved and they were able to meet people's needs with the current level of staff. Comments from staff included, "There's enough now we get the third person [meaning staff member] and the shifts always get covered" and "Staffing is fine now we have three in the afternoons."

Recruitment procedures were in place to ensure staff employed were suitable for their role. Staff had to attend a face to face interview and provide documents to confirm their identity. Staff also had a range of checks completed before they were allowed to support people, these included previous employment references and checks by the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. We noted one staff member's application form included gaps in their employment history that had not been explored. Having unexplored gaps in employment could impact on a staff member's suitability to work with vulnerable adults. We discussed this with the manager who confirmed they would explore and record the reasons for the gaps and they sent us evidence that they had completed this.

All of the people we spoke with and their relatives told us they felt safe living at Centenary House. One person told us, "Yes, I feel safe. I've got a lock on my door." Other comments included; "Safe, yes, the staff are friendly", "I feel very safe. The family know I'm safe" and "Yes, I feel safe. They're all very friendly, I'm happy here." Comments from relatives included; "I have no concerns about safety" and "Yes I feel [name of person] is safe, I have never seen anything that has given me concern."

Staff also felt people were safe living in the home. There were systems in place to protect people from harm and abuse. Staff were aware of the indicators of potential abuse and how to report any concerns, and they were confident that any concerns would be investigated by the manager to ensure that people were protected. They were also aware of the whistleblowing policy and that they could report concerns to agencies outside of the organisation such as the Care Quality Commission (CQC). One staff member said, "If I suspected anything I would go to [name of manager] I am confident he would take the right action and if he didn't I know I can go to CQC. I know all about the whistleblowing policy. I haven't had to use that here. I trust the carers here but if I thought for one minute they were doing something wrong I would 100% report it." This meant people were supported by staff who knew how recognise and report abuse.

There were risk assessments in place relating to people's individual care. They gave information about how risks were minimised to ensure people remained safe. Assessments covered areas where people or others could be at risk such as moving and handling, risk of falls and risk relating to difficulties swallowing food. The staff we spoke with were aware of the risks relating to people and the measures in place to reduce the risk.

When incidents or accidents happened in the home staff recorded these on incident forms. Incident forms were reviewed by the manager to determine if any action was required. Staff told us incidents and accidents did not regularly occur in the home and records confirmed this.
Where an incident had occurred we saw lessons were learned and improvements were made. For example, when people had experienced a fall we saw people had movement sensors in their bedrooms which had reduced the amount of falls they experienced. We also saw where an external agency had made comments about the lack of information staff had available to handover to them, measures had been put in place to ensure this information was available.

Good

Is the service effective?

Our findings

People told us they thought staff had the right skills and knowledge to carry out their role. Comments included; "Staff knowledgeable, yes I think so. If one doesn't know they ask one of the others", "Yes, they are knowledgeable", "Yes, I think they are well trained" and "Skilled, yes, they are good at their job, knowledgeable."

Staff told us they received an induction when they started working in the home and they commented positively about it. One staff member told us, "The induction covered everything, I did some shadowing and if I was stuck there was always someone to ask." Another commented, "They made me feel relaxed, I read the care plans and they showed me the recording charts, I did some shadowing and training. I was told if I was unsure about anything I should ask, they were very supportive." The induction was linked to the Care Certificate. The Care Certificate standards are recognised nationally to help ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us they had one to one supervisions (meetings with their line manager to discuss their work) and they found them supportive. They also confirmed the manager carried out informal discussions and observations to offer support and feedback. One staff member told us, "We have supervision every six months, I feel 100% supported." Another commented, "We have a chat about how we are getting on, what training we need and if we are happy in our jobs. [Name of manager] also observes us assisting people to reposition them." The manager was also in the process of arranging annual appraisal meetings with staff to discuss and provide feedback about their performance.

Staff told us they felt they had enough training to keep people safe and meet their needs. They told us they preferred the face to face training rather than completing eLearning sessions on the computer. The manager told us they were arranging more face to face training sessions for staff for 2018 in response to the feedback they had received from staff. One staff member told us, "So far the training has been very good." Other comments included; "We are kept up to date with all of our training, I like the face to face training as it sinks in more. [Name of manager] asks us what training we would like to do" and "If you suggest any training they will arrange it."

