Carleton Court Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This was an unannounced inspection carried out on the 21 October 2014. At the last inspection in June 2013 we found the provider was meeting the regulations we looked at.

Carleton Court provides accommodation and care for up to 24 people who require nursing or personal care. The home is a converted manor house and accommodation is provided over two floors; the first floor is accessed by a lift and a staircase. There is disabled access to the home, which is set in its own grounds, with parking available. Carleton Court is close to the centre of Skipton.

The home employs a registered manager who has worked at the home for nearly three years. A registered

Summary of findings

manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found that there were not enough, qualified, skilled and experienced staff to care for people well. This meant that staff did not have time to interact appropriately with people using the service or ensure that they were appropriately supervised and supported. This is a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The recruitment processes followed by the home when employing staff were robust, which meant that people were kept safe and that staff were suitable to work with vulnerable people.

People told us they felt safe in the home and we saw there were some systems and processes in place to protect people from the risk of harm. However we saw that regular checks to ensure that safety equipment such as the fire alarm system were in good working order was not being carried out.

People received their prescribed medication when they needed it and appropriate arrangements were in place for the storage and disposal of medicines. However this did not include regular auditing by the home, therefore the service could not be confident that medication was being given safely.

There were poor systems for staff to follow to minimise the risk of infection. We found that some areas of the home were unclean as there were offensive odours present. This meant that people could be put at potential risk from infection. Areas within the home's environment were poorly maintained and required work. Most of the communal areas were in need of re-decorating. In some areas we saw floor coverings were damaged. Furnishings in areas for example the sun room were damaged with some furniture not fit for purpose This is a breach of Regulation 15 (Safety and suitability of premises), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People who lacked capacity were protected under the Mental Capacity Act 2005 as the provider was meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, appropriate policies and procedures were in place. Staff had received training to understand and ensure safeguards would be put in place to help to protect people.

Staff had completed all mandatory training and had received supervision and annual appraisals.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. Care plans contained a good level of information setting out exactly how each person should be supported to ensure their needs were met. Care and support was tailored to meet people's individual needs and staff knew people well. The care plans included risk assessments. Staff had positive relationships with the people living at the home. The atmosphere was busy with staff having little or no time to spend with people either individually or jointly in the communal areas of the home. People living at the home also told us that staff did not have the time to engage with them and didn't always respect their privacy.

We observed interactions between staff and people living in the home. Staff were respectful to people when they were supporting them. However, at times interactions and communication between people living at the home and members of staff were poor. For example, mealtimes were not a pleasurable experience for people who required support with their meals due, to the poor practice used by staff. We saw people's privacy and dignity was not always respected by staff, as we observed staff not knocking on people's doors before entering their rooms.

There was no programme of activity that was stimulating and meaningful for people living at the home. People told us that there was a lack of activities at the home to keep them occupied. Therefore people did not have access to proper and appropriate activities.

No complaints had been received by the home since the last inspection. Notifications had been reported to the

Summary of findings

Care Quality Commission as required by law. There were not always effective systems in place to monitor and improve the quality of the service provided. Staff did not always meet as a team where they had the opportunity to discuss their practice. Although staff were supported individually to raise concerns and make suggestions when they felt there could be improvements.

We contacted other agencies such as the local authority commissioners and Healthwatch to ask for their views and to ask if they had any concerns about the home. Feedback from Healthwatch was there no concerns raised about this service. The local authority commissioners had concerns relating to the cleanliness of the home, with odours in some areas. They also had concerns about damaged furniture being used and a shortage of staff. Commissioners had no concerns around care as people looked well cared for when they visited. Although they did have concerns around people's care plans which had not been reviewed i.e. continuity re instructions from a GP re antibiotics for one person had not been documented.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. The home followed safe recruitment practices to ensure staff working at the service were suitable. However there were not always sufficient, qualified, skilled and experienced staff to meet people's care needs well.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

Individual risks had been assessed and identified as part of the support and care planning process. However within the home's environment fire alarms were not tested regularly and furnishings were poorly maintained with some furniture not fit for purpose. The service did not apply good infection control practices in keeping the home clean and free from odours.

Is the service effective?

