Bupa Care Homes Limited

Carders Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Carders Court is a care home providing nursing and personal care for older people. It is situated in the Castleton area of Rochdale. The home is purpose-built, single storey and comprises of five separate houses, each with 30 single bedrooms. There were 118 people accommodated in the home at the time of the inspection. There is car parking to the front of the home and there are garden areas around each unit for residents to sit out in good weather. .

We last inspected this service in November and December 2016. The service did not meet all the regulations we inspected and were given requirement actions for medicines (no means to identity people who had a dementia), keeping people safe, the service did not always follow the principles of the Mental Capacity Act, complaints were not always responded to, accurate record keeping and the supervision and appraisal of staff. The service sent us action plans to show how they intended to improve. However, although the service had made some improvements since the last inspection, during this inspection we found one breach of regulation 12 (2) (g), the proper and safe management of medicines, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The service did not have a registered manager although a person was due to be interviewed to be registered with the Commission . 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since the inspection a person was registered with the Care Quality Commission..

Some aspects of medicines administration were not safe. Some of the medicines records were not signed for, had been administered incorrectly or were not sufficiently well documented to provide information for safe administration.

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to any incidents to.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

Staff were recruited robustly to help ensure they were safe to work with vulnerable people.

We saw there were good systems for the prevention and control of infection and staff wore personal protective equipment when required.

We saw the service followed the principles of the Mental Capacity Act to protect people's rights.

People were provided with a suitable diet and were offered support if necessary. Professional help was sought where a person's nutritional assessment showed they were at risk.

Staff received a suitable induction and training was ongoing. Staff were able to discuss their careers during regular supervision.

The environment was suitable for the people accommodated at the home.

People who used the service and their families thought staff were kind and caring. Staff were careful to preserve people's dignity.

All records were stored securely and available for inspection including plans of care.

People who used the service had access to a complaints procedure and we saw that their concerns were investigated, as were any incidents and accidents.

People were provided with a range of activities suitable to their age and gender. This included access to clergy for their religious needs.

Plans of care contained sufficient information for staff to follow good practice to meet their needs. The plans were regularly reviewed to keep people's health and social needs up to date.

People, relatives and staff thought the manager was supportive and available to talk to. They also said the service was much improved since the area quality manager, new manager, unit managers and clinical care lead had commenced working at the service.

Managers conducted a range of audits and acted upon any shortfalls to help improve the service.

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.

Policies, procedures and staff training helped keep people safe. Staff had been recruited robustly and should be safe to work with vulnerable adults.

Staff had been trained in medicines administration and managers audited the medicines system. However, we found several errors for medicines administration including gaps in medicines records and misleading information around thickening agents.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant the rights of people who used the service were protected.

People were given a nutritious diet and said the food provided at the service was good.

Supervision and appraisal was regular and gave staff the opportunity to discuss their career or performance with their managers.

Is the service caring?

Good

The service was caring.

People who used the service and relatives told us staff were kind and caring.

We observed that any care was given in private to protect a person's dignity.

Visiting was unrestricted for people who used the service to remain in contact with their relatives and friends.

Is the service responsive?

Good

The service was responsive.

Plans of care had been completed with people who used the service and regularly updated.

There were suitable activities for people to attend if they wished.

There was a complaints procedure for people who used the service to raise any concerns they had. We saw that the manager investigated any concerns in a timely manner.

Is the service well-led?

Good

The service was well-led.

All the people we spoke with, relatives and staff said the new manager was available and approachable.

Records were maintained and available for inspection. This included all management audits and policies and procedures.

The manager had a date set for interview as part of the registration process to be registered with the CQC.

Carders Court 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 was an unannounced inspection and was conducted by a pharmacist inspector on the 13 June 2017 and 2 inspectors and an Expert by Experience on the 14 and 15 June 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert was experienced with people who were elderly and were living with a dementia.

We commenced this inspection at 6am because of information we received regarding another BUPA home. This was to check there were not significant numbers of people up and dressed.

During the inspection we spoke with ten visitors/relatives seventeen people who used the service, the manager, the area quality manager, a registered nurse, a member of the laundry staff, the chef, two domestic assistant, an activities coordinator and six care staff.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us

We requested and received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help plan the inspection.