We looked at the training records which evidenced all staff received basic training such as fire safety, safeguarding, first aid, moving and handling and infection control. Staff had also received training in dementia and the manager told us they had arranged for staff to attend end of life and equality and diversity training for 2018.

We reviewed how people were supported in line with The Mental Capacity Act 2005 (MCA). The 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.

Care records showed that people's capacity had been assessed where they lacked the capacity to make specific decisions for themselves. For example, we saw capacity assessments had been carried out for decisions relating to sensor mats being used to alert staff to people's movement and help keep them safe and also for the use of bedrails. Where the outcome of the assessment was that the person did not have the capacity to make the decision, a best meeting was held with relevant others including the person's relative, social worker, districts nurses and their GP. Relatives confirmed they were involved in best interest meeting where required. This meant people's legal rights in relation to decision making were being met.

Staff had received training in the MCA and we found their understanding of how the Act related to the people they support was mixed. They described how they gave people choices and respected their wishes and the manager told us they had arranged for further training in the MCA for staff in 2018. People confirmed staff sought their consent before providing assistance. One person told us, 'Permission, yes they ask and explain before giving care" and another commented, "Permission, oh yes."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for two people who required DoLS had been made both of which were pending assessment by the local authority.

People received the care and support they required because staff assessed their needs and took account of their wishes when they provided support. Each person had a care plan which identified their needs and showed how these needs would be met by staff. Care plans had been reviewed and changes had been made when people's needs had changed. Staff we spoke with had a good knowledge about each person and what was important to them.

Staff had an understanding of equality and diversity and they told us they discussed equality and diversity as part of their induction and during staff meetings. Staff spoke of meeting people's individual needs through care planning, understanding their life histories and getting to know people as individuals. The manager told us how they had planned for all staff to attend equality and diversity training in 2018.

People's care records showed referrals had been made to appropriate health professionals when required. These included the chiropodist, optician, the district nurse and audiologist. When a person had not been well, we saw that the relevant healthcare professional had been contacted to review their condition. This meant people's healthcare needs were being met and they received on-going healthcare support. A health professional commented on how they thought the staff team were aware of people's needs and that they followed advice and guidance. One relative told us, "They get the Dr in if they are at all concerned and the district nurse comes in every week, they always let us know, I am happy [names] healthcare needs are met."

People commented positively about the food provided. Comments included; "Food, quite good, you get a choice. I can have drinks and snacks outside of meal times or something from my goody box", "I find it quite acceptable, ordinary food, not a lot of fancy stuff. You can always help yourself to drinks if you want" and "Food, perfect."

People were supported to maintain a healthy diet and people who were at risk of malnutrition were assessed and monitored by staff where required. We observed people had access to drinks in the communal areas and in their bedrooms. We observed staff encouraging people to have a choice of drinks throughout the inspection to ensure they remained sufficiently hydrated.

We saw records of one person who was having their fluid monitored because they could be reluctant to drink. The person's fluid intake was low. Staff told us they regularly offered the person drinks and they recorded how much they drank and when they refused, records confirmed this. The person's GP had been regularly involved in reviewing the person's wellbeing and they had confirmed they were happy with the current fluid intake.

There were two main meal options on the menu each day and if a person did not like what was on the menu they could choose something else. One person said, "Yes you can have something else if you don't like what is on offer. I tell them what I don't like." The cook demonstrated knowledge of people's likes and dislikes and dietary needs and they had a list of these available in the kitchen.

We observed the lunchtime meal which was a relaxed and unhurried event. We observed people being assisted with their meals in a way that respected dignity and at a pace led by the person. Three courses were served at lunchtime and people appeared to enjoy the food they were eating. Staff ensured there were condiments available on the tables for people to use if they chose.