Requires Improvement

The service was not effective. People's experience at lunch time was not always pleasant due to poor practices used by staff at the home, when assisting people with their meals.

People who lived at the home and who were unable to make their own decisions were protected by the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. Staff understood how to apply for an authorisation to deprive someone of their liberty.

People had regular access to healthcare professionals, such as GPs and district nurses.

Is the service caring?

Requires Improvement

The service was not always caring. People told us they were happy with the care and support they received and their needs had been met. It was clear from speaking with staff they had a good understanding of people's care and support needs and knew people well.

We saw there was very little interaction and communication between people living in the home and members of staff. We saw people's privacy and dignity was not always respected by staff.

We saw that there were no plans in place to support people at the end of their life.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive. People did not always have choices regarding their daily routines. For example when people wanted to go to bed or when they wanted to get up. There was no programme of activity that was stimulating and meaningful for people living at the home.

People's health, care and support needs were assessed and their choices and preferences were discussed with them. We saw people's care plans had been updated regularly and where there were any changes in their care and support needs.

No complaints had been received by the home. People knew how to make a complaint if they felt the need to do so.

Is the service well-led?

Requires Improvement

The service was not well led. There were some systems for monitoring quality at the service in place. However, most audits had not been carried out regularly and were no longer up to date.

There was a lack of management presence.

People living at the home were encouraged to share their views about the home where they lived. Relatives and friends were also asked about their views of the service.

Notifications had been reported to the Care Quality Commission as required by law.

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.

This inspection took place on 21 October 2014 and was unannounced.

The inspection team consisted of one inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider is asked to complete 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 were provided with information before the inspection from the service.

We also reviewed the information we held about the service, such as notifications we had received from the registered provider. We planned the inspection using this information.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent eight hours observing how people were being supported and cared for.

We inspected all 23 Key Lines of Enquiry (KLOE's) and used a number of different methods to help us understand the experience of people who used the service. During our visit we spoke with the registered manager, two members of care staff. We spoke with one visitor. We also spoke with two visiting health care professionals. We spent time speaking with four people individually and with several people informally who were sitting in lounges. We looked at all areas of the home including people's bedrooms, the kitchen, laundry, bathrooms and communal areas. We looked at how four people's care and support was being carried out. We looked at the recruitment and training records for three members of care staff. We observed two mealtimes which included breakfast and lunchtime. We also observed how medication was being given to people.

We also telephoned to speak with three care staff following the inspection visit.

We contacted the commissioners from the local authority and Healthwatch to ask for their views and to ask if they had any concerns about the home.

Requires Improvement

Is the service safe?

Our findings

People living in the home told us they felt safe. One person told us, "I had to come here as I wasn't coping at home; I know there is someone around if I need help." Another person living at the home said, "On the whole they(staff) are pretty good. I am in my room now (2.30pm) so I won't see anyone until tea time unless I buzz for them." They went on to say that they had to wait for long period of time at night for staff to come to see to them, but this did not happen during the day.

Relatives confirmed they felt their family member was safe. A visiting relative told us, "I know my relative is safe here. I needed help and they do that here. The staff know my relative well."

The home was arranged into two main sitting areas. One where a TV was on and another referred to by staff as 'the sunroom' where a radio played popular music. We spent time in both areas talking to people and did not observe any staff staying in either area. This meant that at times there was no one available to attend to people's needs or supervise their safety and wellbeing.

One member of staff, the cook, was the most visible member of staff during the morning and afternoon, as we observed her helping people with their physical needs as there were no care staff available in the lounges. For example one lady complained her legs were cold so the cook brought her a small blanket and helped put the blanket around the lady's leg.

We observed care staff taking the hoist into people's bedrooms. We did not see them actually using the hoist at this stage however, one person described their experiences when being hoisted and said "It can sometimes hurt when I am being hoisted especially if they swing you around. I think they get the belt too high. One or two of the staff know how to do it better than others." We fed this back to the manager who agreed to look into this matter to ensure that all staff were using hoisting equipment appropriately.

The manager showed us the staff duty rotas and copies for the last two weeks were obtained. They explained how staff were allocated on each shift. They said where there was a shortfall, for example when staff were off sick or on leave, agency staff were used to cover or the shortfalls were covered by existing staff working additional hours. The manager told us staffing levels were assessed depending on people's need and occupancy levels. The rotas we looked at reflected what we had been told.