During the inspection we carried out observations in the public areas of the home and undertook a Short Observation Framework for Inspection (SOFI) observation during the lunchtime period on the unit for people living with a dementia. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.
During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for ten people who used the service and medication administration records for 22 people

on four of the five units. We also looked at the recruitment, training and supervision records for ten members of staff, minutes of meetings and a variety of other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Our medicines inspector looked at the way medicines were handled in four out of five units in the home. We looked at records about medicines and arrangements for administering and storing medicines. We found that medicines were not managed safely in one unit. The concerns identified meant that the home was in breach of regulation 12 (2) (g), the proper and safe management of medicines, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, at the last inspection a previous breach of this regulation had been around a lack of photographs on the MAR records, which meant that agency or new staff could not identify people safely. At this inspection photographs had been added to the records to help with identification.

A person who used the service said, ""They [the staff] come around three times a day with the medicines. A few times a day they have a red tabard on." A relative said, "I've peace of mind because they have all his medicines sorted." We saw two members of staff administering medicines to some of the people living in the home. The carer we watched at teatime gave medicines in a safe and kind way. Most medicines that should be taken at specific times in order to be effective were administered at the right times. However, a nurse offered one person a medicine that should be taken 20 minutes before food after their lunch. This meant that the medicine would probably be ineffective. They also signed this person's MAR before giving the person their other tablets. National guidelines recommend that medicines should be signed for immediately after administration in case the person declines the medicine. This was also the home's policy. We saw one medicine trolley left unattended in a corridor with the keys in the lock. If medicines are not kept safely there is a risk of mishandling or misuse.

We looked at 22 people's medication administration records (MARs) on three units. We counted a sample of people's medicines and compared the quantity left to the information on their MARs. Records were completed carefully and handwritten entries on MARs were signed by two people (checking by a second person reduces the chance of a mistake). We saw two 'gaps' in administration records, meaning it was not clear whether the person had taken that dose of medicine. The stock count of one medicine and the MAR suggested one person had been given a double dose on three mornings. The person had not been harmed.

Some people were prescribed one or more medicines to be taken only 'when required'. Extra guidelines (protocols) were kept with most of these people's MARs explaining how the medicine should be used. However, one person was prescribed both a mild and strong painkiller when required. There were no protocols to help nurses decide which painkiller to offer. Another person was prescribed two medicines when required for the same symptom. Protocols were in place but they didn't tell the nurse which 'when required' medicine to give the person first to try and relieve their discomfort. However, this person had the mental capacity to ask for the desired pain relief.

Some people were prescribed a powder to thicken all their drinks because they had difficulty swallowing. A record was made each time the powder was used and protocols were in place for each person stating the required consistency for liquids. We looked in detail at the records for three people prescribed a thickening powder. According to their records, two people's fluids were being thickened to a different consistency to

that stated in their protocol and care plan. This could put them at risk of choking. The home immediately investigated this concern and told us that these people's drinks were thickened correctly and the administration records were wrong.

Some people were prescribed a moisturising or barrier cream. Carers signed a separate chart when they applied these creams and the records we saw showed that people's skin was cared for properly.

Medicines were stored securely though the lock on one medicine trolley was faulty. We checked the trolley on the second day of the inspection and found it was in good working order. Some medicines were not kept at the right temperatures. Records showed that the temperature in one room where medicines were stored was regularly above 25 degrees Celsius. This is the maximum temperature recommended by manufacturers to ensure medicines remain effective and safe. Records also showed that the temperature of two medicine refrigerators was sometimes too high. The service sent us a record of the audits completed prior to the inspection, which had already picked up the temperature of the rooms and therefore management was taking action to address the problem. We saw that audits had shown the temperatures of fridge recordings were high and new fridges have been ordered.

Medicines that are controlled drugs (subject to tighter legal controls because of the risk of misuse) were stored in the way required by law. Staff regularly checked controlled drug (CD) stocks, which is good practice to prevent mishandling. The stock balances of the sample of CDs we checked were correct. However, we found two discrepancies where the date of application of a patch recorded on the person's MAR and in the CD record book were different.

All the people we spoke with said they felt safe at Carders Court. Comments included, "It's very good here I was getting stressed at home, I feel safe here" and "I feel safe". A family member said, "You can go home and you know they are safe."

At the last inspection we found incidents where information was either not recorded or could not be found. This put people at risk of harm because there was no way of knowing if any action had been taken to minimise or protect people, including safeguarding incidents. At this inspection we found all accidents and incidents had been recorded and investigated.

