

Regal Care Trading Ltd

Loose Court

Inspection report

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Tel: 01622747406

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 26 April 2016 and was unannounced.

Loose Court is registered to provide accommodation and personal care for up to 42 older people with dementia. Accommodation is provided on two floors with a lift between floors for easy access. The home has a garden area which provides a safe outdoor space. The premises are situated on the outskirts of Maidstone. People had a variety of complex needs including onset of dementia, physical health needs and mobility difficulties.

There was a registered manager at the home. 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.

Medicine was being administered crushed to one person, which is called covert medicine administration. The correct process for covert administration of medicine had not been followed.

One to one staff supervision had not been consistent. There were gaps in supervisions which showed that staff had not sometimes had supervision for six months or more.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Although the registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and the home complied with these requirements. However, the process had not been fully adhered to regarding medicines and restrictions in the home.

Effective systems were in place to enable the registered manager to assess, monitor and improve the quality and safety of the service. However, shortfalls had not been identified by the registered manager and actions had not been taken in a timely manner to improve the quality of the service.

The provider had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the home; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager. Relatives felt their people were safe in the home.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's individual risks and were able to tell us about the arrangements in place to manage these safely.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. Staff were not hurried or rushed and when people requested care or support, this was delivered quickly. The provider

operated safe recruitment procedures.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. The chef prepared meals to meet people's specialist dietary needs.

People were involved in their care planning, and that staff supported people with health care appointments and during visits from health care professionals. Care plans were amended immediately to show any changes, and care plans were routinely reviewed every month to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice, and to go out into the community as they wished.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

During this inspection, we found breaches of regulations relating to fundamental standards of care. 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 always safe.

Medicines were not always managed and administered to people safely.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

There were enough staff employed to ensure people received the care they needed and in a safe way.

There were effective recruitment procedures and practices in place and being followed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Members of staff were not appropriately supported. Staff supervision were not up to date and annual appraisals did not take place.

People's rights were not protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to care and treatments had not been assessed.

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good ●

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about their care.

The staff in the service were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good ●

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The quality assurance system was not effective in rectifying shortfalls identified.

The home had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There was a robust staffing structure in the home. Both management and staff understood their roles and responsibilities.

There were effective systems in place to monitor and improve the quality of the service provided.

Loose Court

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 26 April 2016 and was unannounced. The inspection was carried out by two inspectors.

Not everyone was able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing people and how care was delivered and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

However, we were able to speak with three people, two relatives, two care staff, two senior care staff, the hairdresser, the activity coordinator, chef, deputy manager and the registered manager. We also requested information from healthcare professionals involved in the home. These included professionals from the community heart failure specialist nurses, NHS and the GP.

We looked at the provider's records. These included four people's records, which included care plans, health care notes, risk assessments and daily records. We looked at four staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside spaces available to people.

At our last inspection on 09 April 2013, we had no concerns and there were no breaches of regulation.

Is the service safe?

Our findings

Our observation showed that people were safe at the home. One person said, "I feel safe here". Relatives felt their family members were safe in the home. One relative said, "Yes, totally safe here". Another relative said, "He is very safe here".

Medicines were stored safely. There was lockable storage available for stocks of internal and external medicines. Staff knew how to respond when a person did not wish to take their medicine. We saw that they offered it at other occasions during the day according to GP's guidance and tried administration by other trained staff. The senior care worker told us that if the medication was not taken within a couple of hours they would call the GP.

The medication administration record (MAR) sheets showed that people received their medicines at the right times. The system of MAR sheet records which was in use allowed us to check medicines, which showed that the medicine had been administered and signed for by the staff on shift. Medicines were correctly booked in to the service by staff and this was done in line with the service procedures, which meant that medicines were available to administer to people as prescribed by their doctor.

There were PRN protocols in place for people who were prescribed medicines to be taken 'as required'. There were two different types of protocols in use. Some protocols were laminated so that they stood out and contained more information than the ones that were not laminated. Information included the dosage criteria such as "Only give one if X becomes agitated". There were clear instructions for staff about when and why medication should be given such as certain behaviours displayed. There was also guidance given around actions to take prior to administering such as "Try to distract X by sitting and talking to him". Expected outcomes were documented and also when escalation would be needed such as to the GP or mental health team.

Topical creams were kept securely in locked cabinets in people's bedrooms. People had body maps and topical MAR sheets in their bedrooms which care staff completed when they applied creams to people.