During our inspection we observed for the majority of the time there were three members of care staff including one senior carer, to care for 24 people. This did not include the manager for the home. The ancillary staff on duty the day we visited was one domestic, one cook and one kitchen domestic. The rotas we looked at showed that the home employed a maintenance person who worked two days a week. The manager said that they currently had vacancies and were actively recruiting. The manager also told us that the deputy manager had left the home in November 2013 and their post had not been filled. The home currently had vacancies for a thirty six hours care assistant, a twenty two and a half hour cooks post and a twenty four hour night care assistant post.

Through our observations and discussions with relatives, staff members and other visitors, we found there were not always enough staff to meet the needs of the people living in the home. We also saw that staff did not have time to engage with people. We found that there were long periods of time when people were sitting in communal areas with no staff being present. We did not see care staff coming into the lounges to check if people required anything or to check that everyone was well. All three members of staff were busy assisting people with their care in their bedrooms. We spoke with two members of staff later in the day one said, "We could do with some more staff at certain times of the day." Another member of staff told us "It is generally ok although sometimes we could do with extra staff." Staff we spoke with confirmed that staffing levels remained the same at weekends.

We spoke with the manager regarding the staffing levels and they agreed that more staff were needed. This is a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to maintain appropriate staffing levels.

We looked at the recruitment records of three care staff including one newly appointed care assistant. We found robust recruitment and selection procedures were in place and the manager told us appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers and a

Requires Improvement

Is the service safe?

Disclosure and Barring Service (DBS) check had been completed before they started work in the home to show staff employed were suitable to work with vulnerable people. The records we looked at confirmed this. The manager told us no members of staff were subject to disciplinary action.

We looked at four care plans and saw risk assessments had been carried out to cover activities and health and safety issues. The risk assessments we saw included mobility and nutrition. The risk assessments identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum of restrictions.

During our visit we spoke with two members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, and could identify types of abuse and knew what to do if they witnessed any incidents. All the staff we spoke with told us they had received safeguarding training during 2013 or 2014. The three staff training records we saw and the overall training record for all the staff, confirmed that all staff at the home had received safeguarding training.

The home had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. Staff we spoke with confirmed they knew how to access them.

We saw written evidence that the manager had notified the local authority and CQC (Care Quality Commission) of safeguarding incidents. The records demonstrated that the manager had taken immediate action when incidents occurred in order to protect people and minimise the risk of further incidents.

Medicines were kept safely. The arrangements in place for the storage of medicines were satisfactory. We saw that people had a photograph attached to their medicine record. We looked at the medication for four people, including one person who was receiving a controlled drug. We saw controlled drugs were stored in an approved wall mounted, metal cupboard and a controlled drugs register was in place. We completed a random check of the controlled drugs stock, against the register for one person and found the record to be accurate. We also randomly checked four people's medication from the monitored dosage system (MDS). These were found to be accurately maintained as prescribed by the person's doctor and staff had recorded administration correctly leaving a clear audit trail. We saw that staff responsible for administering medication had received training in how to do this safely. This meant that people could be confident that medicines were administered by staff who were properly trained.

We observed the medication round at lunch time and found the member of staff was patient and gentle in manner whilst supporting people taking their medication. We saw people being asked if they required painkillers or not. We observed the member of staff explaining what medication was being given. We saw people were given a drink with their tablets and one person encouraged to drink when taking their medication.

We toured the premises during this visit and we found that while some areas of the home were clean and were satisfactorily maintained other areas were not. Both lounges we saw were clean and had no odours, although some of the furniture in the small lounge although dated was not damaged. Other areas were poorly maintained and were in need of a refurbishment. For example paintwork in the communal areas needed attention and some areas were poorly lit, for example the small dining area and the lounge, increasing the risks of falls. There was a lot of old furniture which was cluttering all of the communal areas. For example there were several small occasional tables in the sun lounge, some of which were either badly stained or damaged and were not fit for purpose These also could constitute a trip hazard to people as they moved around. We also saw that the net curtains in this room were badly discoloured.