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. There was information in each lift which reminded staff of their responsibilities to safeguard people. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and to report any incidents to. There was a whistle blowing policy and a copy of the 'No Secrets' document available for staff to follow good practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations.

We spoke with staff about safeguarding issues and their responsibilities in reporting poor or abusive practice. Staff comments included, "We have the Rochdale Metropolitan Borough Council (RMBC) safeguarding policies and procedures and I would use them"; "I am aware of the whistle blowing policy. If I saw poor practice I would be prepared to report it"; "I have never seen anything I've been concerned about but I'd report anything to the manager or senior on duty. I know I can also contact CQC or the Local Authority and families always need to be informed"; "I am aware of safeguarding and have had the training. I am aware of the whistle blowing policy. I have reported poor practice in the past. It was sorted out" and "I am aware of the whistle blowing policy but you would probably have to restrain me if I saw someone being abused. Of course I would do something about it." Staff were aware of the need to protect people from

possible abuse.

Two people who used the service told us, "Sometimes the staff are a bit sparse, but it's usually ok" and ""I ring the bell and they will take me to the toilet, I sometimes have to wait when they are short of staff, on average they are ok." All the other people we spoke with did not have any concerns about staffing numbers. At the last inspection visitors complained that sometimes the home was short of staff but did not do so at this inspection. We also saw in staff files some staff were on induction for the night shift. The manager also said they were still recruiting, mainly to try to reduce the need for any agency staff.

Comments staff made included, "We do struggle for staff at times. There are a lot of new staff", "Things have improved. There are a lot more staff now and unit managers", "I feel we have enough staff on duty but we don't always have time to do 1-1's because we are busy with some challenging needs", "The numbers of staff have increased. We are occasionally short but nowhere near as often as it was" and "There are a lot more staff now".

We looked at the numbers and qualifications of staff on duty. We saw that there was a manager, an area quality manager, a clinical services manager, two administrators, a cook and two kitchen assistants, a housekeeper and five domestics, two laundry assistants, a maintenance man, a gardener, an Admiral nurse (dementia specialist) and the regional director came in to support staff. There was a manager on each unit, four registered nurses, four senior care staff and 22 care staff. There was also a hostess on three units. This was an increase in the numbers and experience of staff since the last inspection with the main improvement being managers on each unit.

We looked at ten staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that checks were undertaken on qualified nursing staff to ensure they remained registered with their professional body, the Nursing and Midwifery Council.

We saw that the electrical and gas installation and equipment had been serviced. There were certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), the lift, hoists, the nurse call and fire alarm system. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. Radiators had a control valve to minimise the risks of burns. We saw that staff entered any faults in a booklet which was signed off when any work had been completed. The maintenance of the building and equipment helped protect the health and welfare of people who used the service and staff.

The fire alarm system had been serviced. Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in a folder near the front of each unit so staff could get hold of them in an emergency to present to the fire brigade. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a power failure.

We looked at ten plans of care during the inspection. We took a selection from each of the five units. Each care record contained a risk assessment for falls, moving and handling, tissue viability and nutrition. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service. However, some cupboards were left open and contained discarded equipment. It would be good practice to keep all cupboards locked to prevent possible harm to people who used the service.

People who used the service said the home was clean and tidy and made comments such as, "It's lovely and clean here". During the tour of the building we noted all of the units were clean and there were no malodours.

There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy. Management conducted a daily 'walk around' and checked cleanliness as part of the process.

There was a laundry sited away from any food preparation areas. There were three industrial type washing machines and two dryers to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to.

Good

Is the service effective?

Our findings

We looked at what consideration the provider gave to 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005) and were aware of how to protect people's rights. At the last inspection we saw people who did not have mental capacity had not had an application for a DoLS. At this inspection we saw that the system for recording, applying for and updating any applications was now being completed.

Part of the process for applying for a DoLS was to have best interest meetings. This could include professionals, staff from the care home and family members if appropriate. People who used the service had access to an Independent Mental Capacity Advisor or advocate. These professionals acted upon someone's behalf to ensure their rights were protected.

A registered nurse told us, "There is always someone here to get advice around DoLS and the mental capacity act." The was a clinical metrics board in the manager's office recording details for each unit within the home with information on: Modified diets; weekly weights; diabetics; wounds; falls; challenging behaviour; anti-psychotics; covert medicines; anti-coagulants; CD/Patches; bed rails; DoLS, DNACPR's. The information on DoLS recorded the details for each unit including: The name of the unit; the number of DoLS applied for and date; the number granted; the expiry date of current authorisations and the date the information was updated. We saw there were 36 granted DoLS applications and 44 currently waiting to be processed by the local authority. We had been notified of the DoLS authorisations.