We found medicine being administered covertly to two people. There was a covert medicine administration policy in place for this medicine. It stated that '2 - Covert medication should only ever be seen as a last resort and as an emergency procedure, rather than routine and care staff should discuss the case with the service user's GP and relatives and obtain their written consent and approval prior to any covert administration of refused medication. 3 - All cases must also be discussed fully with the pharmacist prior to administration. 5 - An assessment of mental capacity as specified in the Mental Capacity Act 2005 should always be completed before the use of covert medication is considered and 9 - Staff should never crush tablet or capsule medication and mix it with food or drink in order to administer it unless told they may do so by a pharmacist'. The home's policy referred to the National Medical Council (NMC) guidelines which should be followed when deciding whether it is appropriate to administer medicines covertly. The NMC guidelines stated that 'Medicinal products should not routinely be crushed unless a pharmacist advises that the medication is not compromised by crushing, and crushing has been determined to be within the patient's

best interest'. A mental capacity assessment had not been completed to assess if the person had capacity to make specific decisions, which was confirmed by the registered manager. A best interest meeting involving the staff, the health professional prescribing the medicine(s), and other people to agree whether administering medicines without the person knowing (covertly) was in the resident's best interests had not taken place. However, in this person's care file there was a fax from the GP which stated that "It is ok to give her meds covertly". It was documented in one of the professional feedback sheets for that person that the person's daughter had been consulted with who had agreed to give the person's pills covertly. However there was no documentation about the approval for the other person. There was no detailed management plan in place re covert administration for this person. The registered manager was asked how medicines were administered covertly and the said that they were either put in food or crushed. The home policy stated "Staff should never crush tablet or capsule medication and mix it in with food or drink in order to administer it unless told they may do so by a pharmacist. This practice is potentially dangerous and may alter the properties of the tablet or capsule causing the resident to absorb the medication quicker than intended and suffer side effects". This meant that staff administered medicines covertly without following the correct procedure in order to keep people safe.

The examples above showed that the home failed in proper and safe management of medicines. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. A member of staff said, "Safeguarding is about keeping people safe from abuse. If I am concerned or witnessed any abuse, I will report it to my line manager". Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were specific to each person. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as diabetes. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. This ensured staff had all the guidance they needed to help people to remain safe.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one

person who had had a number of falls. There was a clear plan in place which staff were aware of and used.

Accident and incident forms were completed when people were involved in accidents such as falls. Details of people's injuries were documented and any action taken was recorded. Other information included which staff were on duty at the time, who witnessed the incident, any further action needed and who was informed and when. The records contained body maps which showed where on the body people had sustained their injuries. Outcomes of investigations were documented with any action needed to minimise the risk of the incident happening again set out. In one person's incident record, the action to reduce the risk of the incident happening again was to "Ensure all Zimmer frames were tucked into the side of residents' chairs". It was observed during the inspection that people's frames were tucked into the furniture next to them. After each incident, there was a 24 hour observation sheet completed which was broken down into immediate checks for the first six hours and then two hourly for the next 18 hours.

There were suitable numbers of staff to care for people safely and meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. We also observed that there were sufficient staff on duty to meet people's needs, for example supporting people attending hospital appointments on an individual basis. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their bank staff team to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster is based on the needs of people. Staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly. This demonstrated that both the registered manager had staffing levels based on people's needs in order to keep them safe.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed in 2015. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2016. Fire equipment was checked weekly and emergency lighting monthly. Staff had completed a fire competency assessment.

There was a plan for staff to use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

The design of the premises enhanced the levels of care that staff provided because it was spacious, well decorated and had been suitably maintained. Corridors were spacious with good lighting and was very clean and fresh.

Is the service effective?

Our findings

One person said, "Very good. Makes you feel contented. They do come on time when I call them. If I have any concerns, I will speak to the manager".

Relatives said, "If concerned, I will speak with Karen. The food is very good." and "My mother is in this home. I will give them 10/10. It is a three star home. Anything I can think of they provide".

All staff completed training as part of their probationary period. New staff had provider's comprehensive induction records which they worked through during their probationary period. Staff told us that they were mentored by both deputy manager and the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further experience gained from working in the home, and through further training. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the home. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene.

Members of staff felt supported by the registered manager, however one to one formal supervisions had not regularly taken place. All the staff files we looked at showed that their last one to one formal supervision on 07 October 2015 and previously was dated 10 December 2014. Members of staff spoken with told us that if they have any problem, they will speak with the registered manager. One member of staff said, "We do supervision but not as often as we should". The registered manager confirmed that they had identified gaps in staff supervision and are working on it. The registered manager supplied us with a plan. The provider's supervision procedure stated, 'Supervision is provided in dedicated time and takes place at least once in every two months. This showed that the registered manager had not complied with their own procedure regarding staff supervision.

Yearly appraisals had not been carried out. We found no records in all the staff files we looked at to show that yearly appraisals were being carried out by the registered manager. Appraisals would have enabled staff to improve on their skills and knowledge which would have ensured continued effective delivery of care to people.

Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of

Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. While staff and the registered manager understood their responsibility for applying for DoLS, they did not understand the process for assessing people on their capacity to make their own decisions and what to do if they needed support to do this when people's freedom was restricted. For example, DoLS applications were made for people with dementia in the home to make them safe. However, an assessment on their ability to make specific decisions or consent to actions was not carried out. There were electronic key pads on doors and bottom of the stairs in the home but people had not been assessed under the MCA and their consent sought to these restrictions. The registered manager had not considered if people could be supported in a less restrictive way such as increasing staffing to support people. Steps taken in the home did not follow the principles of the Mental Capacity Act (MCA) 2005.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 11(1) and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people received any care or treatment they were asked for their consent. Staff interacted well with people, and asked them where they wanted to go and what they wanted to do. They obtained people's verbal consent to assist them with personal care such as helping them with their meals, or taking them to the toilet. Staff were aware of how to treat people with respect and that they allowed people to express their consent to different tasks. There were consent forms in place in each person's care plan. Consent forms had been appropriately completed by people's representatives where this was applicable. The forms showed the representative's relationship to the person concerned, and their authorisation to speak or sign forms on the person's behalf or in their best interests.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. Records of allergies were kept in people's care plans. For example, one person was allergic to fish. We saw this in the kitchen food plan adhered to by the kitchen staff. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff twice a day and upon request.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and they are offered snacks and at other times"; "People can get food and drink during the night if they want it, like tea and toast". We observed that people who were awake early in the morning were offered drinks and snacks.

People and relatives were very positive about the quality of the food, choice and portions. One relative said, "Food is good, I have had some". We observed lunch in the dining room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or want something not on the menu. The cook said, "We always give other things like fish etc. if they do not like

what is on the menu". There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The cook was aware of the dietary requirements of people and she was very actively involved in the delivery of the food and service. Diabetic desserts were available for those with diabetes. The cook told us that they provided variety of food and special needs/requests such as soft diet like pureed food and diabetic diet for diabetic people are taken care of. This showed that staff ensured people's specific nutritional needs were met.

People or their representatives were involved in discussions about their health care. A relative said, "Staff ring me if there are any problems. They involve me in the care such as assisting with choice of clothing for my mum".

The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the home regularly. A healthcare professional said, "I have found the staff to be always helpful and co-operative in achieving the best individual care and ensuring that any specific health needs are met".

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing.

Is the service caring?

Our findings

People told us that staff were caring. Comments from people included, "Staff are all very good. I am very happy here" and "Staff are good. Nothing to grumble about".

Relative commented as follows, "My mum is happy here. I can't fault them", "My friend has been here a year. It has been lovely. He could not have been in a better place. Staff are lovely. Good with the residents. They are very caring and extremely good".

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. One person became a bit agitated and bent the deputy manager's hand back as she was supporting them to walk through the dining area. The deputy manager made it clear to the person that they were hurting her however she did not get angry or aggressive with the person. They calmly asked the person to stop and changed the subject which relaxed the person. Staff also provided reassurance for a person who was becoming agitated throughout the morning. Staff offered the person reassurance and gave them cuddles when she asked for them. This showed that staff were knowledgeable about how to care for the person.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. For example, one person came to sit next to inspectors in the conservatory and chatted with us. This showed that people's choices were

respected by staff. Another person chose to have their lunch in privacy in the sitting area in the corridor. Staff respected this and served them.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. Staff covered people with blankets when necessary to preserve their dignity. People were assisted with their personal care needs in a way that respected their dignity.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the home.

Is the service responsive?

Our findings

One person said, "I collapsed a few weeks ago in my bedroom and pressed the nurse call and they responded quickly".

Relatives commented, "Senior carers went to hospital with him and phoned me to inform me. I come here once a week. Can visit anytime. They always make me welcome".

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. A relative told us, "We are informed and involved every step of the way".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. A person who experienced falls was provided with equipment that alerted staff when they stepped out of bed so they could provide help and reassurance. People were placed under observation following a fall and their progress was recorded. If needed they are referred to the 'falls clinic'. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a G.P.'s visit and a review of their care. This showed that management and staff responded to people's changing needs whenever required.

We saw in one person's care plan that it said they wore glasses. The person was observed throughout the day wearing glasses. Records were kept of people's appointments with other healthcare professionals such as GP's, opticians and dentists

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone, visits, and meals.

People were able to express their individuality. Staff acknowledged people by name as they walked past them in the lounges and corridors. People were responsive to staff and were eager to talk to them. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and

suggestions in consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, identification of photographs and reminiscence, bowling, exercise, music, dancing and arts and craft. One to one sessions included arms and hands massages, reading aloud and sing-along. The activities coordinator organised activities for each month. During our visit, the hairdresser was doing peoples hair. They said, "I come once a week. I am given list of people to see. For example, I did nine people today. I started here in November and it has been good". People were observed waiting for the hairdresser. People were pleased with how their hair looked afterwards. One person said, "I look forward to the hairdresser coming".