There was an unpleasant odour in some of the corridors and bedrooms and we did not notice or smell any air freshening devices. We toured the environment and six out of the seventeen bedrooms we looked at had unpleasant odours. We saw in one person's bedroom the carpet was stained and the room smelt unpleasant. We saw that in some communal areas such as corridors on the first floor were not clean. Also on the first floor near the fire door, leading to a corridor, the carpet had been damaged and had been taped together posing a trip hazard. In one bedroom the carpet had been damaged in the entrance and this had also been taped together. This meant that people could be put at risk from falls. We were informed by the manager that this had been caused by the door guard

Requires Improvement

Is the service safe?

(which allows the door to be held in place by safe means but closes when the fire alarms are activated) had been fitted. The provider had failed to protect people against risks associated with the adequate maintenance of the environment. This is a breach of Regulation 15 (Safety and suitability of premises), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked for copies of cleaning schedules for the home. None were available at the time of our inspection. However a copy of a new cleaning schedule was sent to the Care Quality Commission following our inspection. The manager informed us that she intended to introduce this. We spoke with staff about keeping the home clean and well maintained. One staff member told us, "We are always kept busy. We have asked for more staff. Most days we are under pressure. The environment and furniture has become shabby, including people's bedrooms." The provider had failed to protect people against risk associated with not maintaining effective systems to the maintenance of appropriate standards of cleanliness within the home. This is a breach of Regulation 12 (Cleanliness and Infection Control), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our observations we saw that in one of the dining areas, which had the only access into the sun lounge, we saw people who lived at the home struggling to walk through to and from this area, as the area between the two rooms became overcrowded with people. This seems to be especially during the times when meals were being served or if tables were being cleared away. Also when there were several people, all moving at the same time, because people were either in wheelchairs or had walking frames and this area became congested. The provider should consider how they could best make this area safer during busier periods of the day, such as at mealtimes.

We saw that accidents and incidents had been recorded and appropriately reported, which included actions that had been taken by the home. We observed throughout our visit that call bells were being answered and responded to in good time by the care staff, although staff appeared to be constantly busy and rushing around.

We saw health and safety records which showed that most maintenance checks had been carried out regularly by the maintenance person. Safety checks for fire safety equipment, lifting equipment and water temperatures had been completed and most records were up to date, which meant that people could be confident that the equipment they were using was safe and fit for purpose. However we found the fire records were not up to date especially the fire alarm tests. We found records showed that there were gaps in the weekly tests. In May and June 2014 records showed that the fire alarms were tested monthly. Whilst in July, August and September 2014 fire alarms were tested twice in those months. This is not in line with the guidance from the Local Fire Authority and requires attention from the provider.

Requires Improvement

Is the service effective?

Our findings

During our inspection we spoke with two members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We also spoke with three members of staff following the inspection by telephone.

Staff we spoke with said they had received training that had helped them to understand their role and responsibilities. One new member of staff told us, "I have just completed my safeguarding and risk assessment training." Another member of staff said, "I have done training in moving and handling, safeguarding, fire and I have completed my NVQ (National Vocational Qualification) level 2. I have done all the mandatory training we need to do."

We looked at the training records for two members of staff, which showed they had completed a range of training sessions. This included safe handling of medicines, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There was evidence from the records of on going training and they showed which staff had attended training recently or had refresher training. This meant that the manager could be sure staff were fully trained to appropriately support people living in the home.

All of the staff we spoke with told us they had received supervision every three months. One said, "I have supervision every three to four months." Staff confirmed that an appraisal was conducted. Staff told us they had opportunities to talk to the manager if they wanted to discuss anything but this was usually on an informal basis. We saw from the three members of staff files we looked at that staff had received an appraisal during 2014 and supervision meetings had taken place in April, June and September 2014. This meant staff were given the opportunity to discuss their development and training requirements. The staff we spoke with told us they felt that they received good support from the manager. One said, "I am supported well by the manager. We make suggestions and we are listened to." Another said, "We receive supervision every six to eight weeks. The manager is very approachable."

We looked at four care plans. The care plans we looked at showed the manager had assessed people in relation to their mental capacity, to determine if people were able to make their own choices and decisions about their care.

