Carleton Court Care Limited

# Carleton Court Care Home

## Inspection report

108 Carleton Road
Pontefract
West Yorkshire
WF8 3NQ

Tel: 01977702635
Website: www.carletoncourt.co.uk

Date of inspection visit:
28 February 2017
02 March 2017

Date of publication:
21 April 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection of Carleton Court Care Home took place on 28 February and 2 March 2017 and was unannounced. The home was last inspected during June 2015 and there were no breaches of regulations at the last inspection.

Carleton Court Care home is registered to provide personal care and accommodation for up to 32 older people; some of whom are living with dementia. The home is a converted property providing a number of communal areas on the ground floor, with bedrooms situated on the ground, first and second floors.

One of the directors of the registered provider is also the registered manager of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Carleton Court Care Home. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Risks to people had been assessed and measures put into place to reduce risk. The building was well maintained and regular safety checks took place.

Medicines were managed, stored and administered safely and appropriately, by staff who had been trained to do so.

Appropriate safe recruitment procedures were followed. Staff told us they felt supported and we saw evidence staff had received appropriate induction, training and ongoing support and supervision.

We observed staff obtained verbal consent from people prior to providing care and support. People's mental capacity was assessed and we saw decisions were made in some people's best interests. However, some mental capacity assessments were not decision specific, in accordance with the Mental Capacity Act 2005. Appropriate Deprivation of Liberty Safeguards authorisations had been sought where people were lacking capacity and were being deprived of their liberty in order to receive care and treatment.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received appropriate support in order to have their nutritional and hydration needs met. A variety of drinks and snacks were offered to people throughout the day.

We observed staff to be kind and supportive and people told us staff were caring. We observed people's privacy and dignity was respected. There was a pleasant, relaxed atmosphere in the home.

Care and support was provided in a person centred manner. Care needs were regularly reviewed and people were involved in their care planning. People told us they could make their own choices in relation to their daily lives. Appropriate information was shared between staff to enable continuity of care.

The directors and the registered manager were visible throughout the service during our inspection and they knew people's needs well. Regular staff meetings and resident meetings were held and the registered manager sought feedback from people.

Regular quality assurance audits were undertaken and the registered manager ensured that, where actions were identified, these were recorded and monitored.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service was safe.

People told us they felt safe.

Medication was managed well and was administered in a safe way by staff that had been trained to do so.

Risks to people were assessed and measures were in place to reduce risks.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had received appropriate induction, training, support and supervision to enable them to provide effective care and support to people.

Assessments of people's mental capacity were not always decision specific, in accordance with the principles of the Mental Capacity Act 2005.

People received support to access health care services and to meet their nutrition and hydration needs.

### Is the service caring?

**Good**

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

### Is the service responsive?

**Good**

The service was responsive.

Care plans reflected people's needs, preferences, choices and personal histories.

We observed people making their own choices relating to how they wanted their care to be provided.

Complaints were well managed.

## Is the service well-led?

Good

The service was well led.

Staff told us they were supported by the registered manager and they felt the service was well led.

The registered manager held regular meetings with staff and people who lived at the home.

Regular audits and quality checks took place and these resulted in continued improvements to service provision.

# Carleton Court Care Home

**Detailed findings**

## Background to this inspection

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

The inspection took place on 28 February and 2 March 2017 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and we gathered information from the local authority, including the commissioning and safeguarding teams. The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with five people who lived at the home and four relatives, the registered manager and directors of the organisation,  an assistant care manager, the activities coordinator, a senior carer, three care staff, the cook, kitchen assistant and laundry assistant as well as a visiting healthcare professional.

We looked at six people's care records, three staff recruitment files and training data for all staff, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Good

# Is the service safe?

## Our findings

All the people we asked told us they felt safe living at Carleton Court Care Home. One person told us they felt safe because, "All the people here make me feel safe." Another person told us, "It's quite calm, there is no rushing about, there are not a lot of strangers about the place, they are all people you have seen before, I can't find anything wrong with it."

