HC-One Limited

Carrington Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

About the service:
Carrington Court care home is owned by HC-one and is situated near the centre of Hindley, Wigan. The home can accommodate up to 48 people who need care and support. At the time of the inspection the home was fully occupied.

People's experience of using this service:

People felt they or their relatives were safe living at Carrington Court.

There were systems and processes in place to keep people safe from the risk of abuse.

Risk assessments were completed appropriately and updated as required.

Staff were recruited safely, with all relevant checks in place and staffing levels were sufficient to meet people's needs.

Medicines systems were safe, and staff had appropriate training.

Staff had received infection control training and wore appropriate personal protective equipment (PPE), to deliver personal care.

Care files included assessments and documented health needs and routines.

Staff had a thorough staff induction programme, on-going training and refreshers and were knowledgeable and competent.

Staff supervisions were completed regularly and there were annual appraisals.

People enjoyed the food and there were plenty of choices.

Food and fluid and positional charts were completed as required.

GPs and other professionals were contacted when required.

The building had wide corridors and doorways to help people who had restricted mobility move around.

The service worked within the legal requirements of the Mental Capacity Act (2008) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff interacted respectfully with people who used the service and spoke in a friendly manner.

Care plans clearly reflected respect for people's diversity and equal treatment for all those who used the service.

Staff were seen to respect privacy and dignity.

Care plans were person-centred, and people were given as much choice and control over their lives as possible.

There was a range of activities and outings and people's wishes were fulfilled where possible. There was a complaints log and the service had received a number of compliments.

End of life wishes were recorded in care files, where people had expressed them, and some staff had completed training in this area.

The registered manager and provider were aware of their responsibility regarding duty of candour.

The service had a manager in place, who was registered with the Care Quality Commission (CQC) as required.

CQC notifications of significant events that the service is required to tell us about, were sent in as required.

Safeguarding issues, accidents and incidents were reported to the relevant bodies and any incidents reviewed to look at lessons learned.

Previous ratings were displayed on the provider's website.

Relatives felt management and staff were efficient and effective at liaising with external healthcare professionals and other external bodies.

The service analysed data for any trends and patterns to aid improvement. Working in partnership with others.

The service was involved in intergenerational project work with local college and primary school around facilitating activities.
Rating at last inspection:
At the previous inspection, published on 24 August 2016, the service was rated good.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. Inspection timescales are based on the rating awarded at the last inspection and any information and intelligence received since we inspected. As the previous inspection was Good this meant we needed to re-inspect within approximately 30 months of this date.

Follow up:

We did not identify any concerns at this inspection. Going forward we will continue to monitor this service

and plan to inspect in line with our re-inspection schedule for services rated Good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	Good
Is the service effective? The service was effective Details are in our Effective findings below.	Good
Is the service caring? The service was caring Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	Good

Carrington Court

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert on this occasion had experience with older people.

Service and service type:

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced.

What we did:

Prior to the inspection we reviewed information and evidence we already held about the home, which had been collected via our ongoing monitoring of care services. This included notifications sent to us by the

home. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We asked for feedback from the local authority and professionals who work with the home. We also contacted four health and social care professionals who deal regularly with the service. We received no negative feedback.

We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people living at the home and eight visiting relatives about their experiences of the care provided.

We spoke with the registered manager, area director, the lifestyle coordinator, the cook and three care staff individually and had a group discussion with other care staff.

We reviewed five care files, four staff personnel files, training records, health and safety records, meeting minutes, audits and other records about the management of the home.

We 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.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

• People felt they or their relatives were safe living at Carrington Court. Comments included; "I'm very pleased [relative] is here"; "Yes, it's great – [relative] is completely settled"; "Yes, I'm very comfortable here".

Systems and processes to safeguard people from the risk of abuse
• There was an up to date, appropriate safeguarding policy and procedure in place.
• There was a safeguarding log which included the nature of the concern, whether this was upheld, and actions taken.
• The service had a safeguarding audit tool in place to ensure any concerns were monitored.
• A quality report was produced for the provider.
• Safeguarding training and refreshers were up to date.
• Staff were aware of safeguarding and whistle blowing procedures and were confident to report any concerns they may witness.
• The local authority Quality Performance Team had visited the home recently and felt the service was responsive with the safeguarding process.

Assessing risk, safety monitoring and management
• Individual risk assessments, for issues such as choking, skin integrity, mobility and falls, were seen within people's care files and these were complete and up to date.
• High risks were discussed within regular clinical meetings to monitor and review the risks and measures in place to minimise those risks.
• Accidents and incidents forms were completed appropriately, and actions taken to reduce further incidents.
• All health and safety measures were in place including certificates of maintenance and servicing of equipment.
• A fire risk assessment was in place and a new assessment had recently been completed.

