CareQuality Commission

Carleton Court Residential Home Ltd

Carleton Court Residential Home Limited

Inspection report

Carleton Road
Skipton
North Yorkshire
BD23 2BE

Tel: 01756701220
Website: www.carletoncourtskipton.co.uk

Date of inspection visit:
29 February 2016

Date of publication:
22 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

When we inspected this service in October 2014 we identified three regulatory breaches and rated the service as requires improvement overall. The breaches identified related to staffing, premises and equipment.

We undertook a focused inspection in June 2015 to check that the registered provider had followed their plan and to confirm that they now met with the legal requirements. We found the provider was no longer in breach of regulations and had made significant improvement to the service and the care people received. However, in order for this service to be rated as good we needed to see consistent good practice over time, therefore we would return and review these areas again at the next inspection.

This inspection took place on 29 February and 31 March 2016 and was unannounced. This inspection was a re-rating inspection carried out to provide a new rating for the service under the Care Act 2014 and to see if the registered provider and registered manager had made the improvements we required during our last inspection.

At this inspection the provider had failed to ensure the provision of safe care and treatment for people using the service. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

They had failed to ensure that the premises were clean, safe and well maintained. This was a breach of regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

They had failed to ensure that there were sufficient staff to support people living at the service. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was clear that the provider had failed to establish and operate systems and processes which would ensure and demonstrate their good governance of the service. We found that the standards of governance and leadership at the home were poor and ineffective. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we have asked the provider to take at the back of the full version of this report.

Carleton Court provides accommodation and care for up to 24 older people. Nursing care is not provided. At the time of this inspection the service was providing care for 23 people.

The home employed a registered manager who has worked at the home for over four years. 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.

The service was not safe. Although some people living at the home told us they felt safe they described staff shortages and having to wait to be attended to. We found people went long periods in communal areas where they were unsupervised and had to rely on each other for assistance.

We observed that care staff were consistently busy with care and non-care tasks such as laundry and food preparation.

Prescribed creams for topical application were not dated on opening and were not discarded every month. This posed a risk of people being treated with medicines which may no longer be effective. People's needs were regularly assessed, monitored and reviewed, but we found examples where action was not taken to make sure care delivery met people's individual needs. Risk assessments were completed but risks to people were not always minimised due to the lack of staff at the service.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals. However, these professionals raised concerns with us relating to staffing levels and care delivery.

Satisfactory recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. These included obtaining references from previous employers to show that staff employed were safe to work with vulnerable people.

The home's infection control procedure that was not adhered to. We found examples where the home was inadequately clean, some equipment was in need of replacement and there were unpleasant odours in some of the corridors and one of the bathrooms.

The principles of the Mental Capacity Act 2005 were being followed by staff. Consent to care and treatment was sought. When people were unable to make informed decisions we saw a record of best interest decisions. The registered manager had a clear understanding of the Deprivation of Liberty Safeguards (DoLS).

We saw people had access to regular drinks, snacks and a varied diet. If people were at risk of losing weight we saw plans were in place to manage this.

Staff were described as being 'lovely and caring' and we saw some good practice where staff were kind and attentive. However, we also saw poor practice such as people using the service who looked unkempt; wearing clothes that were stained and several who were without socks or stockings.

We did not observe any activities taking place during our visits and several people told us they were bored and lacking things to do.

Some people and their relatives had completed an annual survey. However, where concerns had been raised we found these had not been actioned by the registered manager or provider.

There were auditing and monitoring systems in place to identify where improvements were required. However not all audits we saw were up to date, for example, infection control and cleanliness of the service. Relevant actions plans were not in place to follow up and demonstrate how any identified shortfalls had or would be addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Insufficient deployment of staff was placing people who used the service at risk of not receiving safe care and treatment.

Auditing was not effective as issues raised during the inspection had not been picked up or dealt with properly.

The service did not apply good infection control practices in keeping the home clean and free from odours.

Medicines were not being managed safely.

The service followed safe recruitment practices to ensure staff working at the service were suitable.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had received training in a variety of topics. However staff did not have the skills to provide care and support to people living with dementia.

People had regular access to healthcare professionals, such as GPs, speech and language therapists and district nurses. However, some health care professionals raised concerns about some people's health care needs being met.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The principles were being applied appropriately in line with legislation and guidance.