The relatives we spoke with told us they felt their family members were safe. One relative told us, "There is a good staff to resident ratio and I don't ever worry at night about my relative. We visited nine homes before coming here and I wouldn't ask [Name] to go anywhere I wouldn't go myself." A further relative said, "[Name] hardly ate or drank at home but that is all sorted out now. The staff here are very patient with [Name] and the balance between risk and respecting independence is managed well."

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. We saw the safeguarding policy and whistleblowing policy were on display and included details of who to contact if staff or anyone had any concerns. A member of staff told us they would report any suspected abuse to the registered manager and told us they would whistle blow to the Care Quality Commission if they felt concerns were not acted upon. This helped to ensure people were protected from abuse because the registered provider had policies in place and staff knew what actions to take to protect people.

In all of the care records we inspected we saw risks associated with different areas of care such as such as physical health, mental health, communication, mobility, nutrition, continence and social care were considered and reviewed monthly. Care and support was planned and delivered in a way that reduced risks to people's safety and welfare. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

We observed examples of safe care and treatment being provided, in line with people's care plans. For example, people who were identified as being at risk of pressures sores were sat on pressure relieving cushions, as outlined in their care plan. We checked records and saw people had been assisted to change position when required to reduce the risk of pressure sores developing. These records included what position the person sat in, so staff could effectively ensure appropriate pressure relief.

Moving and handling plans contained information specific to the person's needs. For example, one plan we sampled stated, 'Two staff to hoist from bed to chair. Hoist use upper sling - place the second loop on the facing hook. Lower sling place the first loop on opposite hooks. Make sure straps go under both legs, not between legs, as this is more comfortable for [name].' Containing this level of detail helped to ensure staff followed safe moving and handling procedures. A staff member told us, "I've been in the sling as part of my training. We make sure we talk to people and try to put them at ease." We observed staff assisting a person to move with the use of a hoist and staff appeared confident and spoke with the person throughout the manoeuvre, which helped to put the person at ease.

We saw people used equipment, such as walking frames for example, which were labelled for the person. This meant people were using equipment that was specifically for them to use. This helped to keep people safe by ensuring they were using appropriate equipment and also helped to reduce the risk of the spread of infection.

We saw evidence regular checks of safety features such as nurse call bells, electrical sockets, fire detection systems and water temperatures and equipment such as wheelchairs and portable fire extinguishers were regularly checked and serviced. Portable appliance testing had taken place and lifting equipment had been regularly serviced and tested. This showed actions were taken to help ensure the premises and equipment were safe.

Personal emergency evacuation plans had been devised for people living at Carleton Court and these were regularly updated. These outlined the details of the individual's room, location, level of risk and equipment that would be required to assist the person in an emergency. We highlighted to the registered manager we felt these would benefit from containing further information such as exactly what assistance would be required, taking into account the person's level of understanding and the registered manager was responsive to this suggestion.

We looked at how accidents and incidents were recorded. We saw they were recorded appropriately and evidence could be seen of subsequent observations and actions taking place. Furthermore, accidents and incidents were analysed regularly and this enabled the registered manager to identify potential trends. Factors such as location, time and type of incident and actions taken were considered. As a result, a member of day staff began their shift an hour earlier because the analysis had identified a particular time of day where more staff would reduce the risk in accidents. This showed the registered manager had taken action to reduce risk, following appropriate analysis.

Throughout our inspection, we observed people's needs were met in a timely manner by staff. All of the people we spoke with told us they felt there were enough staff to meet their needs, although one person told us they felt more staff were required at night. All the people we spoke with told us they did not feel they had to wait for care and one relative told us their family member received, "Prompt attention." All the staff we asked told us they felt there were enough staff in order to provide safe care and treatment to people, although one staff member told us they felt it would be useful to have more staff during busy periods. We observed, although staff were very busy, they took time to talk to people. Staff were able to give people the time they needed to make choices and we observed staff were proactive in identifying people's needs.

