Virk Family Limited

# Carrington House Care Home

**Inspection report**

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## Ratings

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

## Overall summary

We inspected the service on 14 October and 29 October 2015. Carrington House Care Home is registered to provide accommodation for up to 27 older people. The service is situated over three floors with a small shaft lift for access to the upper floors. On the day of our inspection 22 people were using the service.

A new manager was in place at the service. The new manager confirmed that they had applied to become the registered manager and we received confirmation that their application had been successful following our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection on 19 November 2014, we asked the provider to take action to ensure people were protected against the risks of receiving care that was unsafe. This

# Summary of findings

was because we found that the procedures in place to ensure that a person received their diet and medicines in an appropriate form were not effectively managed. This placed the person at risk.

On this inspection we found that procedures had improved but the provider was still not fully effective in managing risks to people. We found that some people's care plans did not contain the required information as to how risks to people could be reduced or staff were not always following guidance on how to keep people safe.

People were protected from the risk of abuse and staff had a good understanding of their roles and responsibilities if they suspected abuse was happening. Staffing levels were sufficient to support people's needs and people received care and support when required.

We found that people received their medicines as prescribed but the management of medicines required further improvement.

People were supported to make their own decisions where they were able. For people who lacked capacity to make their own decisions, capacity assessments were in place for some decisions but not for others. Applications had been made to ensure that people were not deprived of their liberty without the required authorisation.

People were supported to eat and drink enough, however there was a lack of care plans to ensure that people had their nutritional needs properly assessed. Referrals were made to health care professionals for additional support or guidance when needed.

People were treated in a caring and respectful manner and staff delivered support in a friendly and supportive manner. People who used the service and their relatives knew who to speak with if they had concerns and were confident that these would be responded to.

The views of people who used the service were sought in monitoring the quality of service provision. Regular audits were undertaken within the service and action taken where required.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not consistently safe.

People were not always supported effectively with risks to their health.

We found that people received their medicines as prescribed but the management of medicines required further improvement.

Effective systems were in place to recognise and respond to allegations of abuse.

There was enough staff to meet people's needs and staff able to respond to people's needs in a timely manner.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective.

People were supported to make independent decisions where they were able but capacity assessments had not always been carried out where required.

People were supported to eat and drink enough, however there was a lack of care plans to ensure that people had their nutritional needs properly assessed. Referrals were made to health care professionals for additional support or guidance when needed.

**Requires improvement**

**Is the service caring?**
The service was caring.

People's privacy and dignity were respected by staff in a caring manner.

People were encouraged to make choices and decisions about the way they lived and were supported to maintain their independence.

**Good**

**Is the service responsive?**
The service was not consistently responsive.

Staff were not always aware of how to respond to people's changing needs.

Some people were able to pursue their interests independently of staff and we saw other people supported with individual activities. Staff and relatives told us they thought that activities provided could be improved and we saw evidence that this was being responded to.

People felt comfortable to approach the manager with any issues and complaints were dealt with appropriately.

**Requires improvement**

**Is the service well-led?**
The service was well led.

**Good**

# Summary of findings

People felt the management team were approachable and were positive of improvements that had been made to the service. People felt that their opinions were taken into consideration. Staff felt they received a good level of support and could contribute to the running of the service.

There were systems in place to monitor the quality of the service and where issues were identified there were action plans in place to address these.

# Carrington House Care Home

**Detailed findings**

## Background to this inspection

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

This unannounced inspection took place on 14 and 29 October 2015. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with 11 people who were living at the service and two relatives who were visiting their relations. We spoke with four members of staff, the registered manager and the provider. We observed care and support in communal areas. We looked at the care records of four people who used the service, two staff files, as well as a range of records relating to the running of the service, which included audits carried out by the manager and provider.

We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing car to help us understand the experience of people who could not talk with us.

Requires improvement

# Is the service safe?

## Our findings

At the last inspection on 19 November 2014, we asked the provider to take action to ensure people were protected against the risks of receiving care that was unsafe. This was because we found that the procedures in place to ensure that a person received their diet and medicines in an appropriate form were not effectively managed. This placed the person at risk. Although improvements had been made, during this inspection we found that procedures were still not fully effective in managing risks to people.