Most people were provided with a choice of nutritious food. However, people living with dementia were not always supported to eat their meals by staff at the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff had a good understanding of people's care needs. However, we saw poor care practices where people were not adequately supported in their day to day lives.

Staff lacked the skills and understanding of how to provide up to date dementia care.

People who were able to speak with us told us they were happy with their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always aware of people's personal preferences or their wishes.

There was no programme of activity that was stimulating and meaningful for people living at the home.

The provider had not received any complaints since 2015. However, should people wish to complain a procedure was in place for them to use.

People told us they felt confident any concerns would be addressed. However, we saw that a survey had been completed and issues highlighted at that time had not been addressed fully.

Is the service well-led?

Requires Improvement

The service was not well led.

People we spoke with, including health care professionals, raised concerns regarding staffing levels and the provision of care.

There was a lack of good management and leadership, which had led to potential risk.

There were systems in place to monitor the quality of the service however, these were not always effective. For example, audits regarding infection control had not been carried out regularly and were no longer up to date.

The provider had actively sought the views of people but had not taken any action regarding the concerns that had been raised about staffing levels at the service.

Care Quality Commission

Carleton Court Residential Home Limited

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.

The first day of the inspection took place on 29 February 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, who were supported by a specialist professional advisor (SPA). A SPA is a health and social care professional with a background relevant to the service being inspected. The SPA for this inspection was a registered nurse with experience of working with older people. We were also supported by an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses care services. The expert-by-experience who assisted with this inspection had experience of using health and social care services and caring for people who used these services. We returned to the home on 7 March 2016 to give feedback to the provider and registered manager.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding (this is where potential abuse may have occurred and a referral for investigation is made to the local authority safeguarding team) and any accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports. Before the inspection the provider completed 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 improvements they plan to make. We planned the inspection using this information.

We looked at most areas of the home including some bedrooms (with people's permission) and all of the communal areas. During the first day of inspection we looked at records which related to people's individual

care. We looked at care planning documentation for seven people and other records associated with running a care service. This included two recruitment records and the staff rota. We also reviewed records required for the management of the service such as audits, statement of purpose, satisfaction surveys and the complaints procedure. During our visit to the service we spoke with the registered manager, a senior care worker and two care staff. On the first day of the inspection we spoke with eight people who lived at the service. We spoke with four relatives of people who lived at Carleton Court. We telephoned the specialist nurse practitioner from the Craven Care Homes Quality Improvement Support service.

We visited the service again on 31 March 2016. This visit was carried out by two inspectors, as we had concerns that people were not always safe because there was a lack of sufficient staff at the service. We spoke with five people living at the service during this visit and observed people's care. We spoke with a visiting district nurse. We telephoned the Advanced Practitioner from the District Nurse Team and spoke with three GP's who visit the service.

We received information from Healthwatch. They are an independent body who hold key information about the local views and experiences of people receiving care. CQC has a statutory duty to work with Healthwatch to take account of their views and to consider any concerns that may have been raised with them about this service. We also consulted North Yorkshire County Council to see if they had any feedback about the service, and we have incorporated this in our report.

Inadequate

Is the service safe?

Our findings

During the previous inspection in October 2014 we identified that there were insufficient staff available to meet people's needs and the deployment of staff was not well organised. We subsequently carried out a follow up inspection in June 2015 and found that sufficient staff had been employed to meet people's needs and to maintain their safety and wellbeing.

During this inspection we saw daytime staffing numbers were two care staff supported by a senior care assistant for twenty three people. During the night there were two care staff on duty. We were informed by the registered manager that there were always three care staff on duty each day. The rotas showed there was one domestic on duty each day including the weekends, a cook who was assisted by a kitchen assistant and a maintenance person who worked six hours per week.

The registered manager used a dependency tool to determine that appropriate staffing levels were maintained. When we asked her about the adequacy of current staffing arrangements she told us that the staffing levels had been based on the recent assessments she had carried out.

Staff expressed concerns regarding the staffing levels in respect of the layout of the home, as there were two lounges on the ground floor and people in bedrooms on the first floor.

We observed care staff being busy throughout the day. There was evidence of call bells being activated for staff to answer but these were not always answered quickly. We saw in one lounge that a person kept trying to stand up from their chair and did not understand that they were at risk from falling. With no staff present we saw other people who lived at the service in this lounge kept saying "No", "Sit down", "Stay where you are". The person responded to them and did as they were asked and sat back down. We observed this happened at least three times in the space of 30 minutes that we were sat in this lounge. We saw staff later in the morning in the lounge again when they were going around the home with a tea/drinks trolley.