We discussed dependency tools and models for determining staffing numbers with one of the directors, who explained they had been considering different models but had not yet implemented a dependency tool for Carleton Court. A dependency tool is a system which helps to calculate the number of staff required, depending on people's dependency levels. This was ongoing and we saw evidence of this. One of the directors was a registered nurse and they were able to draw on their own experiences to help determine staffing levels. It had been identified an additional member of staff was required over the tea time period, so one member of staff now worked until 5pm on the day shift, as opposed to 4pm. This offered extra support around the busy period of tea time and showed the registered provider had been responsive in providing safe staffing levels.

We inspected three staff recruitment files. We found safe recruitment practices had been followed. In two of the files we inspected we found the registered manager had further explored gaps in potential candidates' employment history. The registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps

employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were administered and managed safely. Medicines were administered in a calm, patient and kindly manner by a staff member who was wearing a tabard to indicate they should not be disturbed. This reduced the risk of errors being made. The member of staff used an effective recording system which showed whether the person had taken their medicine or whether the medicine had been declined.

Medicines were stored appropriately and were locked away securely. The medication administration records (MAR)s included a photograph of the person, which reduced the risk of medicines being given to the wrong person. Records were clear and easy to understand. We counted random samples of medicines and the balance remaining reconciled with the records.

Some medicines, such as paracetamol for example, were administered on a PRN (as and when required) basis. We found PRN protocols were in place and these included information such as frequency, dose, signs which indicate the medicine would be required and the effects of the medicine. This helped to ensure these medicines were administered appropriately and at safe intervals.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely, as required, and the drugs that were required to be logged in the register were recorded as such. This showed controlled drugs were managed appropriately. We checked a random sample and found the amount of medicine remaining was correct, according to the register.

Some people were prescribed topical creams. These were appropriately stored and staff signed to indicate they had applied creams, at the time it was applied, ensuring accurate records were kept.

Regular audits took place to determine whether medicines were being managed safely and effectively. We saw, where any concerns had been identified as a result of the audit, action had been taken to address the concerns. A 'medication improvement book' was in use which was completed by the assistant care managers and this book identified any staff learning which was then cascaded to staff.

People and relatives told us staff wore personal protective equipment (PPE) when providing personal care and all of the staff we asked told us they had access to adequate supplies. A member of staff told us, "I always wear PPE. The cleaners ensure we have a supply in stock." We saw soap and paper towels were available in bathrooms. This helped to prevent and control the risk of the spread of infection.

Requires Improvement

# Is the service effective?

## Our findings

We asked people whether staff were effective. All the people and relatives we spoke with told us they felt staff knew how to do their jobs well. One person told us, "They are well trained, I can tell by their attitude." Another person told us, "Staff know their job, there are never any faults, everything gets done properly."

We were provided with a training matrix which provided an overall view of staff training. This was well organised and showed staff had received training in areas such as safeguarding, moving and handling, medication, food hygiene, infection prevention and control, health and safety and first aid. Staff told us they felt they received adequate training for their roles. One staff member told us, "We sometimes go on the same course, to re-cap."

Records showed staff had completed an induction prior to commencing their roles and this included shadowing more experienced members of staff. Various aspects of induction were signed off by the staff member and their mentor such as residents' hygiene, continence care, cleanliness, nail care, skin care, moving and handling, assisting people with eating and drinking and the importance of documentation and records, as well as important aspects of health and safety. This showed staff received appropriate information prior to commencing their roles.

A staff member told us, "We have supervision quite often." This member of staff confirmed formal supervision was useful. Another staff member told us, "You can talk about any personal issues or if you're having problems with any particular resident." We looked at records of supervision and saw items such as moving and handling, professionalism and culture, promoting choice and effective infection control were discussed. In the most recent staff supervisions, we saw the manager had explored staffs' knowledge of the Mental Capacity Act and, if staff were lacking in their knowledge, they were signposted to a source of information to refresh their knowledge.