Deprivation of Liberty Safeguards (DoLS) had been taken account of where appropriate for those people whose care files we saw. In one person's care plan under the heading 'my mental wellbeing' was recorded 'I am able to make my own choices.' In others we saw that it was clearly documented that people had the capacity in making their own decisions. Whilst in another care plan we saw where a best interests meeting had been held with the appropriate people involved. Best interest decisions are a collective decision about a specific aspect of a person's care and support made on behalf of the person following consultation with professionals, relatives and if appropriate independent advocates.

During our inspection we sat in both dining rooms and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We saw people being assisted to the dining room. However, there was little interaction between staff and people living at the home in one dining area. People were not given a choice of where to sit and when people required assistance with their meal the practice used by staff was poor. For example, we saw a member of staff standing to the side of a person's chair and bending over them to assist them to eat. We saw a second member of staff kneeling on the floor beside the person they were assisting to help eat their lunch. However we observed in the second dining room people being taken to a table and helped into a dining chair or adjusted in their wheelchairs in a safe and caring way.

We did not see a menu for the day displayed anywhere in the home which informed people about what choices they had about their meals. This meant that people were not kept informed or had any information that reminded them about what choices were available to them at each mealtime.

We spoke with people at the home about food provision. People we spoke with were happy with the food provided. One person told us, "The meals are brilliant I get loads to eat and it's all tasty." Another person said, "We have got a good cook, she makes lovely puddings and my egg sandwiches in a morning. They (staff) will bring my breakfast up here to my room I preferred that, then there is no rush." One person told us, "Someone (staff) comes round each day to ask you what you want next day. Like

Is the service effective?

today it's cottage pie but if I didn't want it they would offer me an alternative. The food is well presented and there's plenty of it. At tea time we get things like beans, egg or cheese on toast, sandwiches that sort of thing. We also get home made cake in the afternoon." The cook said, "If anyone doesn't want something I will always do something different for them."

One relative told us, "The home are very generous the cook asks me most days if I want to stay for lunch that's as much for (relative) as for me." At this point the cook did come and ask the relative if he wanted to stay for lunch and told them the menu choices. They went on to explain, "They ask the previous day what people want. I think it's to give them an idea as most people have forgotten by today." We noted a jug on the windowsill in the sunroom with light coloured liquid in it. A relative explained it was juice for the residents. They said, "That's what they call juice. It is not nice, when it's gone it's gone. They (staff) don't ask them (residents) if they want it, they have to help themselves. Most can't of course."

We observed the meals were plated up by the cook after staff had checked what people would like to eat. The food appeared well presented and smelt appetising. However not everyone was asked if they would like assistance and we observed some people had difficulty getting the food to their mouths. For example one person kept dropping the food from the fork into their lap. This person did not manage to eat much of their meal. Although we saw staff asking them if they had had sufficient no action was taken to assist them in eating a sufficient quantity of food.

We observed two people being helped to cut their food up. However, only one member of staff did this using the knife and fork in an appropriate way and level to the resident. Although we saw the other staff member simply pressed a knife into the food a couple of times leaving still large pieces of food for the person to cope with.

People did not appear to be rushed to eat their meal however, the lunch time meal experience was not pleasant for some people living in the home due to poor practices used by staff at the home when assisting people with their meals.

We recommend that the provider looks at how the dining experience could be improved to ensure people are not put at risk.

We were told by relatives that they were encouraged to stay with people as long as they liked. One relative told us, "I usually stay about 5 hours."

We spoke to people about if they felt they were supported with healthcare professionals such as doctors and nurses. One person said, "I have had to have the doctor because of my cough. There is no problem the staff call him." Another person said they had been visited by the doctor saying "They (staff) are quick to get the doctor in if you need them." We observed a staff handover during the day and over-heard staff contacting the district nurse to report a person who required their dressing to be changed.

We were told that the district nurse visited the home regularly to carry out health checks or to support people with their medical conditions. We had the opportunity to speak briefly with two visiting nurses. One said, "We normally visit once a week. Staff listen to advice we give regarding people's healthcare and carryout any requests we have made immediately or soon after. We have no concerns about people's health here."

Requires Improvement

Is the service caring?