We spoke with health care professionals, one of which told us, "The dependency levels of some people in the home are high now and have been for several months now, and because staffing is low this impacts on the care people receive."

We saw care staff working in the laundry. They told us that care staff had responsibilities for the laundry as a laundry assistant was only available one day a week. This created risks for people living at the home as staff were having to spend time on non-care duties leaving people alone in the communal areas.

During the morning, whilst checking medicines with the senior care assistant on duty, we heard a call bell ringing for approximately two minutes and found this had been activated by a member of care staff upstairs who required help hoisting someone. Eventually the senior care assistant had to stop the medicines round and go upstairs to assist as the only other member of care staff on duty was busy downstairs. This meant that people were at risk due to a lack of available staff. It also created possible delays in people receiving their medicines at the correct time.

People using the service told us, "They (staff) don't come to see you. You are just told press the buzzer and then they will come running – probably 20 minutes later if you're lucky. It is not my expectation of a care home as I would expect more attention." Another person told us, "Yes they (staff) answer the call bell but not always quickly it can take them longer than 10 minutes to come and see to you." Another person told us they thought there was a shortage of staff at the home.

On our second visit we saw another person who tried to stand and get up from their wheelchair. They had been given a cup of tea which slipped to the floor breaking the cup into pieces. Another person then tried to bend down to pick the fragments of broken cup. The visiting district nurse and one of the inspectors intervened and prevented them from overbalancing. There had been no care staff in the vicinity.

A senior care assistant on duty at this visit told us there were between seven or eight people who required support from two care assistants with two people who required a hoist for moving around. This meant that when a person was being hoisted the senior care assistant was the sole member of staff available to support other people within the home, answer the telephone, administer medication and deal with visitors and health care professionals. We established there were insufficient staff on duty and deployed throughout the 24 hour period to protect and care for people safely and well. When we questioned the provider's representative about our findings in relation to staffing and the safe delivery of care they told us that people's care needs were being re-assessed and the number of staff had increased.

We observed the tea time meal and saw this was being served by the domestic who had returned in the afternoon. We observed one person struggling in the dining room as their table had not been put in an easy position for them to eat their food. The tea time meal had been prepared by one of the care assistants, assisted by a member of domestic staff, which had taken them away from providing support to people. We identified that the insufficient deployment of staff was placing people who used the service at risk of not receiving safe care and treatment.

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

We looked at the recruitment records for two staff and found they had completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. Both of them had attended an interview and two references and Disclosure and Barring Service (DBS) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

We toured the premises and we found that while some areas of the home were clean and were satisfactorily maintained other areas were not.

Overall the home did not look or feel clean. We found there was an unpleasant odour in some of the corridors and bathrooms. Some communal areas such as corridors on the ground and first floor were not clean and the new flooring was stained. On the staircase leading up to the first floor there was dust on the stairs and skirting boards. The window ledges were cluttered and dusty. In the downstairs toilet we found brown staining on the disabled grab rail. In the dining room equipment such as stools, cushions and footplates from a wheelchair were piled up in corners. Tablecloths and place mats were stained with food from lunch and had not been cleaned properly.

A tablecloth on a dresser in one dining room was badly stained. We informed the registered manager of this and later in the day we saw that this had not been removed and staff had turned this over to the cleaner side

of the tablecloth. When we pointed this out to the registered manager they told us they had asked staff to address this.
We saw staff did not follow safe hand washing techniques and did not use disposable aprons and gloves during medicines rounds or when attending to the people's personal care needs.

We saw cleaning schedules in place which were being completed by the domestic staff and audits carried out in February 2016 by a senior care assistant regarding the cleanliness of the service. The audits identified some of the areas of uncleanliness that we had identified. For example, unclean window ledges, sinks, toilets and commodes. There was no action plans in place which told us how the provider had or was going to take action to address these matters.

We saw in one person's room the bed had been made with a badly stained bottom sheet. In another room which was now vacant we found personal possessions.
We saw the furniture in the sun lounge and small lounge was old and worn. We found that some areas in the home such as the sun lounge felt cold. People were sat with knee blankets. We checked with people to see if they were cold. They said they were comfortable although one person informed us that their bedroom had been cold the previous night. They said, "It was cold in my bedroom yesterday but it's better today". We informed the registered manager immediately who instructed the maintenance person to check the boilers. This was done during our visit and the heating was increased on the boiler. Portable heaters were distributed around the home to ensure areas were warm. The registered manager assured us that air temperature checks would be carried out daily to ensure the environment was at a consistent warm temperature, so as not to put people at risk from hypothermia. We have since received written confirmation from the registered manager that new boilers had been installed.