As well as regular supervision staff received annual appraisals. These considered staff members' achievements, learning, challenges faced, difficult aspects of their role, targets for the next year and a development plan to help staff achieve their targets. This showed staff received regular appraisal of their work and support in order to help ensure they performed their roles effectively.

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 so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Mental capacity assessments had been completed and, where

people lacked capacity and were being deprived of their liberty to receive care and treatment, appropriate DoLS authorisations had been sought and granted.

The staff we spoke with were clear of the principles of the MCA and demonstrated they were aware of the importance of assuming people had capacity to make their own decisions. Records showed a person was given medicines in a covert manner, that is, without their knowledge. We saw evidence the person's mental capacity had been assessed in relation to making this decision and the person was lacking capacity. Therefore a decision had been made in the person's best interests, in consultation with the person's family, other healthcare professionals and GP. This demonstrated the registered provider was acting in accordance with the MCA and the National Institute for Health and Care Excellence (NICE) guidelines.

We saw some mental capacity assessments that were generic, that is, not decision specific. One person shared a room and, whilst there was evidence the person lacked capacity in other areas of their care, there was no evidence to indicate whether the person's capacity to make this specific decision had been explored or whether the decision to share a room had been made in their best interests. We highlighted this to the directors who agreed to address this.

Throughout our inspection we saw staff asked people for consent, prior to providing care and support. People were involved in their care and on an occasion when we saw a person declined support and did not give consent, staff accepted this. We saw some consent forms had been signed, for example consenting to photographs. However, these had not always been signed by a person with appropriate authority to do so. We highlighted this to the directors, who agreed to address this.

People living at the home told us they were happy with the food and all the people we asked told us there was choice. One person told us, "The food is very good. I love my food." A relative told us, "The food is good. There is a good choice and variation and plenty of it." The cook was knowledgeable about people's dietary needs. Specific produce was bought for people with certain dietary requirements, such as diabetic marmalade and jam for example.

We overheard staff making comments such as, "Do you want me to help you cut it up?" and, "Would you like a bit of gravy on that?" and "Tell me when to stop," and, "Do you want some more?" We saw and heard, when staff were taking away cups and plates, people were asked whether they had finished or whether they wanted more. When one person had not drunk their drink, a member of staff recognised this and asked the person if they wanted a fresh drink pouring. The staff member brought the person another drink and then prompted the person to drink it. This showed people received appropriate support to meet their nutritional and hydration needs.

Appropriate equipment was used to assist people with their meals. For example, we saw plate guards in use where appropriate, which help prevent food being spilled from plates. This helped to ensure people could remain as independent as possible when eating their meals and maintained their dignity.

The atmosphere at meal times was relaxed and appeared to be a social occasion. People were chatting and staff were assisting people where necessary. People were asked for their preferences, including portion sizes. We observed people were given alternatives if they changed their mind about what they wanted to eat or if they did not like an aspect of their meal. People were offered cold drinks, beer, sherry or wine and, although staff were aware of personal preferences, people were given choices. We saw fluids, fruit and snacks being offered to people throughout the day.

We spoke with a visiting health professional who told us they had no concerns regarding people's diet and

nutrition. They told us staff were knowledgeable about people's dietary needs and appropriate plans were put into place and acted upon in terms of people's nutrition.

We looked at the layout and design of the building. There were a number of communal areas on the ground floor which offered people choice about where they wanted to sit and what activities they wanted to join in. There were smaller areas, where people could sit quietly and chat. We saw there were some pictures and prompts which would help people to reminisce. Although toilets were signposted and names were indicated on bedroom doors, there was limited signage on the first floor, where most bedrooms were situated, to assist people to navigate. Following the inspection the registered provider advised they had increased the size of toilet direction signs and sought guidance from a dementia specialist.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety and we saw there were some orientation boards on display with the correct information displayed.