A staff member said, "You just need to speak to people about what you are doing and give them a choice about everything like watching TV. Consent is also recorded in people's files." We saw that people who could do so had signed their consent to care and treatment. We also saw staff asking people for their agreement or enquiring what people wanted prior to undertaking any personal care.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We observed and were told that the chef asked people what they wanted and provided an alternative to what was on offer to help encourage people to eat.

People who used the service said, "The food is very good", "The food is beautiful", "The food is very good, you can have a fry up in the morning but I have toast and flakes" and "The food is marvellous." I get asked if I want to eat in my room or in the dining room. I usually go to the dining room for my tea." A relative said, "The food quality is not good, I think they leave us to last and we get what is left. I've raised this with [named senior manager] we had a meeting today and he told us what action he intended to take. Time will tell but it has changed and I'm hopeful it will get better."

There was a menu on display which was supported by pictures of the food so people knew what they were ordering. People were shown the choices of meal so they could point to their choice or asked what they wanted. We observed a meal and saw that staff engaged with people who used the service.

There was a four weekly menu cycle. There were three meals a day with a hot option provided each time. People could have any of the usual breakfast meals, lunch was a smaller option with the main meal served at the evening. Supper was provided and each unit had a kitchenette to make snacks and drinks. Fluids were offered at intervals during the day.

There were sufficient tables and chairs for people to sit at in order to promote a social atmosphere although if people preferred could take their meal in their room. Tables were pleasantly set with cutlery, napkins and ornaments to decorate the tables. On some tables we saw people had a choice of condiments for people to flavour their food. On other units condiments were available but not put on tables because of the risk of people living with a dementia not being able to use them safely.

We observed mealtimes to be a social occasion and staff interacted with people who used the service. People who required assistance with their meals were given support individually and discreetly.

We visited the kitchen and saw there were sufficient supplies of fresh, frozen, canned and dried foods including fruit. The chefs were given information around allergens from their head office. There was a board in the kitchen which showed people who were on specialised diets and the service provided pureed, mashed, diabetic and soft diets if people required them. The service had access to a specialist provider who they could contact should a person require food for a specific cultural or ethnic need such as Halal. At this inspection we did not see any person who required this type of food.

Supplements were kept on the units and care staff were responsible for ensuring people received them. Some foods were fortified with milk and cream by kitchen staff. We saw that people had a nutritional risk assessment and where required had access to dieticians and speech and language therapists (SALT). We saw that people's weight was recorded regularly so that staff could monitor any weight gain or loss. We saw from the records that most people had put on a little weight.

From looking at the plans of care we saw that people who used the service had access to professionals, for example hospital consultants, community nurse specialists and district nurses. Arrangements were made for people to attend routine appointments to podiatrists, opticians and dentists. Each person had their own GP. At the last inspection family members told us some appointments had been missed. There were no such complaints at this inspection.

Staff said, "I had an amazing induction. It was a full week and the second week I was not counted as one of the staff numbers on the rota (supernumery)" and "I've been here 17 years but I remember having a formal induction book to complete and I worked through this." The manager said, "If they are new to care or do not have an NVQ they have a trainer who takes them through the care certificate." The care certificate is considered to be best practice for staff new to the care industry. We saw from staff records that the

induction covered all aspects of working in a care home from key policies and procedures to key training including the use of equipment. All grades of staff then worked under supervision until they felt confident to work with vulnerable people and managers assessed they were competent to do so.

Staff we spoke with told us, "The training is ongoing. We have access to the training and they give us time to do it. There is training and support to meet our registered nurse accreditation", "Things have improved. We are doing a lot more training" and "We get enough training in everything and sometimes this is in a group or individual training. I've recently done safeguarding, moving and handling and food hygiene. I've also done training for senior staff by BUPA and this helped me to better understand about completing care plans properly. I did dementia training a while ago and medicines."

From looking at the training matrix, staff files and talking to members of staff, we found basic training had been undertaken. Two members of staff had completed a recognised training course at Bradford University (care of people with a dementia) which would enable them to deliver the training to other staff. We saw that staff were trained in moving and handling, safe food hygiene, infection control, health and safety, first aid, fire safety, medicines administration and mental capacity and DoLS. Further training was offered around the care of people with dementia, behaviours that may challenge and end of life care. Staff were then offered a course on health and social care such as a diploma.