We found the provider had failed to protect people in that premises were not being used safely. We found that premises and equipment used to deliver care were not clean or properly maintained. Appropriate standards of hygiene were not maintained.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The service had emergency contingency plans in the event of a fire. These included a fire risk assessment and personal emergency evacuation plans (PEEPs) for individuals. We saw fire alarm tests usually took place weekly in line with the fire authority's national guidance.

Appropriate checks of the storage, disposal and receipt of medicines had taken place. This included daily checks of the temperature in the rooms and refrigerators which stored items of medication. We saw that the room temperature had been recorded daily, but the fridge temperature had last been recorded on 20 February 2016 as the thermometer was reportedly broken. This had been reported to the registered manager and maintenance person but no-one had acquired a new thermometer.

Appropriate arrangements were in place for the recording of medicines including when required (PRN) medicine. However, we found that on two occasions records had not been completed fully. We saw there were two missing signatures on two different people's medicine records, both at night time on 23 February 2016. Prescribed creams for topical application were not dated on opening and were not discarded every month. In one person's room there was an unmarked tube of epiderm and a tub of epiderm leaking onto the shelf.

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

Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs. Controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register and saw they tallied correctly. We saw that medicine audits were carried out monthly by the registered manager, to ensure people's medicines were managed safely.

Since an incident where someone had left the building unnoticed measures had been put in place to ensure people remained safe. The sun room door was now alarmed and the patio area of the sun lounge had been made secure.

The service had an up to date safeguarding policy, which offered guidance to staff. All of the staff we spoke with told us they had received safeguarding training. Training records we saw confirmed this.

We saw that the risk assessments in people's care records relating to the safety of the environment and equipment used in the home were up to date and had been regularly reviewed. We saw records confirmed equipment was serviced and maintained regularly. We observed staff using a hoist safely whilst ensuring people's dignity was maintained.

Accidents and incidents were recorded. These were regularly reviewed by the registered manager to ensure that appropriate actions had been taken and to identify any trends or further actions that were needed. We were sent a copy of the accident analysis carried out by the registered manager which showed that there had been 17 falls from 12 January 2016 to 11 February 2016. We saw these falls mainly involved three people and that involvement with other professionals and a multi-disciplinary meeting had taken place to ensure the service managed one person's falls. We discussed this with the registered manager who said that the number of falls had now reduced. Falls risk assessments were being undertaken for all residents and staff were monitoring people closely who were at risk from falls.

Requires Improvement

Is the service effective?

Our findings

People we spoke with said that overall the meals at the home were good. One person said, "The food is good" another person said their meal "Was so, so." Another person said after having their lunch, "I enjoyed that."

The meal time was well organised and people had a choice of meal and a drink. The tables were set nicely with condiments, table cloths and flowers. Only one person requested a clothes protector and we saw other people had serviettes. We saw that a menu for the day was displayed on a white board on the wall next to the dining room, which informed people about what choices they had about their meals. However, the writing on the white board was small and illegible making it difficult to read. We observed staff supported people where necessary with their food. The lunchtime meal appeared to be appetising and most people were offered choices. However, people living with dementia were not shown the food available at lunchtime, but instead were told by staff what was for lunch. People appeared not to understand what they were being asked and could not decide what they wanted to eat.

We observed the cook coming in to the dining room and asking people for their views about their lunch. We saw that everyone responded positively. We observed on one occasion a person in their room asked for a cup of tea and this was immediately provided. It was noted that everyone had a fresh jug of juice/water of their choice put in their rooms every day. This meant that people were supported to drink plenty of fluids to maintain their wellbeing. We observed people were offered a biscuit with their drinks throughout the day, although biscuits were handed out by the staff rather than people being able to pick their own. This meant that people were not always supported to be as independent as possible.

We were provided with a copy of the Statement of Purpose for the service and saw that this did not include any information that the home offers a service for people living with dementia. During our inspection of the service we found several people living at the home who were living with this condition.