We saw evidence staff had called the NHS non-emergency number in order to obtain medical advice when this was necessary. Referrals had been made to other healthcare professionals when appropriate and we saw requests for medication reviews when necessary. This showed people living at the home received additional support when required to meet their care and treatment needs. People and all the relatives we asked told us people received prompt medical support if and when they required this. One person told us, "There are plenty of doctors." A relative told us, "They are very hot on healthcare professionals. They persevered with my relative to get appropriate incontinence help and it is all sorted now."

Good

# Is the service caring?

## Our findings

The overwhelming majority of people told us staff were caring. One person told us, "Staff know who is who and who are friends. A friend of mine was ill so they took me to her bedroom to visit her." Another person told us, "Staff are very good, they come when you want something, they come even before you want them so you don't get into difficulty. They are about all the time, so I don't think, 'I wonder where the staff are.'" A further person told us, "A couple of staff are not as patient as they should be considering my limitations."

All of the relatives we spoke with told us they thought staff were caring. One told us, "Staff are great – wouldn't have [Name] here if they weren't." Another relative told us, "Staff are naturally caring and treat my relative with dignity and respect. The manager saw quite quickly that [Name] does not like to be rushed and has worked hard to help staff get to know them personally. Top marks for that."

A member of staff we spoke with told us they liked working at the home and providing support to people. They told us, "I'd have left if I didn't like it."

Throughout our inspection we heard staff treat people with dignity and respect. Consent was sought from people before staff intervened. We heard staff say phrases such as, "Can I take your apron off [Name]?" and, "Can I wipe your mouth for you?"

It was evident care staff, managers and directors had positive relationships with people living at Carleton Court. We found members of staff, directors and the registered manager were knowledgeable about people's backgrounds and life histories. Throughout our inspection we heard many staff engage with people, talking about their families and their interests.

The people living at Carleton Court looked clean and smartly dressed. Gentlemen appeared cleanly shaven and we saw some ladies were wearing nail varnish. A hairdresser visited the home weekly. This helped to enhance people's dignity. When a person spilled a drink, this was wiped and cleared away immediately, with minimum fuss from staff. This further provided evidence people were treated with dignity.

We observed care staff, the registered manager and kitchen and catering staff speaking with people. Staff bent down to the person's level and spoke clearly, giving people time to think and answer. All the staff we observed appeared to be patient and listened to people's needs.

There were times when staff provided support to a person who was displaying repetitive behaviour and who required much reassurance from staff. We observed staff provided care and support in a friendly but professional manner and we did not see any staff showing signs of impatience. Staff were effective at recognising signs the person was becoming fretful and then appropriately distracting and guiding conversation so as to reduce the person's anxiety. Staff did this in a caring and reassuring manner.

We observed a member of staff assisting a person to eat their breakfast. The member of staff allowed the person to set the pace and took their time. They reminded the person what they had ordered and remained

focussed on the person, even though other activities and conversations were happening around them. The member of staff spoke gently to the person throughout their meal and provided assistance, whilst encouraging the person to be as independent as possible. For example, the staff member guided the person to their own cup and encouraged the person to place the cup to their mouth. This helped to ensure the person retained their independence where possible, whilst receiving the support they required.

We saw a member of staff say to a person, "Do you want me to clean your glasses? I wear glasses and I know what it's like when you can't see through them." The member of staff then assisted the person to remove their glasses and cleaned them.

People's needs were met in terms of their spiritual and religious needs. The registered manager and staff were aware of the importance of this. People's needs were considered at the care planning stage and staff were aware of what was important to people. Some people were assisted to places of worship such as a local church for example.

One person had been assessed as lacking capacity and were being deprived of their liberty, with appropriate authorisation. An independent mental capacity advocate (IMCA) had been appointed for this person. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live. This showed people could access independent advocacy support if they needed this.

A member of staff told us of ways in which they tried to ensure people's privacy and dignity was maintained such as by closing curtains or doors. One staff member said, "Some people have always been independent. How would I want to be treated? That's how I think of it." This staff member went on to tell us they would always use a towel to cover a person if they were assisting the person with personal care. We observed staff offering care and support to people in a discreet manner and whilst protecting people's privacy.