Staffing and recruitment
• Staff were recruited safely, with all relevant checks in place.
• On the day of the inspection there were enough staff on duty to meet the needs of the people who used the service and rotas demonstrated staffing levels corresponded with the dependency level of the people who used the service.
• The staffing levels were flexible, and one person was currently receiving one to one support as required.
• People felt that there were enough staff to meet their needs in a timely manner. All bedrooms had call bells, but some people said they didn't need to use them as "There is always someone walking about". A family member commented that while staff were very busy and "always seemed rushed" they were always patient and "took time" with their family member. Another visitor told us, "There are enough staff, always

someone around."

Using medicines safely
• People who used the service felt that medicines were administered correctly and in a timely manner and that they could get pain relief when they needed it. Two people we spoke to were able to self-administer skin creams, in one case with the help of a family member.
• There was an up to day medicines policy and training had been undertaken by all staff.
• Regular competency assessments were carried out on staff to help ensure their skills remained current.
• We observed the medicines round at lunchtime and saw this was completed competently and patiently, with consent sought and explanations given to people regarding the medicines they were taking.
• Thickeners for drinks were mixed as required and recorded appropriately for every drink taken.
• The systems for ordering, administering, storage and disposal were safe.

Preventing and controlling infection
• The latest infection control audit had achieved 95%.
• The service had achieved a 5-star rating, which is the highest achievable.
• All staff had received infection control training and wore appropriate personal protective equipment (PPE), such as plastic gloves and aprons, to deliver personal care.

Learning lessons when things go wrong
• The local authority Quality Performance Team had looked at the response to a complaint which they felt had been responded to in a positive way. The service had learned lessons and made changes to improve service delivery.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Each care file included a pre-admission assessment and an admission assessment.
• Care plans documented all health needs and there was clear guidance on people's routines and needs with regard to maintaining good health and well-being.
• Things that people must have for their well-being were recorded, such as equipment and nurse call button to hand.
• Care plans and risk assessments were regularly reviewed and were complete and up to date.
• Food and fluid and positional charts were completed as required.

Staff support: induction, training, skills and experience
• People felt the staff were competent to meet their needs or those of their relatives. Comments included, "Yes, they are well-trained"; "Exactly so"; "Yes, they look after them here"; "Yes, [relative] is well looked after – there has been no problems with falls since coming here". Another family member said staff knew their family member's preferences and would provide extra helpings at the times when they were in the mood for eating. All the people we spoke to told us that they could get plenty of hot drinks and that juice or water was always available.
• The service had a thorough induction programme for new staff and on-going refresher training for all mandatory subjects.
• Additional training was offered, and staff were encouraged to develop specialist knowledge in areas of interest to become champions. This meant that there were staff members who took leadership in areas such as tracheostomy care, infection control, domestic violence, dignity, audiology, cancer and dementia.
• Nursing and residential triage (NART) training was planned to help staff make decisions about when to refer people who used the service for on-going treatment and care.
• Staff supervisions were completed regularly and there were annual appraisals. The service kept a log to ensure all supervisions were completed in a timely manner.
• Themed supervisions were conducted where the service felt knowledge needed to be increased. For example, there had been a recent supervision on how to recognise the signs of sepsis to help ensure staff were aware of these.

Supporting people to eat and drink enough to maintain a balanced diet
• When asked about food, comments from relatives included; The food looks good. [Relative] is a good eater and likes the food"; "The food is excellent and [relative] likes the tea – they make [relative] lots of tea"; "Oh gosh yes, it's very good"; "Very good"; "Pretty good – lots of vegetables"; "[Relative] enjoys what they eat and their weight is stable".
• We undertook a short observational framework for inspection (SOFI) in one of the dining rooms. SOFI is a

way of observing care to help us understand the experience of people who could not talk with us. Menus were displayed, showing a choice of breakfast of cereals or porridge, toast and preserves, a cooked breakfast and yoghurts.
• Care staff were gentle and patient with a person who kept getting off their seat, continuously reassuring them. The person wouldn't settle and eventually a nurse helped them back to their room.
• Staff were courteous and encouraging, particularly when asking people what they wanted for pudding. People who did not want the set dishes were gently encouraged to have yoghurt. One person just wanted cream, which was provided, and then they were gently coaxed to have some fruit with it.
• The lunch was a pleasant experience, with tables set nicely. Appropriate cutlery and plate guards were used for one person. Clothes protectors and napkins were offered. No one required assistance with their meal. There was good staff interaction. People were asked if they wanted more and a choice of food and drinks were offered. There was no pureed food, but staff knew how this should be served. Some people were fed in bed and staff assisted as required. People spoken with said they had enjoyed their lunch.
• Eating and drinking care plans were in place as well as MUST assessments. Weights were monitored where required and there were appropriately completed charts for food and fluid intake where needed.
• Special diets were recorded and adhered to by all staff.
• There were hydration stations around the home where those who were able could help themselves to drinks. Those who were unable to do this were offered drinks on a regular basis.
• Some people were fed via percutaneous endoscopic gastrostomy (PEG), which meant they were unable to eat their food orally and received it through a tube into their stomach. These people had appropriate care plans in place to guide staff on PEG feeding and care.
• There were menus in place and choices given for pureed diets as a response to requests from those on pureed foods.