At the last inspection records showed and staff told us they had not had supervision regularly. At this inspection we saw supervision and support was ongoing. Staff told us, "I have had my supervisions and appraisals. We get chance to discuss our careers", "I have had supervision. They are a two way discussion. I had one on Tuesday and it was a good one. It was about me. There is a good staff team most of the time", "We have supervision and appraisal. They are a two way process and we can tell them what training we would like to do" and "We get supervisions and I've just had one when I was on Brookfield unit. I'm not sure how often they are on my unit now but I've had an annual appraisal and I found it to be useful." Supervision gave staff the opportunity to discuss their needs and managers to discuss their performance.

We toured the building during the inspection and visited all communal areas, many bedrooms, bathrooms and shower rooms. Bedrooms we visited had been personalised to people's tastes, some with furniture, photographs and ornaments. We saw some areas had been decorated and a staff member said, "They are improving on Linden Unit. We are getting new chairs. They have decorated the unit."

Communal areas contained a variety of seating and were homely in style. There was sufficient seating for all people accommodated at the home although we saw that people could sit in their rooms if they wished. The corridors were wide to allow wheelchair access and had hand rails for people to steady themselves if they needed to.

Bathrooms and toilets had aids to assist people with their mobility to help them attend to their personal hygiene. There was a choice of bath or shower and we saw people's preferences were recorded in their plan of care. There were accessible gardens with seating for people to use in good weather. The garden for people who had a dementia was secure and safe for people to use. There was a person employed to keep the gardens in good order and we saw the person working during the inspection.

There was signage to help direct people around the home and memory boxes were on order to further help people living with a dementia locate their personal space. There were memory therapy items such as old photographs on display to help people feel familiar with their surroundings.

Some units had themed areas, for example, a bar area where people were able to sit with their families and

have a drink of alcohol or soft drink if their conditions allowed. There was also a tea room on one of the units. People who were accommodated in other units were welcome to use the facilities.

During the inspection we carried out observations in the public areas of the home and undertook a Short Observation Framework for Inspection (SOFI) observation during the lunchtime period on the unit for people living with a dementia. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

There was a relaxed unrushed atmosphere and staff interacted with people in a respectful and dignified manner, recognising people as individuals' and encouraging their engagement. There was very little discussion or laughter between people who were dining on this unit. Staff provided assistance to people who required it as identified in their care plan. The dining room was clean and homely with nicely laid out crockery and cutlery. Prior to serving any food, staff washed their hands and used appropriate personal protective equipment (PPE) such as gloves and aprons. Several people ate in the adjoining lounges and two were assisted by staff appropriately.

Good

Is the service caring?

Our findings

All the people we spoke with were satisfied with their care and staff attitude and made comments such as, "She's a lovely girl [the person indicated a staff member]" and "I had a look around before I came, it's absolutely wonderful, everyone has been so nice. I love it here."

Staff we spoke with said, "The care is spot on. The care staff are very good. I am happy working here and love it.", "I would be prepared to have a member of my family be cared for on the unit I work. I am happy here especially since the improvements. Staff want to be here now. The morale has improved. I love the residents they become like family. That's why I do the job", "I love the residents. I like caring for them. I like to give them the best care that I can", "All my life I have looked after people. I love looking after people. The people who live here are like family. My relative was on one of the units here. So yes I would be ok with a member of my family living here."

Relatives told us, "The staff are wonderful, they allow her [our relative] choice but encourage her to get involved with trips and to eat in the dining room.", "They treat them [residents] as part of their own family", "The staff are the best thing they go over and above what they should do" and "It's amazing care, if there is anything wrong there is always a member of staff you can talk to."

We observed a member of staff who saw that one lady had a bra strap showing. The staff member discreetly went to the person and tidied her clothing preserving her dignity. A family member told us one person was asked to a social occasion at short notice. One of the staff members emptied her own handbag to let the person use it. Over the two days of the inspection we observed staff in communal areas interacting with people who used the service. We saw that staff had a caring attitude and people received personal care privately which helped preserve their dignity. Staff were observed to knock on a person's door and wait for a reply before entering.

A person who used the service said, "I wanted to vote so [unit manager] arranged for me to be taken in a taxi." We saw from looking at the plans of care that people were asked about their choices. This included if they wanted a family member to be involved, food preferences, lifestyle and what a person could do for themselves. This enabled people to be treated as individuals.