The manager was in the process of updating people's care plans. We found that some people's care plans did not contain the required information as to how risks to people could be reduced. For example, one person had been assessed as requiring a mobility care plan as they were at risk of falls. This was not in place so it was unclear how the person was supported with their mobility to reduce the risk of falls. Another person's care needs had been formulated into care plans without first identifying what risks the person faced from these. We drew this to the registered manager's attention who corrected this by our second visit.

Additionally we found guidance from a professional to reduce risks to a person was not followed. One person had been assessed by the Speech and Language team (known as SALT who advise on nutrition and swallowing difficulties) due to a risk of them choking. Recommendations were written in the person's care plan however these were not being fully implemented. This placed the person at risk of choking. Staff did not understand the importance of these recommendations and told us they would welcome more training and guidance about risks people faced when swallowing.

The outcome of a recent safeguarding investigation had made some recommendations as to how one person should be supported to ensure their safety when using bed rails. The recommendations had not been properly recorded in the person's care plan and we established the person was not receiving the recommended support.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care plan included detailed information to help staff understand the person and how they presented themselves. There was guidance on how staff should support the person to keep themselves and other people safe.

We found that Personal Emergency Evacuation Plans (PEEPS) were in place. These contained information about the supports each person would need to evacuate the service in the event of an emergency situation, such as a fire.

People told us they felt safe and were aware of what to do if they felt unsafe or were not being treated properly. One person told us that they felt, "A lot safer with [new management]" whilst another said they felt safe, "Because there was nothing to worry about."

People could be assured staff were confident in reporting, and acting on, any issues which could compromise their safety. Staff had received training in protecting people from the risk of abuse. Staff we spoke with had a good knowledge of how to recognise and respond to allegations or incidents of abuse. They understood the policies and knew the process for reporting concerns and escalating them to external agencies if needed. We saw that the contact details of the local authority safeguarding team were displayed in a prominent position in the home.

People felt there were sufficient staff to meet their needs. We spoke to people who used call alarms to alert staff when they required assistance. All of the people we spoke to told us that that the response time of staff was "acceptable" and one person told us that staff responded, "straight away."

We observed that call bells were answered promptly and when people needed assistance this was given in a timely manner. We saw staff had the time in the morning to sit and spend time with people and have a chat with them. We found that systems were in place to determine how many staff would be required to support people through analysing people's needs. .

Staff told us that they felt there was enough staff to meet people's needs. One member of staff told us the staffing levels, "Are a lot better."

People could be assured that staff employed at the service were suitable to work with adults receiving care and support. Records showed people were only supported by

Requires improvement

# Is the service safe?

staff who had been safely recruited and had undergone a thorough pre-employment screening procedure, including the Disclosure and Barring Service (DBS), as part of the recruitment process. DBS checks help employers make safer recruitment decisions.

People who used the service told us they were happy with how they received their medicines. We found the people received their medicines as prescribed and medicines were stored safely. People were given their medicines by staff who had been trained and assessed as competent by the registered manager to do so. We saw staff administering medicines safely and records showed people were given their prescribed medicines correctly.

Safe practices were not followed to ensure people's medicines were correctly recorded on the medicine administration record (MAR sheet.) Handwritten entries were not checked by another member of staff to ensure they had been copied onto the MAR sheet accurately. This posed a risk of error if the member of staff did not enter the correct information.

We also found that MAR sheets did not have a photo of the person on the front sheet and that information about a person's allergies was not recorded. This had been identified during a medicines audit and the manager confirmed that they had contacted the pharmacist to have MAR sheets updated.

Requires improvement

# Is the service effective?

## Our findings

People felt they received care from sufficiently skilled and competent staff. One person told us, "I think they do (know how to provide effective care), some are better than others."

Staff told us that on commencing employment they were required to undertake an induction process which they felt equipped them for the role. They told us the induction process allowed them to familiarise themselves with the needs of people who used the service and also gave them the opportunity to read the organisation's policies and procedures. We saw evidence of staff being enrolled on the 'Care Certificate' to ensure that their knowledge was up to date and that they could carry out their roles effectively. The Care Certificate is a national qualification for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support.

Staff told us that training to ensure that they could remain competent and confident in performing their roles and responsibilities was required and was high on the list of priorities for the manager. Recent training in areas such as moving and handling, safeguarding and record keeping had been provided to staff. One staff member told us, "I am getting training now. I never got any before." This information was supported by records examined during our inspection. There was a training plan in place to ensure staff received the required training.