There was a weekly activities timetable displayed in people's care files and people confirmed that activities were promoted regularly based on individual's wishes. There was also a monthly activities newsletter which was displayed on the notice board. The activities coordinator said, "I plan my activities once a month. Research, discuss with residents. Mostly it's about what they like to do".

The provider contacted other services that might be able to support them with meeting people's mental health needs when required. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

We saw in one person's care plan that it said they wore glasses. The person was observed throughout the day wearing glasses after being prompted by staff as a reminder. Records were kept of people's appointments with other healthcare professionals such as GP's, opticians and dentists. At 11.15 am we heard one person screamed from the conservatory area. Within three minutes a member of staff had called an ambulance and had rushed to get a wheelchair for the person because they could not move. The person was brought through the lounge in a wheelchair with a member of staff supporting her head. The person appeared to be having a seizure and was growling and bubbling at the mouth. The deputy manager retrieved the person's DNAR (do not attempt resuscitation) form from their care file along with the person's hospital passport and asked another member of staff to make copies of the person's current MAR charts. Staff were calm and acted professionally throughout the incident without causing any distress to anyone else in the home. Once the ambulance had arrived, a member of staff called the person's next of kin to keep them informed of the situation.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the home. The relatives feedback received for May 2016 scored from good to excellent.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). A complaint was received 15 April 2016. This led to the local authority to visit the home. The complaint was from neighbour regarding overgrown fir trees. Management team responded by cutting the tree back on 18 April 2016. This demonstrated that the provider responds and acts on complaint to people's satisfaction.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward

any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". We saw complimentary messages sent to the registered manager and staff. These included comments such as, 'I would like to thank you all for caring for my mum over the last year. You made my mum's last year settled and happy'.

Is the service well-led?

Our findings

One person said, "The manager is very good". Relatives told us that the registered manager was very approachable and responsive. They said, "Management is very good".

Staff told us, "Management is trusting, approachable, caring and I feel listened to", "I like the registered manager because she understands and includes us in everything. I can talk to her. If I have a problem, I go to her" and "Lovely, can talk to them and they listen".

There were systems in place to review the quality of service that was provided for people. Regular audits were carried out to monitor areas such as monthly medication audits 2016 scored 96%, personnel audits scored 100%, do staff files contained evidence of appraisal? Answered 10 of 17, compliance 47%, financial audit, scored 100%, meals and nutrition 100%, infection control 100%, environmental 100% and care documentation scored at 100%. All these audits were carried out in April 2016. However, the personnel audit had not identified the areas we had identified regards supervision and the care documentation scored 100% had also not identified the issues we found regarding care plans. These demonstrated that the regular auditing of the service did identify some of the issues identified at this inspection. However, it had not picked up on all of the issues such staff supervision, person centred care plans and covert administration of medicines.

Records relating to people's care and the management of the home were not consistent and can be confusing. Staff were responsive to people's needs when they deteriorated and they were observed responding rapidly in a situation where a person became ill very quickly. However, the person's care records showed that they had been through two similar deteriorations since November 2015 where the emergency services had been called. It was documented in their multidisciplinary notes what had happened, however their risk assessments and care plans had not been updated to reflect their current health. In one of the records, it referred to a referral which the hospital said that they would make to the epilepsy clinic in November however the person had not seen the epilepsy nurse or doctor and the service had not followed up on why the person had not received further treatment. There was no guidance for staff around signs to look out for that the person may be deteriorating.

One person was a diet controlled diabetic. They had a diabetes care plan in place, however in some places it said that they were diet controlled and in other places it said that they were medication controlled. This was confusing and meant that conflicting information could result in the person not receiving the appropriate care that they needed if there were temporary staff who did not know the person well. The care plan did however give staff information about the signs that they should look out for if the person was unwell from a hypo or hyper.

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records. This is a breach of Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had a clear set of vision and values. They pride themselves in 'providing comfortable homely home with excellent standards of care'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs based on their assessed needs.

The management team at Loose Court included the registered manager and the deputy manager. Support was provided to the registered manager by the provider representative who supported the registered manager with the inspection. Both the area manager and operations director visited while we inspected and were part of our feedback session. The registered manager oversaw the day to day management of the home. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the provider who provided all necessary resources necessary to ensure the effective operation of the service. We observed the presence of the provider in the home and found people chatting with them. This showed that the registered manager and staff were well supported by the provider.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

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 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 11 HSCA RA Regulations 2014 Need for consent Steps taken in the home did not follow the principles of the Mental Capacity Act (MCA) 2005.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The home failed in proper and safe management of medicines. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to operate an effective quality assurance system and failed to maintain accurate records. This is a breach of Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support,

training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.