Our findings

People we spoke with who used the service told us the staff were caring and always treated them with respect. One said, "The staff treat me with dignity and respect. They help me to help myself but I can be a bit lazy at times and if they ask me if they can help, I will let them." Another person said, "On the whole I am happy with the care I get here." One person told us, "I was living alone and my relative brought me here, they showed us round and I came for a two week stay. I liked it so decided to come back."

Another person living at the home said, "On the whole they (staff) are pretty good. I am in my room now (2.30pm) so I won't see anyone until tea time unless I buzz for them." They went on to say that they had to wait for long period of time at night for staff to come to see to them, but this did not happen during the day. The relative of one person we spoke with told us, "It's all very caring and calm, my relative is 91 and they would object if they weren't happy."

During the visit we observed staff spoke respectfully to people and would make sure they made eye contact with them. The nurse call system in the home seemed to be answered promptly but staff did not always have time to engage with people on an informal level. For instance we did not see anyone sit and talk to people in any of the communal areas as the staff were busy all the time helping people with their physical needs. We did not see staff knock before entering people's rooms. In fact as we were speaking to one person a member of staff walked in to pick up the person's care plan without knocking.

We spoke with two members of staff during the day. Both staff were able to demonstrate their understanding about obtaining people's consent . Staff were able to describe how they supported people to remain independent and have choices and control over their lives and how they respected people's privacy whilst supporting them with their care. However, when we spoke with people living at the home if any improvements could be made at the home and what they would like them to be. One person said "Most staff knock on your door although there is one staff on night duty who just barges in. It can be a problem because they wake me up." This meant that people were not always treated with respect by all staff at the home.

Two people confirmed that they had been involved in developing and reviewing their care plan. One person we spoke with said, "I have a care plan, I think I did sign it. One of the staff came and sat down with me and we went through it." The relative we spoke with told us, "They went through everything when (relative) first came. We had to change doctor and I know it was all done properly."

One member of staff we spoke with told us, "I like working at Carleton Court it is like a big family." Another said, "It is a nice little home. The staff are nice, warm and friendly." Another staff told us, "The care is good and overall it is nice place to work."

We reviewed the care plans of four people living in the home. People's care plans contained several sections which covered for example, an initial assessment, life history, medical history, including body maps, risk of pressure sores, mobility and dexterity and diet and weight. Care plans we saw contained information on the person's likes or dislikes.

However, in all of the four care plans we looked at the section with regard to people's end of life care were blank and had not been completed. This meant that staff were not clear as to how people wanted their care needs met when they were at the end of their life and this area needs to be addressed by the provider.

Requires Improvement

Is the service responsive?

Our findings

We looked at four people's care records which showed that every area of identified risk also had an accompanying detailed care plan, which incorporated people's choices and preferences as well as their identified needs. This meant that co-ordinated assessments and care planning was in place to ensure effective, safe, appropriate and personalised care. Two of the four care plans we looked at had been signed by the person where possible or by their representative. Two care plans we saw had not been signed. We saw where there were concerns about either people's weight or diets they had been referred to a dietician. We saw in the care plans we looked at an action plan in place for people who were diabetic and these were detailed for staff which also described signs and symptoms. Whilst in another person's care plan we saw that they had been referred to a speech and language therapist. We saw care plans were regularly reviewed to ensure people's changing needs were identified and met. . Where accidents or incidents had occurred we found detailed recordings in each person's care plan of the incident and the action the home had taken to address this. There were separate areas within the care plan, which showed specialists had been consulted over people's care and welfare. These included health professionals such as the doctor and District Nurses.

During our visit to the home we observed that there did not appear to be a lot of activities to keep people occupied nor did the staff have the time to just sit and talk to people. We asked people about how they spent their days. People we spoke with including a relative told us that there were not any activities available to stimulate them. One person we spoke with said, "I don't do anything very practical they are lacking in things to do, putting our intellect to use. Organisation is lacking for instance why aren't we sat talking. I know we aren't mobile but they could do things that make us think, use our memories, get us discussing things. They could bring people in to tell us about their jobs, that sort of thing."

One relative told us, "There's not a lot of occupational therapy or that sort of thing. People just sit eyes closed and wait for dinner. The days are punctuated by mealtimes. Some people have quite severe problems; I never see staff taking them out or anything. Not even into the garden."