We saw that care and personal records were stored safely and only available to staff who needed to access them. Staff were taught about confidentiality and the need to share information if they needed to.

We were told by relatives/visitors that they could visit any time. Visiting was unrestricted to help people remain in contact with their family and friends. One visitor told us they could bring their dog which was enjoyed by the family member. All the relatives/visitors said the home was much improved and they were made to feel welcome by staff.

Some staff had undertaken end of life training and there was a section in the care plans which informed staff of the basic wishes of people who neared the end of their lives. The service was also enrolling staff on a local

hospices training program for end of life care. We saw that where people wanted to they informed staff about their last wishes which included details such as burial or cremation, their choice of undertaker

We saw that most people's religious or spiritual wishes were recorded in the plans of care and visiting clergy offered people the chance to attend a service or holy communion if this was their chosen way of practicing their faith. We that a member of the local clergy visited the home during the inspection to administer spiritual support to a person who was unwell.

On one unit the unit manager had researched the best type of dog to have as a pet. The staff member had bought a recommended type and brought it in each shift to interact with people. This was highly regarded by people who used the service and families.

Good

Is the service responsive?

Our findings

A person who used the service said, "I've been here about twelve months, it's ok I've no complaints." At the last inspection we found that complaints were not always responded to in a timely or appropriate manner. The records we looked at during this inspection showed all complaints were investigated and responded to. All of the complaints were recorded and placed in a file. This was confirmed by the comments made by family members who said the new manager took time out to see them if they had any concerns. Two examples we saw included a new blender being bought for a complaint about pureed food and the chef/kitchen staff attending a meeting when they had forgotten to put an item of food in the trolley.

There was a suitable complaints procedure located at various points around the building. Each person also had a copy in the documentation provided on admission. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission.

We also saw that any accidents, incidents and safeguarding referrals were investigated and ways to minimise repeat episodes sought. There was also a compliments file which contained many comments which included, "Fantastic staff, efficient, kind and helpful. The introduction of a puppy dog (Teddy) is a great idea and this can be seen in the resident's reactions, they love the dog. Overall cleanliness is great. Cannot fault the commitment of staff at all levels from cleaners, staff and management" and "Dear manager, I am writing to express my gratitude for the care and support received during the time relative was living at Carders Court. We knew from the moment we met [named member of staff] on our preliminary visit that this was the place where mum would be most happy. All the carers on the unit are wonderful. They go the extra mile for all the residents and think carefully about how everyone is feeling."

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People who used the service told us, "I've been out to the Zoo and I'm going to Blackpool. The unit manager takes me out shopping." Relatives said, "[My relative] is invited on trips but she doesn't go on many, she went on the barge trip" and "Our relative has been out the pub and on trips out to Blackpool, she loved the canal trip." The activities coordinator told us, "The new manager is brilliant; this is a different place since he came here. Anything I ask for (activities equipment) he gets."

There were available activities which were suitable to the people accommodated at Carders Court. There was a record of what people liked to do in the plans of care and if they wished to join in activities. Two activities coordinators helped provide the activities. The activities included arts and crafts, gardening, visiting school choirs, outside entertainers including a teddy boys and teddy girls show, religious services, films, birthday parties, exercises, quizzes, pamper sessions, hairdressing, various board games, dominoes, puzzles and reminiscence therapy. There were also trips out to places of interest or local shops and markets. The activities coordinators kept a log of the activities and who attended. A coffee morning was held on one of the units each week. People were offered a choice of entertainments to help keep them occupied.

Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their

representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority had also provided their own assessments for some people to ensure the person was suitably placed. This process helped to ensure that people's individual needs could be met at the home.

Since the last inspection all plans of care had been reviewed. This was because at the last inspection some plans had not been reviewed regularly or updated. We looked at ten plans of care at this inspection and found the plans were fully completed and regularly reviewed. When any changes occurred we saw the plans had been updated. This meant staff were given up to date information to meet people's needs.

Plans of care were divided into headings, for example senses and communication, choices and decisions, my day, my life, my story (a background history with details of hobbies and interests), continence, eating and drinking, healthier happier life, mobility, skin care, washing and dressing, breathing, religion, mental health and safety. Plans of care showed what a person could do for themselves and contained a lot of personal information about their likes and dislikes which showed they or a family member had been involved in developing them. There was a detailed daily record which reflected the day a person had or if they had been ill or seen any professionals.