Good

# Is the service responsive?

## Our findings

We reviewed six people's care records. Information contained within care records included details regarding people's needs in relation to areas of care such as physical health, mental health, communication, mobility, nutrition, continence and social care. Care records contained a photograph of the person and appropriate details such as the individual's family history, interests and religious persuasion. This information is useful to enable staff to build positive relationships with people and for people to receive personalised care and support.

We saw detail such as, '[Name] likes a sherry on a night and likes cold milk.' Information relating to people's likes and dislikes were included in care records along with information regarding their cultural wishes. It was evident staff were knowledgeable about people's needs from the support they provided to people. For example, one person's care plan indicated, '[Name] likes to sit in pink lounge. Likes to be near TV with good view. Staff need to sit and have one to one with [Name]. Sit in front or side of [Name], making conversation.' We saw the person was sat in their preferred position and staff bent down, to the side of the person, providing one to one reassurance. This showed care was delivered in line with the person's care plan.

The information contained within care plans included each individual's needs and outlined how those needs were to be met, with support from staff. Associated risks were identified and minimised. Care plans were reviewed regularly and we saw letters had been sent to people living at the home, inviting them to contribute to the reviews of their care plans. We saw evidence people had been involved in reviews of their care. All the relatives we spoke with told us they were involved in compiling their family members' care plan and they felt fully informed and involved in their family members' care. This showed people's needs were reviewed regularly and people were involved in this process.

We noted one person's care plan indicated staff were to provide support for the person's continence needs. We felt the plan would benefit from further information regarding exactly how staff should assist the person. Another plan indicated staff should assist with meals and drinks but we felt the level of detail could be improved in order to provide sufficient information to guide staff as to exactly how to appropriately support the person. We highlighted this to the registered manager and a director, who were receptive to this and agreed to consider further detail.

Daily records of care and support were recorded by staff. These were detailed and showed people were supported according to their care plans. These records were locked in a room accessible only by staff. This meant information was secure and records were kept of the support provided.

The assistant care manager told us there was a formal handover between each shift and this took place in the treatment room. In addition to this, a communication book was used which contained pertinent information. This meant relevant information could be confidentially shared between staff to enable continuity of care to be provided.

The registered provider employed an activities coordinator, who had previously worked in the home in

another role for many years. A member of staff said, "It's much better now [Name] is here as activities coordinator." The activities coordinator knew people well and we observed many positive interactions. A recent addition to the activities programme was a knitting circle. The activities coordinator was encouraging people to continue with an activity which some people thought they could not do or to learn a new activity. This gave people a sense of achievement and people spoke with enthusiasm about the activities coordinator. We looked at the activities schedule and we saw activities were planned for each day, including individual and group activities such as yoga, crafts, reminiscence sessions, bingo and external entertainers.

Two people told us they attended a church coffee morning once a week and this was important to them. Another person attended a local community facility regularly to attend an arthritis event. A relative told us they thought their family member was getting bored but added that, now spring was here, their relative would spend time helping the gardener. Other people told us about chair exercises and other activities as well as entertainers that came into the home. We saw staff took time to engage with people and one person was enjoying completing jigsaws and other people were singing and dancing or making Easter cards.

A person told us a member of staff had attended an observatory with them, because they had a shared interest, and they were planning another trip. This person told us, "They take the trouble to do things like that."

We saw people were offered choices throughout the day, in relation to what they wanted to eat, or drink, what they wanted to do and where they wanted to sit. We saw, when one person could not decide what to drink, a member of staff helped them to decide by showing the person the choices and asking if they'd like to try different ones to determine which they would prefer. The person was given the time they needed to make their choice. Staff recognised the importance of people making their own choices, even though this meant staff were required to be patient and take time. A member of staff told us, "We can't presume. We always ask people's choices."