People lived in a home that was not purpose built and was in need of some redecoration and up grading to make sure it provided a comfortable home. The provider had a refurbishment plan in place and we saw some of the action points had been completed, for example some chairs had been replaced in the lounges and new flooring had been fitted. We saw the provider had a plan in place for the works they intended to carry out in 2018 that included decorating the lounge improving the outside garden area and replacing carpets.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout both days we saw staff spoke to people respectfully and showed kindness and patience when supporting them. Staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

People commented positively about the staff working at Centenary House. Comments included; "The staff are kind and caring. I get on well with them", "I like them all, they are all good to me", "Staff are very nice, kind and caring" and "They are ever so good to me, everybody."

Relatives also commented positively about the staff. Comments included, "They staff always seem to be caring and [name of relative] seems to like the staff, they chat with her and have a laugh" and "One of the things that really impresses me here is that [name of manager] chooses staff who really care."

People told us staff knew them well. One person said, "I get on well with them, they know what's important to me." Another commented, "Oh yes, they know what's important to me."

Staff spoke positively about people; they demonstrated empathy and were able to tell us about people's likes, dislikes and what was important to them. One staff member told us how they had developed a positive relationship with one person who had been anxious when they first moved to the home. They commented, "[Name] was scared and anxious when they first moved in because it was all different for them. I spent time chatting with them, they will talk to you for hours, we've managed to create a bond and [name] is much more settled now."

Another staff member told us how they supported a person who could be reluctant to accept support. They told us, "[Name] doesn't always accept support, we try a different approach, go back with a cup of coffee or get another staff member to offer support, and you explain what you're doing as you're going along. They are vulnerable and I like to think how I would like my granddad to be treated and how I would want someone to treat me." This meant people were supported to develop positive relationships with the staff.

People had a document called 'This is me' in their care plans. These were used to record information relating to the person's life history including their previous occupations, family details, likes and dislikes. Information such as this is important when supporting people who might have dementia or memory loss. Some of the documents required further information and the manager told us they were in the process of contacting family members to obtain this information.

People's privacy and dignity were respected. One person told us, "The staff are very nice, they keep my dignity." Another commented, "They help me keep my dignity when I have a shower." Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains and explaining what they were doing. We observed staff supported people discreetly when they required support with personal care.

People chose what they wanted to do and how and where to spend their time. Some people chose to stay in their rooms; others chose to spend time in the lounges. One relative told us, "[Name of relative] doesn't like to move too quickly in the morning and the staff respect their wishes." Relatives told us they were kept informed about any changes and were involved in decisions where people were unable to fully express their views.

We saw feedback cards from relatives to the manager and staff team giving positive comments about the staff. Comments included, "We are very grateful for all of your care and support" and "Thank you for all the care you give."

People were able to see visitors when they wished. There were relatives and friends visiting people in the home during the inspection. Relatives told us that they were known by the staff team and always made to feel welcome. One relative told us when they first came to the home they were made to feel, "Very welcome."

Good

Is the service responsive?

Our findings

During our last inspection on 6 and 7 September 2016 we found there was a failure to provide meaningful activities reflecting the likes and dislikes and life experiences of people living in the home. We also found that people's care plans were focused on tasks and did not reflect personalised information. At this inspection we found improvements had been made.

People told us they were happy with the activities on offer, one person told us, There's always something going on, cards, bingo, playing the organ, somebody comes in." Other comments included; "I take part in activities, I enjoy them" and "Yes I join in activities, I'm very happy doing everything." One relative told us, "[Name] really benefits from the activities and looks forward to them."

There were a range of activities on offer in the home; these included external companies coming into the home for music and exercise sessions. During the inspection we observed upper body exercise to music which was enjoyed by the participants as demonstrated by their engagement and smiles. There was an activities coordinator who arranged in house activities that included card making, bingo, games and puzzles. One relative commented positively about the activity coordinator stating their family member had become much more involved in the activities since they had started working. The evening before the inspection the homes Christmas Party was held and people spoke positively about this. One person told us, "I enjoyed the party yesterday." We saw the record of activities on file and saw one to one sessions were also held for people on a regular basis.