We recommend the provider reviews their Statement of Purpose and ensures staff receive appropriate support and training to follow good practice guidance in meeting the needs of people living with dementia.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working within the principles of the MCA. Throughout the inspection

we saw evidence of staff supporting people to make decisions and seeking consent. Where appropriate care plans contained mental capacity assessments in relation to decisions about people's ability to consent to care. Where it was deemed the person lacked the ability to consent to their care we saw records of best interest decisions. It was evident the person and their representatives had been involved in the best interest decision making process. There were two people living at the service who had an authorised DoLS in place, a further 15 applications had been made to the local authority for consideration. The registered manager demonstrated a good awareness of the legislation and was working within the principles of the Act.

People were supported to maintain their health and had access to health services in an emergency or as needed. Care plans we looked at showed people had been referred to the mental health team and other health care professionals such as the Speech and Language Therapy Team (SALT) where needed. Records showed that the recommendations made by professionals were being followed and adhered to by staff at the home. Care plans contained clear information about peoples' health needs. A dietary chart was in place for people at risk from malnutrition. There was evidence of the involvement of healthcare professionals such as the doctor, respiratory nurse, tissue viability nurse and SALT team where there was concern about a person's nutritional wellbeing. We saw in one person's care record there was involvement with other professionals and a multi-disciplinary meeting had taken place to ensure the service managed this person's falls. All care records we looked at had consent to care forms signed by people living at the service or their representative.

One healthcare professional we spoke with told us, "We have a strong relationship with staff and the manager of the home. The manager always makes sure that staff from the home attend training that district nurses facilitate. They (staff) are very responsive, open and honest with us."

A visitor told us that they were kept informed of what was happening if their relative was ill and needed a visit from the doctor or nurse.

We saw that staff training was organised by the registered manager and openly encouraged.

The registered manager had a training matrix (overall training record) which enabled them to keep a track of when staff were due to attend refresher training. All of the staff files we checked contained up to date training records and certificates. Staff had completed basic training and additional training such as basic first aid, moving and handling, safeguarding, diet and nutrition. We also found that staff had not received any training in dementia care.

Staff told us they received regular supervision. Records we looked at showed that staff had received regular supervision with the registered manager. Handover records were comprehensive and handover for all staff was held at the beginning of shifts to pass on relevant information. We found there to be good communication between the staff team.

During our visit on 31 March 2016 we spoke with two district nurses who were visiting people at the home and spoke with two GP's by telephone. One GP said, "I have no specific concerns. The manager is always helpful and so is (name) who is the senior carer. They (staff) do know their residents. They (staff) do everything we ask them, although they are always very busy." Another GP said, "There is good support from senior staff at the home." They went on to say that some people had become frailer and may now need nursing care. One district nurse told us, "(Name) is falling a lot and needs lots of assistance; they have had numerous skin tears. We are getting a lot of falls here and there is very few staff about and it takes time to find them." A senior nurse practitioner nurse told us, "The girls working there work hard – the staff work really hard. There is not enough staff." The registered manager agreed during feedback that some people

had become frail and may need re-assessing.

Requires Improvement

Is the service caring?

Our findings

During both our visits we spent time in the lounge areas of the home. There were long periods of time when there was a lack of staff presence in these areas. There was little or no interaction between people and as a result of this most people slept throughout the morning as there were no activities taking place to stimulate them. On occasions when staff did approach people they did so in a sensitive way and engaged people in conversation which was meaningful and relevant to them. However, this was usually briefly as staff were kept busy throughout the day and did not have the time to spend with people. Staff were observed as being caring towards people at the service and chatted as they made their way around the home doing jobs.

During our second visit to the home on 31 March 2016 people we spoke with told us they thought they were well cared for. One person told us, "I am looked after well, although they are short of staff." Another person said, "Staff are very good here, although there is not enough of them." We observed that one person kept going into the dining room and lounge looking for staff as they wanted the toilet. However, there were no staff present for them to be assisted. One of the inspectors directed the person to the toilet. We then went and found a member of staff to assist the person which they did. We found people at the service were left to their own devices with little or no presence of staff in the communal areas. On the second day of our visit we observed that some people were unkempt and not appropriately dressed. We saw one person had a stained cardigan on and several people had no socks/stockings or tights on. We fed this back to the registered manager who instructed staff to address this immediately. The registered manage told us that because of the lack of sufficient staff, this had led to people not always getting the appropriate care.