Staff working with other agencies to provide consistent, effective, timely care
• GPs were contacted when required.
• Appropriate referrals were made to other agencies, such as dieticians and speech and language therapy (SALT).

Adapting service, design, decoration to meet people's needs
• The home had wide corridors and doorways to help people who had restricted mobility move around.
• There were pleasant seating areas all around the home as well as communal lounges.
• The décor and signage were appropriate for the people who used the service, with room numbers and name plaques on bedroom doors.
• Pictures included some black and white 'old photo' styles to aid reminiscence.
• Where oxygen was in use there was signage on the door to indicate this.
• There was a pleasant garden area with appropriate seating.

Supporting people to live healthier lives, access healthcare services and support
• There were records and correspondence between the service and other professionals and agencies.
• Hospital appointments were recorded and supported when required.
• Other agencies, such as podiatrists and opticians attended regularly.
• People had appropriate equipment, for example pressure relieving and mobility devices.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least

restrictive as possible.
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• On admission people's mental capacity was assessed and this was updated as required.
• Best interests decisions were documented within care files where appropriate, for example, when someone was unable to consent to having bedrails, but required these to keep them safe.
• A DoLS tracker was in place so that the service could ensure authorisations were reviewed and re-applied for as necessary.
• Consent was gained where required, for issues such as the sharing of information and the use of photographs.
• Where people were unable to sign this was clearly documented. For example, one person had given verbal consent but was unable to sign due to a stroke. Others may have lacked capacity, and this was also recorded.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• Staff showed sensitivity and friendliness towards family members who had previously been caring for their relatives at home and had a flexible approach to families assisting at mealtimes and with 'pampering' tasks. Family members said they had a 'good relationship with staff'. One relative commented, "Coming here is more like coming and meeting friends".
• Other relatives commented; "I want to say what a fabulous care home this is. The staff care about the person they are caring for. It has taken away my worry, I can sleep peacefully; "I have every confidence in them [the staff]. It feels like a family, home from home"; "The care has been outstanding. Staff are really friendly and considerate, nothing is too much trouble, you can visit any time."
• People who used the service were complimentary about the staff. Comments included; "You can get to know the staff, they are never short-tempered"; "Very good, nice people"; "Very, very good – I bet this is the best home there is".
• Staff interacted respectfully with people who used the service and spoke in a friendly manner.
• Equality and diversity training was in place for all staff.
• There was an equality and diversity statement on the notice board.
• Care plans clearly reflected respect for people's diversity and equal treatment for all those who used the service.

Supporting people to express their views and be involved in making decisions about their care
• There was evidence of within the care planning and review documents of the involvement of people who used the service.
• Regular residents' meetings took place where discussions included security, activities and events, open door policy, laundry, podiatry, staffing issues and staff training.
• People who used the service were encouraged to put forward their suggestions or raise concerns individually with staff or at the meetings. There was evidence that issues raised had been responded to in the meeting minutes.
• There was an independent advocate contact number on the notice board so that people who required support and had no representative could access this.
• Independent mental health and mental capacity advocates were contacted to support people with particular needs.

Respecting and promoting people's privacy, dignity and independence
• There was a dignity champion amongst the staff who was responsible for sharing information and good practice.
• Dignity challenge information was on the notice board.

• Staff were seen to respect privacy and dignity, knocking on doors and waiting to be invited in, explaining any support they were offering and respecting people's responses.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff training in person-centred care was in place.
• Care plans included sections such as, 'Important things about my life' and these had been completed with the people who used the service.
• People's preferred pastimes were also recorded.
• There was a remembering together life story which staff completed with people and used to aid conversation in one to one engagement.
• Communication needs were documented, for example, whether the person was able to use the nurse call button and how they communicated their feelings and wishes. For example, use of body language and gestures.
• If people were unable to use the nurse call button their care plan included the need for regular checks by staff.
• The service had a 'resident of the day' where all aspects of that person's care, including maintenance of their environment, food, documentation and well-being were reviewed and updated.
• There were two well-being coordinators who organised activities and events at the home. A relative commented, "[Relative] looks forward to the activities".
• There was a range of activities and outings and people's wishes were fulfilled where possible. For example, one person had requested a trip to the seaside and this had been done.
• There was singing, reminiscence activities and games. Some gentlemen were enjoying watching horse racing, picking horses to bet on from the newspaper.
• On the morning of our visit, music games were going on in the downstairs lounge, followed by a Karaoke session in the afternoon. A number of the people were not keen on joining in with such activities, some preferring to stay in their rooms. They said the coordinators and other staff would come and chat to them and they felt they got to know them well. One family member told us that their relative did not want to do anything when they first moved in but after a few months they have made friends and are now joining in more. The family had requested a different bedroom, when one became available, to provide a different outlook and improved TV options. They told us Carrington Court had been proactive in facilitating this.
• One to one interaction was given to those who wanted this. A hand massage was being carried out at the request of a family member.
• There were visits by religious representatives for those who wanted this.
• The service produced a regular newsletter to help ensure people were aware of what was going on in the home.
• Visitors were made welcome. One relative commented, "Open visiting is great, they always offer us drinks. There is good Wi-Fi for visitors. [Relative] can use skype to keep in touch – this was set up prior to moving in."