People were supported to stay in touch with friends and family to promote their emotional well-being. People were able to follow their religious and spiritual beliefs because religious services were held at the home. One person told us, "Church ladies come in and take communion. Quite a nice little service and a nice drop of wine." During our inspection we saw a Christmas service being held which people attended and appeared to enjoy.

The staff were responsive to people's needs and wishes. Most people were able to make their needs and wishes known on a daily basis. One person told us, "I am well looked after." One relative said, "[Name] makes decisions about their care, the staff all seem good and [name] is as happy as they can be without being at home."

Each person had a care plan that was personal to them. People's care plans gave information about people's personal routines to make sure staff had information about people's preferred ways of living. Where people required support and encouragement with their routines this was recorded and staff were aware of the support people required.

We found some information was difficult to find in the care plans. For example, the manager told us a GP had been involved with one person whose fluid intake was low, stating they were happy with the intake. Whilst we saw information from the GP confirming this, there was no reference to the GPs input in the person's care plan. District nurses carried out risk assessments relating to people having bedrails on their

bed; again there was no reference to this in the care plans. The manager demonstrated they were in the process of updating the care plans and they were introducing a new care plan format that would include more specific details about people's needs.

People and their relatives contributed to the planning of their care, we saw people had signed their care plans where they were able to, which demonstrated their agreement. One relative told us, "I was involved in the initial assessment and felt listened to, we don't have formal sit down reviews but I'm in everyday and am kept up to date as soon as I walk in. I feel involved."

We discussed with the registered manager how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. One person had limited communication and we saw this was detailed in their care plan. The person had a book of pictorial resources for staff to use to assist the person to communicate. We received mixed feedback from staff about the resources being used as some of the staff felt they knew the person well enough to determine what they were communicating; one staff member however told us they did not use it because the person was not able to communicate. Other staff members said they used the resource at times with success. We discussed this with the manager who confirmed that the resource was used mainly for communication with health professionals and new staff members who the person did not know well.

The staff worked closely with local healthcare professionals to ensure people's comfort and dignity at the end of their lives. At the time of the inspection there was no one who was requiring end of life care. However, we saw a care plan for one person who had recently received end of life care at Centenary House. The care plan was completed with input from the person's relatives and included details of the person's spiritual needs, preference's around their appearance, what was important to them, privacy and input from relevant health professionals. Staff described how they assisted people in a compassionate way at this time. The manager and community nursing staff ensured appropriate medicines were available to people nearing the end of their life to manage their pain and promote their dignity.

People told us they would feel comfortable raising a concern with any member of staff if they needed to. One person told us, "Anything you have to say, you tell who's looking after you." Another commented, "Any worries you chat through with whoever is around."

Relatives also felt confident any concerns would be responded to. One relative told us, "I would, raise any concerns with [name of manager] or any staff member and I'm sure it would be taken seriously. Another commented, "If I have any concerns I talk to [name of manager] and they are usually pretty good." We saw the complaints procedure was displayed around the home for people and visitors to see. There had been three formal complaints received by the service in the past year. Records demonstrated complaints were responded to and action was taken to rectify issues where concerns were raised. For example, where a relative had raised a concern about missing laundry, the manager had arranged for a laundry assistant to work six hours each week.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection on 6 and 7 September 2016 we found the systems to audit the quality of the service were not fully effective. At this inspection we found some improvements had been made, however we found further concerns relating to the safety and quality of the service and the providers audits had failed to identify these. This exposed people living in the home to the risk of harm.

There were systems in place to monitor the service. These included a range of audits completed by the manager and provider. The audits the manager completed covered areas such as medicines, the environment, cleanliness, quality of food, the dining experience and health and safety. The provider also visited the home monthly to carry out a range of checks that included; care plans, health and safety checks, staffing, training and talking to people and staff.