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

Throughout the first day of inspection the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. Staff were respectful when talking with people calling them by their preferred names. We observed staff routinely seeking consent and offering people explanations before support was provided. We saw people treated with dignity and their privacy was respected with people's personal care needs dealt with behind closed doors. Staff were observed knocking on people's bedroom doors before entering even if they were already open.

We observed that people were relaxed with staff and confident approaching them throughout our visit.

Care plans showed individual needs were documented. Care plans we looked at showed involvement with people living at the service, their relatives and reviews being held with health care professionals such as the GP. We saw that there was no-one on end of life care when we visited.

During our first visit people all spoke highly about the staff at the service. One person said, "The staff are lovely and I like it here, it's marvellous." Another person said, "They can't do enough for you, the staff here are lovely. I am very lucky, I seem to be surrounded by nice people," and another said, "It's lovely here."

Relatives we spoke with were also positive about the home and the care their relatives received. Relatives told us their relatives were happy living at the home. A visitor stated that their relative was "Happy here" and there were no issues and they were satisfied with everything.

A health care professional we spoke with told us, "Carleton Court staff are all very caring." A visiting district nurse told us, "Staff here do act upon any comments we make. For example one person's nails needed cleaning and once staff were informed they did this immediately."

We observed staff interaction with each other and with people who lived at the service. All the staff treated each person as an individual giving them time to make choices.

Overall, staff were caring and showed respect for people's dignity and choices, however, their ability to demonstrate this consistently was effected by the staffing levels in the service and non-caring tasks they were expected to undertake.

Requires Improvement

Is the service responsive?

Our findings

We saw that although people at the service did have some planned activity for example playing dominoes, there was very little meaningful activity taking place throughout the day. High quality approaches to providing meaningful and enjoyable activities are a key part of enabling people residing in care homes to 'live well' with dementia (Department of Health 2009). We were informed by the registered manager that there were two hours per day dedicated to activities. These activities were carried out by additional care staff. On the day we visited we did not see any other activities taking place and no additional staff were present throughout the day we inspected.

We asked people about activities available. One person said, "I like to sit in the lounge for a bit of company, I've been here for a while but it's boring. I like to sit with this person because we both served in the war so it's a bit of camaraderie but he's not as good as when I first came in." Two people told us, "There is nothing to do", and "I like to go out I've been an outdoors person all my life, I've got a wheelchair but nobody takes me out." A third person told us they would like to go out more but there was no transport.

Throughout the day we saw that people were asleep in their chairs. The television was on in the main lounge but no-one was watching it. Several people we spoke with spent time in their own rooms – one person commented, "I watch television in my room but not in the lounge, the ladies are usually sleeping." We found that there was music on in the sun lounge, however the tape or CD became stuck and with no staff present to change it, which kept being repeated until staff came into the lounge and addressed this.

We observed that there were two Jehovah Witnesses visiting the home. They had come to do a bible story reading. Three people sat in the lounge were listening and one person commented, "You give us a good lift." However, there were a further three people sat in this lounge who were clearly not participating. We discussed this with the registered manager asking if everyone who sat in the main lounge had been asked if they wanted to listen to the bible story. The registered manager informed us that they had not been asked if they wanted to participate or listen to the bible story reading taking place. We discussed the lack of activities during our feedback with the registered manager and provider. The provider told us they had allocated two hours per day dedicated to activities. The registered manager told us that they did not have enough care staff to ensure people's care needs were being met therefore they were unable to provide activities for people.

During our second visit to the service on 31March 2016 we observed that the radio was on in the sun lounge and heard that Stray FM was playing modern music. One person in the lounge said they would have preferred to listen to classical music. This demonstrated that staff were not always aware of people's preferences and their wishes.

We recommend the provider looks at how improvements can be made for people to have access to appropriate and meaningful activities.

We looked at the arrangements in place to ensure that people received person-centred care that had been

appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. Each person also had their own assessment record, care plan and care records. Records showed that the care plans reflected the information which was gathered during the pre-admission stage. People's individual care needs were reviewed regularly and their care plans provided the most current information for care staff to follow. Care plans were also updated where a changed need was identified. We could see health professionals had been consulted appropriately and their guidance had been included within people's support plans.