Improving care quality in response to complaints or concerns
• There was a complaints log. There had been four complaints which had all been followed up appropriately.
• We saw compliments received by the service. Comments included, "We find the care home very welcoming, staff are always very happy to help with anything your relative needs"; "Thank you for all the care that you gave [person]. All very much appreciated"; "Thanks for the love, care and attention you gave our [relative]." "We would like to say a heartfelt thanks to all staff at Carrington Court including nurses, carers, cleaners, handymen and chefs. With your love, care, support, respect and allowing as much dignity as possible you allowed our [relative]."

End of life care and support
• End of life wishes were recorded in care files, where people had expressed them.
• Some staff had completed Gold Standard Framework training, which is training for care at the end of life. Some staff had applied to do training with the local hospice and had accessed information around common causes of death such as sepsis and pneumonia.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The registered manager and provider were aware of their responsibility regarding duty of candour. Duty of candour ensures providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
• People spoken with felt the service was high quality. One person said, "Any problems I go to the manager, [manager's] door is always open." Another said of the service, "Very structured routine, very clean."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The service had a manager in place, who was registered with the Care Quality Commission (CQC) as required.
• CQC notifications of significant events that the service is required to tell us about, were sent in as required.
• Safeguarding issues, accidents and incidents were reported to the relevant bodies and any incidents reviewed to look at lessons learned.
• Previous ratings were displayed on the provider's website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Two family members said they had previously had other relatives cared for at Carrington Court and had been happy to choose this home for current relatives. Another family member said they would be happy to come to Carrington Court themselves, should it ever prove necessary. One person said, "[Manager] is fantastic, really good".
• Relatives were happy that they were kept informed of any changes in their relative's condition. They felt management and staff were efficient and effective at liaising with external healthcare professionals and other external bodies. One family member told us Carrington Court had been very helpful in supporting them through the process of sorting out additional funding for their relative.
• People described the atmosphere at Carrington Court as 'cheerful' and 'friendly'. Family members reported that they had largely seen the same staff over the period they had been visiting which meant they were able to get to know them.
• People told us they had attended or been informed about residents and relatives meetings and were given

feedback surveys to complete – one quite recently. We saw the results of this survey and feedback had been positive in all areas of care and support.
• The service provided appropriate equipment to aid independence, such as sensors, pressure mattresses, profile beds, moving and handling equipment.
• People who used the service, staff and relatives felt the registered manager was approachable.
• Staff meetings, and meetings for relatives and people who used the service took place regularly and actions put in place to address any issues or concerns raised.

Continuous learning and improving care
• The service analysed data for any trends and patterns to aid improvement. For example, there were monthly records of weight loss, pressure wounds, falls and accidents and incidents. This data was analysed, root cause analysis implemented, and learning taken around how to improve the service.
• There were monthly logs around coroner involvement, safeguarding concerns and investigations and these were also analysed, and learning taken.
• Audits, such as weekly dining audits, medicines audits and health and safety checks were complete and up to date.
• Monthly clinical review meetings took place to look at all clinical issues, issues identified, and actions required.

Working in partnership with others
• A health professional we contacted told us, "I have completed a tracheostomy product awareness session at Carrington Court. The management were prompt to organise and very accommodating. There were a lot of attendees on the session and all were very knowledgeable in the topic and had good understanding in caring for users with a tracheostomy. The staff were friendly and engaged well during the session. I was offered a drink on arrival and they helped me step up for the session."
• The service was working with the Connected Care Home model with Wigan local authority. This was around using technology to support people with independence and access to joined up services.
• The service was involved in intergenerational project work with local college and primary school around facilitating activities.
• There were community circles which organised matches with people who used the service and volunteers who may share common interests. This helped facilitate people who used the service to follow these interests.
• Regular meetings took place with the falls team to discuss and review falls at the home.