People were supported by staff who received supervision and guidance about the way they worked from senior staff. Both of the staff members we spoke with had recently attended supervision with the manager to discuss training needs and their performance. One member of staff said, "The manager is brilliant and I can go to [them] at any time."

People could be assured they would be supported to make independent decisions about their care and support. One person told us, "I feel free to come and go." We observed people coming and going from the service throughout the day and that one person was supported by staff to go to the shop.

We found staff were appreciative of people's rights to spend their time as they pleased and respected people's day to day decisions. Staff had a basic knowledge of the Mental Capacity Act 2005 (MCA). The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability.

We saw that two people had capacity assessments in place for some decisions but not for others. We saw evidence that a capacity assessment had been undertaken and an appropriate decision made in respect of whether a piece of mobility equipment should be used by one person. Another person did not have a required capacity assessment in place regarding the use of equipment to keep them safe. This was brought to the attention of the manager and we saw when we returned to the service for the second day that this had been addressed.

We found that the manager and provider were knowledgeable about the Deprivation of Liberty Safeguards (DoLS) which are part of the Mental Capacity Act 2005 and had made applications where required. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

People expressed mixed feelings on whether they were happy with the food offered. Two people told us that the food was, "very nice" whereas three people told us that they felt the food was of poor quality and one person told us the food, "had gone downhill." One relative also told us that they were, "not particularly happy either in amount" or the food offered to their relation. However, we saw that people had been involved in planning menus by discussing their preferences at regular meetings.

Due to a lack of care plans for some people we could not be sure that people were having their nutrition properly assessed. The manager told us that people were currently being weighed weekly to assess if they had any changes in weight to determine whether further support was required.

We saw people were supported to eat and drink enough to maintain their required nutritional level and remain hydrated. We observed that drinks were offered to people at regular intervals throughout the day and that one person was encouraged to drink by a member of staff noticing that their tea had gone cold and being brought another. People were offered two choices of a main meal and it was planned that the daily menu would be put up on the

Requires improvement

# Is the service effective?

noticeboard with pictures to aid people's choices. We observed people were given the support by staff they needed to eat their meal. We saw that when people had lost weight they had been referred to the nutritionist.

Some of people's individual nutritional needs were not being catered for. Although the relief cook and care staff knew about people's different dietary requirements, people were not always supported to meet these. For example, people who may need additional sugar to help prevent weight loss by providing extra calories were not provided with this. Additional sugar was not added to everyone's food in order to meet the needs of people who required a sugar free diet rather than providing different food suitable to each person's needs. One person's care plan gave guidance on the importance of this person having fortification such as extra sugar in food. However we saw other people were provided with an individual diet specific to their needs.

People told us they had access to health care professionals and staff had sought their advice to support people with their health care needs when required. One person told us that they had received a "very prompt" response from staff in seeking medical attention when they had a stroke.

Staff also confirmed they felt that healthcare professionals were involved in people's care package when required. One member of staff told us, "Yes I think that referrals are made when needed. That has got a lot better." The member of staff also said other healthcare professionals visited the home such as district nurses, dentists and opticians. Records accessed supported this information.

One person's care plan evidenced that they were at risk of developing a pressure ulcer. We saw that staff were following the recommendations from the external professional and were repositioning the person at the recommended intervals to minimise the risk of them developing a pressure ulcer. We saw that another person had a catheter and we saw there was a detailed care plan in place informing staff how to monitor this and signs to look out for that the community nursing team may need to be called.

Staff made referrals to appropriate external healthcare professionals when people needed extra support or their health needs changed, for example the falls prevention team and the community nursing team.

Good

# Is the service caring?

## Our findings

People felt the staff were caring and compassionate. One person told us staff were, “Kind on the whole, I never hear any shouting.” We spoke to two relatives who told us that staff were “lovely.” We also spoke with a visiting healthcare professional and they told us they felt staff were kind to people.

We observed positive and caring interactions between staff and people who used the service. For example we saw a member of staff kneeling by a person’s bedside and holding their hand to provide comfort to the person.

We also saw a member of staff sitting with a person and painting their fingernails for them. There was a lot of chatter and we saw the person was very interested in this and enjoyed the engagement. The member of staff spent over 45 minutes with the person and we saw that this had a positive effect, with the person smiling and laughing and joining in the conversation.