On the first day of the inspection we saw one person was not responding to staff and refusing care and support. The manager had asked for support from the 'Admiral Nurse'. This was a nurse who specialised in finding strategies and support for people who have behaviours that may challenge others or be a danger to themselves. This showed the service responded to the changing needs of people who used the service.

Regular meetings were held on each unit for people who used the service and their families. Topics included care planning, food, new staff, recruitment, setting up a resident's committee, activities and DoLS. The meetings informed people of any changes but also gave them a chance to say how they would like the service to run or improve.

Good

Is the service well-led?

Our findings

The service did not have a 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager had completed all the paperwork required for registration with the Care Quality Commission and was awaiting an interview. Since the inspection a person was registered with the Care Quality Commission..

We asked people who used the service, relatives and staff what they thought of management. People who used the service told us, "I know the manager she brings a little dog in" and "I don't know the woman's name but I see her sometimes [unit manager]. If I wanted anything I'd tell her."

A family member said, "If I had any problems I'd tell the unit senior or unit manager. It was not a good place and we considered moving [my relative] out. But it has improved with the new manager and the unit manager has been part of the improvement."

Staff said, "The manager is approachable and he will give excellent advice. Totally satisfied with him", "The managers are supportive. It is a good job and there is a good management team. They are all supportive and I like working here", "The unit manager is brilliant, she is very good. There has always been a good team spirit but the home overall has improved", "I have not had much to do with the new manager but he seems to be getting things done", "It has improved, everywhere is so relaxed. The manager is visible and comes around two or three times a day. The manager is much more pleasant than the last one. The new manager (unit) is also absolutely brilliant. We have a unit dog which is going down well" and "The managers are very supportive. The home has gone better and the atmosphere is much better."

At the last inspection some records we requested to aid us with the inspection could not be found. All the records we asked for were available and up to date at this inspection.

A staff member said, "We have unit meetings and daily handovers. We are involved in general discussions." Staff meetings were held regularly. There was a daily 'take ten' meeting between all the managers for updates or any requirements each department may have. At general staff meetings we saw topics included health and safety, quality of care, staffing and recruitment. Staff were given a chance to have their say at the meetings. Staff were given a daily handover to have an update on the care and support people needed.

The service asked people for their views at meetings and quality assurance surveys. The results were mainly positive and the manager used the results to help improve the service.

There was a service user guide and statement of purpose which told people who used the service, other professionals and relatives of the facilities and services provided at Carders Court.

We looked at some of the policies and procedures which included Infection control, safeguarding, whistle

blowing, mental capacity and DoLS, complaints, confidentiality, moving and handling, health and safety and medicines administration. Policies and procedures were updated regularly and available for staff to follow good practice.

Although the service had changed their legal status and did not need to display their last inspection ratings we noted that this was displayed on every unit.

Following the last inspection the service had sent us an action plan and then regularly sent us an updated version. We found the management team and staff had worked well together to follow the plan and improve the service. Staff and visitors/relatives also told us the service was much improved.

Managers conducted audits regularly. The audits included the quality of care plans, any safeguarding referrals, DoLS, infection control, health and safety, pressure sores, comments, complaints and compliments, accidents, falls, medicines administration, staff competencies for medicines administration, training, supervision and other aspects of running the service. The audits were comprehensive. We saw that medicines audits were sufficiently robust to pick up any errors in medicines management and took action, for example any faulty equipment was repaired or replaced.

Managers and staff carried out monthly, weekly and daily audits to check that medicines were used safely, and in accordance with the home's medicine policy. The most recent monthly audit had found concerns about the way medicines were handled in one unit. Action was being taken to improve medicines safety, for example all staff were receiving appropriate training.

The home improvement plan showed us what managers found, any actions taken and when completed, for example all care plans were reviewed following our last inspection and have been audited since to show the service had systems in place and were intent on keeping the improvements up. There was also a regular clinical walk around to discuss care issues. The service had employed a clinical services manager. This staff members duties included looking at ways to try to minimise falls, any clinical concerns, admissions and discharges, GP visits and any raised safeguarding issues. We know from our records that this staff member was sending any required notifications to the Commission to keep us informed of any issues.

The area quality manager was at this home supporting the manager and used audits to check on the progress the service was making. This staff member looked at all aspects of running the home, checked that any agreed actions had been completed and who had completed them.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely or effectively.