Some of these audits were identifying shortfalls in the service and the action required to remedy them. For example, where staff required refresher training this was identified and set as an action point. However, the systems in place were not fully effective in identifying all of the shortfalls we found during our inspection. We also found suitable, timely action had not always been taken to ensure improvements were made. For example, the provider and manager's health and safety audits had failed to identify people were at risk of exposure to hot radiators and hot water temperatures. They had failed to identify the water system was not being checked to prevent the growth of legionella bacteria and they had failed to identify the risks relating to people having their bedroom doors propped open in the event of a fire. Whilst there was an action plan in place to replace the bedroom doors with automatic opening devices, this action had not been completed. This had been a recommendation from the fire service 11 months prior to the inspection in January 2017.

At the previous three inspections in September 2016, August 2015 and October 2014 the home has been rated as, 'Requires Improvement.' At the inspections in October 2014, September 2016 and this inspection there have been repeated breaches in regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the systems in place to improve the quality and safety of the service had not been effective.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection on 6 and 7 September 2016 we found the provider had failed to notify the Care Quality Commission (CQC) of events and incidents as required. At this inspection we found improvements had been made. The manager was aware of their legal responsibility to notify CQC of significant events when required.

There was a manager in post who had worked in the home since 2015. The manager was in the process of applying to become the registered manager with CQC. They confirmed they had their registered manager's interview in February 2018. The manager told us they felt well supported by the provider, they told us the provider was available for support on the telephone if needed.

The manager maintained a regular presence in the home. People and their relatives knew who the manager was and felt comfortable approaching them. The manager had knowledge of the people who lived at the home and the staff who supported them. They spent time in all areas of the home which enabled them to constantly monitor standards. One person told us, "You just say you'd like to speak to [name of manager] and he comes. Approachable, yes he sorts everything out." Relatives commented, "[Name of manager] has been very helpful and he listens to us" and "[Name of manager] is good."

Staff also spoke positively about the manager. One staff member said, "I can't fault him, he is definitely approachable." Another commented, "If there is a problem you can go to him and he also lets us know if there are any issues. I like the fact that he will come down from the office and talk to you." The manager told us they promoted an open door policy for staff to approach them. Staff confirmed this. One staff member told us, "He is there for everyone and his door is always open."

Staff talked positively about the team culture at Centenary House. Comments included; "The team are brilliant, we all get on well", "We all respect each other and get on well" and "They are a brilliant team, we all work together and everyone gets on. I genuinely love coming to work they are such a nice group of people to work with." This meant people were supported by staff who were motivated and positive about their work.

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "Staff meetings are very two to three months, we cover everything. It's a chance for us all to get together and we are truthful about any issues, we look at any improvements we can make." Meeting minutes reviewed demonstrated items discussed included day to day items such as recording information about people, expectations around completing the laundry, staffing rotas, medicines and training.

The registered told us their aim for the service was for people to receive the best possible care, to feel safe and happy and for Centenary House to be their home. Comments from people showed this ethos was put into practice. One person said, "I feel secure and happy." Another person told us, "It's a wonderful place." One relative told us, "It's like a family home, people aren't overlooked and the staff know all of the relatives." Staff told us the aims of the service were, "To make sure people are happy and have the best lives possible" and "To make sure people are safe, happy and take part in the activities they choose."

People told us they were able to give feedback on the service, one person said, "Yes, we do very often get asked our opinions and I tell them what I think. Oh yes they look into things and act on them." Resident meetings took place six monthly for people to discuss matters relevant to the home. The last meeting had been held in July 2017 and we saw items discussed included; activities, menus and their general thoughts about the home. The feedback from people in the meetings was positive. The manager told us they regularly had informal meetings with people and their relatives for them to raise any concerns and people and their relatives confirmed this.

The provider also sought the views of people and their relatives by six monthly satisfaction surveys. We reviewed the feedback from the previous survey held in July 2017. Where there were people and relatives raised any concerns an action plan was put in place to address this. For example, where concerns were raised about the laundry, an additional staff member had been allocated on the rota to complete this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected from risks relating to unsafe premises. Risks had not always been assessed to protect people from harm. Medicines were not always managed safely. Regulation 12 (1) (a) (d) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not living in an environment that was suitably clean. Regulation 15 (1) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the services provided were not fully effective. Regulation 17(1)(a)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 22 February 2018.