Staff clearly knew people well and were able to use this to give people the support they needed. We observed one person who on our previous inspection had appeared isolated and unhappy looking well and happy. They were relaxed and spent time in the lounge reading the newspaper and chatting with other people who used the service. We heard this person comment on a member of staff who spoke with them and they said, “She is nice isn’t she.”

People had access to an advocate if required. Advocates are trained professionals who support, enable and empower people to speak up. The manager told us that three people at the service were currently using an advocate and they had approached an advocacy organisation about providing regular sessions at the service.

We saw people were given choices about what they did and how they spent their time. We observed that people spent time in their own bedrooms when they wished and saw that some people chose to have their meals in other areas of the service, other than the dining room

We observed people being given choices of food and drinks. The cook spent time asking people what they would like for their next meal and during lunch we saw people were given the meal of their choice. One person had asked for an alternative meal and this was provided.

People we spoke with told us that staff respected their privacy and dignity. One person said, “Staff do knock [on bedroom door]” and we observed that if the person did not wish staff to enter their room this was respected. We found people had access to private areas within the home which they could use if they wished. We observed people going to and from their bedrooms and sitting in different areas throughout the home.

We also found members of staff were appreciative of the importance of maintaining people’s privacy. One member of staff told us, “We do have some people who share rooms and we would always use screens if we were providing care to somebody.”

We observed staff were mindful of people’s privacy and dignity and ensured any discussions about people were in private. When we observed staff supporting people we saw they respected people’s privacy. In one of the new care plans we viewed we saw there was information recorded which reminded staff to consider people’s privacy and dignity when supporting them.

Requires improvement

# Is the service responsive?

## Our findings

People expressed mixed views on whether their individual preferences and needs were known by staff. One person told us that some staff were "Okay" but that other staff members "responded to a sheet (of paper)." A relative told us that that felt their relation's needs were "understood."

Some people did not have effective care plans in place so staff would know their needs and how these should be met. The manager was in the process of updating people's care plans and not all staff had seen the updated plans. The manager showed us a document which was being used as a temporary measure which included a basic guide of people's health needs, any risks, nutritional needs and how much support they required from staff. The lack of an effective care plan for some people posed a risk that staff would not know about all of the person's needs or how to respond if their health declined.

The staff we spoke with were knowledgeable about people who lived at the service but were not always able to tell us how they would respond to changes in a person's healthcare condition. For example, one person had diabetes. A care plan had recently been produced which detailed how staff should support the person with their condition and what signs and symptoms to look for which may indicate a change in their condition. A staff member we spoke with had not seen the care plan and was not able to tell us what symptoms they would need to look out for. This posed a risk that staff may not be fully aware of how to monitor a person's healthcare condition and respond quickly to any changes which may affect the person's health.

We saw two newly written care files contained detailed care plans which described the support people needed. For example one person's tissue viability care plan described how frequently staff should reposition the person to prevent their skin from damage. Records used to document when care was provided showed the person had received the repositioning support they required.

There was information about people's earlier lives including any achievements and significant relationships in the new care plans. There was also a great deal of details about how each person preferred to be supported.

However we found some bedrooms were not personalised and were quite bare. In one bedroom we were unsure if anyone lived in the bedroom due to the lack of personalisation.

People had not previously been involved in preparing their care plans. The registered manager told us people were not aware they could be involved in planning their care and they planned to make changes so they would be in future. We saw that this had been actioned in the new care plans which contained evidence that the person or their relative had seen and agreed with the contents of the plans.

We saw that there were few planned activities being provided in the service in the weeks previous to our inspection due to the activities co-ordinator providing cover in the in the kitchen in the absence of the usual cook. One relative told us there was, "Nothing going on, that is the problem."

Nevertheless some people told us they had the opportunity to get out and about and pursue their interests and hobbies. One person showed us a collection of bus tickets and we saw that other people had been supported to visit the local shop to purchase items on the day of our inspection. We saw staff had time to sit and talk with people and one person was involved in an activity with an off duty member of staff.