All care plans we looked at had consistent documentation. Care plans we saw covered all areas of daily living and the care people required. They were reviewed on a monthly basis and were up to date. Care plans were rewritten six monthly or more frequently if people's care needs changed. They were initially written by the registered manager but reviews tended to be completed by the senior care workers. There were risk assessments for falls, skin integrity, use of the hoist, challenging behaviour and the input of a tissue viability nurse was evident in one person's care plan.

We saw where advice had been sought records showed this had been followed by staff. Care records had a general risk assessment which was completed in all cases and was comprehensive, informative and up to date. The daily records were completed twice daily by both day and night care staff. We did not get a sense of people's social histories or their experiences and felt that work to improve this linked to the person's current experience would be beneficial. When we fed this back to the registered manager they agreed improvements were needed.

People did not have a hospital admission pack completed with information as to which documents had to accompany them to hospital. All of the individual care files had a current DNAR (Do not attempt resuscitation) at the front. However, people's advanced wishes i.e. whether or not they wanted to go into hospital or not did not appear to have been addressed for some people. We looked to see where this information had been recorded and found it was located towards the back of the file. These two documents should be together with ease of quick access at the front of people's file.

We looked at the arrangements in place to manage complaints and concerns that were brought to the service's attention. The provider had a complaints procedure in place, setting out how complaints could be made and how they would be handled. No one we spoke with had made any complaints about the service. The complaints record showed that there had been no complaints made to the provider since the last inspection in 2015.

Requires Improvement

Is the service well-led?

Our findings

The home employed a registered manager who had worked at the service for four years and who was present during the first day of inspection. The registered manager engaged with people living in the home and was clearly known to them. They were visible around the home during our first visit but was absent for our second day.

There were systems and processes in place to monitor the service. We saw that the registered manager had carried out audits. Audits included regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire fighting and detection equipment. There were also care plan, environment and medicines audits which helped determine where the service could improve and develop. Audits had been completed regarding the cleanliness of the environment at the service where issues around the cleanliness had been identified. However, there were no action plans in place which told us how the registered manager or provider were to address these matters. We did not see any records of provider visits taking place where any issues were brought to their attention and of the action they had taken, although the provider told us during our feedback they visited the service regularly.

We were informed by the registered manager that a recent survey had been carried out with people receiving a service and their families and that 11 replies had been received out of the 23 surveys sent. This information was being collated by the registered manager. We saw from some of the surveys that people had raised concerns about the staffing levels at the service. No action had been taken to address the issues raised via surveys. Surveys had not been sent out to staff or visiting professionals for their views. The registered manager told us that service user meetings did not take place because of people's frailty.

The feedback we received on the day identified a pattern of concerns which included reports of poor staffing levels resulting in delays in people being attended to, increased fragility and complexity of people's needs which staff did not have the skills to respond to; people looking unkempt and a lack of meaningful activities available. Feedback did, however, say that staff were kind and caring and wanted to do 'a good job.'

The provider told us they visited the service at least monthly to support the registered manager. The registered manager told us they wanted to achieve a high standard of care but was failing due to lack of resources. The registered manager told us this led to a rather unsettled and frustrated team and that they had fed this back to the provider. They told us they had respect for the staff and the staff told us the registered manager was 'always there for them if needed.' They said that they listened to opinions and were open to discussion but not very effective at getting things done. One member of staff said, "I am unhappy about the staffing levels and the lack of equipment." Another member of staff had been at the home for many years said, "I love it here. It's just such a shame it is not good any more with some staff not doing their job and a lack of commitment from the owners." One member of staff said, "It's a happy place to work and we all cover for each other, but it could be so much better and the residents are lovely."

From the evidence during the inspection, together with feedback from people who used the service, their relatives and health professionals, we identified that leadership at the service and support from the

registered provider was lacking. This impacted on the effectiveness of the staff team and the quality of care people living at the service experienced. Despite auditing and monitoring systems being in place the number of shortfalls found at this inspection and the subsequent breaches in regulation demonstrated the provider's governance of the service was ineffective.

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

We shared our concerns with the registered provider, both with regard to the shortfalls and breaches in regulation and the general feelings of the staff and culture of the service. They took some immediate action to ensure staffing levels were improved and gave assurances to provide further support to the registered manager and staff to improve morale of the staff team. Since our inspection the provider had sent us details of their improvement plan for the service, which outlined the actions they had taken to improve the service so far.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people by doing all that is reasonably practicable to mitigate any risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to protect people against risks associated with the adequate maintenance of the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not protected people against the risks associated with insufficient assessment and monitoring of the service.