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

When we spoke with people living at the home about if any improvements that could be made at the home to make things better and what they would like them to be. One person said, "There are setbacks sometimes. I really don't like going to bed at 6.30pm. I think they like to get most of us done early so they can get off." Another person said, "You can't always get up when you want. You have to wait until there is a carer that is free though. Going to bed isn't a problem." This meant that people did not always have choices about their daily routines. Although one person went on to tell us "I get up early, about 5am, that's my choice though."

People told us about how the management of the home responded to feedback or to any complaints. People we spoke with told us they would speak to the manger if they had any issues or concerns. One person said, "If I had a problem I would go to the manager. I have had little concerns I have spoken to her and she has dealt with them." Another person said, "On the whole they are pretty good. I would speak to (the manager) if I was worried. I don't have many complaints except I don't like this miserable light and sometimes the laundry is a problem, sometimes I get other peoples clothes and mine go missing. They usually sort it out though."

One relative said "I would speak to the manager if I had any problems." We saw that the home had received no complaints since they were last inspected.

Requires Improvement

Is the service well-led?

Our findings

While people living at the home were aware of the manager's name and role they were not particularly visible or available to speak with people living at the home or staff. During our visit, the manager remained in the office and was only briefly and occasionally present in other parts of the home throughout the day.

We looked at the minutes from the last staff meetings. The last one which was held in June 2014. The previous meeting had been held in February 2014. This meant that staff meetings were not always held regularly to ensure staff had the opportunity to discuss current good practice and any issues that they may have identified whilst working at the home.

The manager told us that they carried out quality audits regularly. We looked at the audits carried out by the manager. These showed that most audits had last been carried out in June 2014. These audits covered areas such as medication and care plans. We saw that the last audit for the kitchen had taken place in August 2014. We saw that audits regarding the environment and infection control had last been carried out in April 2014. There were no action plans drawn up identifying the issues we had raised. This meant that audits were not up to date, and were not being completed in a timely way to ensure that any work that was required was identified and action plans were put in place to ensure the home was safe, clean and well maintained for people living there.

No one who lived at the home that we spoke to were able to tell us if there had been a residents meeting or if surveys were undertaken. However we saw surveys where people were asked about their views and a survey questionnaire was last completed by them in April and May 2014. We saw from the surveys we looked at people were positive about the home. People had made positive comments such as, "We are very pleased with the overall care at the service" and "The best care and love available at all times – thank you."

We were informed that staff handover was three times daily. We observed the afternoon handover at 2pm Handover was late starting as the afternoon staff took over caring duties from those going off. When it did commence the information given to staff by the senior carer was good and concise. However people were not called by name only by room number. The manager was present during handover but gave little input. When we discussed this later with the manager they told us that people's names were usually used rather than room numbers and it could have been that staff felt they needed to protect people's identity during our observation. This was not made clear during the handover that we observed.

We spoke with staff during our visit we also telephoned three members of staff following the visit. All of the staff we spoke with told us that they were supported well by the manager.

We saw that notifications had been reported to the Care Quality Commission as required.

During the course of the visit it was clear that there was a lack of manager presence. We did not see the manager making themselves available to people throughout the day.

We looked at a range of documentation to find evidence of auditing and quality assurance.

There was none or little evidence to assure us that Carleton Court was being well led or well managed. For example, we saw that following audits which had been carried out in June 2014 no action had been taken to making improvements to the environment of the home.

We found that there was a breach of Regulation 22(Staffing) this was because there were not always sufficient staff to meet people's care needs. We looked at the staff rota and found that the home was reliant on the use of agency staff to cover the rota, due to the number of care staff vacancies and short falls in the hours' permanent staff were able to work. We saw there were times when there were no care staff available to people to ensure their care needs were being met and their safety was being maintained at all times.

We recommend that the provider looks at the monitoring systems at the home and how they could be improved, to ensure people benefit from good, effective and safe care.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had failed to protect people against risk associated with not maintaining appropriate staffing levels.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had failed to protect people against risk associated with not maintaining effective systems to the maintenance of appropriate standards of cleanliness within the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had failed to protect people against risks associated with the adequate maintenance of the environment.**