Staff told us the activities provided for people could be improved and one member of staff told us that they felt that people should get out more. The manager had addressed this issue by sending out surveys to relatives asking for their opinions on activities and holding meetings with relatives and people who used the service to gather ideas. The results of the information had been gathered and we saw evidence that more structured activities were planned within the service by external providers and the activities co-ordinator.

People felt they were able to say if anything was not right for them. People we spoke with and their relatives felt comfortable raising concerns with the manager. Comments included, "New manager (is) very good, gets things done," and "Yes, I'd go to [manager]."

The organisations complaints procedure was on display within the service and staff were aware of the complaints procedure. Staff felt confident that, should a concern be raised with them, they could discuss it with the management team. They also felt complaints would be

Requires improvement

# Is the service responsive?

responded to appropriately and taken seriously. One member of staff told us, "If there is a complaint I would go the manager or senior (staff member), the manager would act on any concerns."

We also found that recent meetings had been held with people who used the service and their relatives. The meetings provided a forum where comments and suggestions could be discussed to help identify recurring or underlying problems, and potential improvements.

Records showed that when complaints had been received they had been recorded in the complaints log and managed in accordance with the organisation's policies and procedures.

Good

# Is the service well-led?

## Our findings

People told us they felt confident in approaching the manager if they wanted to discuss anything with them and felt that they had made a positive difference to the service. One person told us "(Things) are much better with new manager." Another person told us, "I'd go to [manager] (with any concerns), [manager] is liked." Relatives and visitors to the service also spoke positively about the change in management at the service, one relative told us, "It has changed brilliantly."

People and visitors to the service told us that the manager was visible around the service. We observed the manager interacting with one person during our inspection. The person clearly felt comfortable approaching the manager to ask about the support they received with personal care. The manager sat with the person and engaging in conversation about the support the staff could provide. It was evident that the manager had a good rapport with the person.

Staff told us that the manager was approachable and was a significant presence in the service. They said they felt comfortable making any suggestions about improvements to the service and that these would be listened to and acted upon. The staff we spoke to had confidence in the manager and were positive about improvements that had been introduced developing an open inclusive culture within the service. One member of staff told us, "The manager is brilliant. I can go to [manager] at any time."

The staff we spoke with told us that they enjoyed their roles and were supportive of a manager who was proactive in developing the quality of the service. For example, there was now a housekeeper working seven days a week. We found systems in the laundry were working better as a result of this and laundry was being completed in a more timely way. We also saw that staff had been given uniforms and badges so that people and their relatives could more easily identify staff and know their names.

Throughout our inspection we observed staff working well together and they promoted an inclusive environment where friendly chit chat was being undertaken between staff and people who used the service. The staff told us that they felt that they worked well as a team and we observed that the service felt more organised and structured than it had on the previous inspection.

The manager was not registered with the Care Quality Commission at the time of our inspection. An application had been received and we were informed that the manager has been registered the day after our return visit. We found the management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).

People benefited from interventions by staff who were effectively supported and supervised by the management team. Staff told us that they had attended supervision sessions and annual appraisals. Staff told us the meetings provided them with the opportunity to discuss their personal development needs, training opportunities and any issues which could affect the quality of service provision. One staff member told us that they stated in their supervision session with the manager that they would like more training and they have been told, and have confidence, that it will be provided. We found staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures without fear of recrimination.

People residing at the service and their relatives were given the opportunity to have a say in what they thought about the quality of the service. This was done by sending out surveys in August 2015. The information from the surveys was collated and a report was produced. The report was used to identify where improvements to service provision could be made and meetings were held to discuss the results of the surveys and the action that would be taken. We saw that some of the actions identified had been introduced such as a keyworker system and new staff uniforms and that other identified actions were in progress.

Internal systems were in place to monitor the quality of the service provided. We saw the provider and the manager were checking the quality of care delivery and safety of the service by carrying out audits. These included regular audits of medication, fire safety equipment and record keeping. We saw that the provider had identified issues when carrying out room spot checks and action required was recorded and it was ensured that action was taken.

Systems were in place to record and analyse adverse incidents, such as falls, with the aim of identifying strategies for minimising the risks. This showed that the provider was proactive in developing the quality of the

Good

# Is the service well-led?

service and recognising where improvements could be made. The manager, with the support of the provider was prioritising improvements in the service and recognised what still needed to be done.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided in a safe way for service users. Regulation 12 (1)(2)(a)(b) |