We looked in some people's bedrooms and found these to be personalised to the individual. We saw photographs and other sentimental items displayed. A relative told us a staff member had placed some posters on their family member's wall, which helped the person to reminisce. The family member told us they were impressed with this attention to detail.

The complaints policy was displayed in reception. People told us they could talk to staff or the registered manager if they had any complaints. We saw verbal concerns were recorded as well as any formal complaints. Appropriate actions had been taken and we saw areas for concern had been addressed. For example, concerns regarding laundry had resulted in improved systems and some money being reimbursed for lost items. Where an informal concern had been raised regarding a particular staff member, this was recorded and appropriate action was taken. This showed complaints and concerns were acted upon.

Good

# Is the service well-led?

## Our findings

The home had a registered manager in post, who was also a director of the organisation. There were three other directors; all of whom were involved in the day to day running of the home.

Improvements were evident since the previous inspection. The registered manager told us they were now more aware of potential risks. They told us, and we saw evidence, they were now placing a greater emphasis on being proactive and preventing risks, rather than being reactive. This showed the registered manager had acted on previous findings and had improved the safety and quality of care provided at the home.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities. The registered manager submitted statutory notifications to the Care Quality Commission in accordance with their duty.

One of the directors of the home had requested Carleton Court Care Home become part of a local Vanguard. The Vanguard initiative aims to move to a multi-disciplinary, proactive model of care and to deliver improvements and greater opportunities to education, training and workforce development within care homes, in order to see a positive impact on the quality and safety of care and increased staff retention.

The director told us, as a result of the Vanguard, they had accessed additional dementia care training and other areas of training such as pressure area care. The director explained being part of the Vanguard had opened up opportunities to meet with other home managers and health professionals in order to improve practice. Best practice had been explored such as the National Institute for Health and Care Excellence (NICE) guidelines for example, with particular reference to oral health and further training had been booked in this area as a result. The director told us they had developed a wider network and had been able to benefit from a range of services that had previously been difficult to access, such as bereavement counselling. The registered manager and other directors attended meetings with the local authority and clinical commissioning groups which enabled good practice to be shared. We were told by the registered manager, "I feel we've had a small part in the debate for care nationally through the Vanguard."

All the people we spoke with told us they felt the home was well led. One person told us it was well led because, "They know who everyone is, it surprises me how well they know who is who." Another person told us they thought the home was well led because, "The home is very clean and they are always cleaning." Another person told us, "Everyone is good, the food is nice, I like being here even though I did not want to come. They are there for you."

A relative told us they also felt the home was well led. We were told, "It's good. Homely in a traditional way and comfortable. People are looked after 24/7. I don't worry at night." Another relative told us, "The manager has a good ethos of caring for people and leads by example. It's well run. The manager does what he says he will do. There is a regular routine and continuity of staff. It doesn't feel like a home but, like home."

The staff we spoke with told us they felt supported and they felt the home was well led. A member of staff told us they felt there was an open culture at the home and they told us staff were able to be open about mistakes and learn from them. This staff member told us, "It's the best home I've been in." Another staff member said, "I feel it's well led, yes." We were told staff felt able to request further training if they felt their skills or knowledge was lacking in a particular area.

The registered manager and directors knew people well and were involved in the day to day running of the home. The registered manager used people's names and clearly knew about people's families and life histories. People were comfortable in the presence of the registered manager.

Following the previous inspection, the registered provider had received some advice from the local authority, specifically in relation to effective infection prevention and control. The advice had been followed and the registered provider's infection control policy had been updated. This further demonstrated the registered manager's commitment to improving the safety and quality of care at the home.

Staff meetings were held regularly. Records showed items such as the absence procedure, confidentiality, the importance of people staying hydrated and relevant procedures were discussed. The meetings were also used as an opportunity for the registered manager and directors to thank staff for their hard work. The most recent minutes showed six staff names were randomly selected and those staff received tickets to attend a local social event. Actions such as this can help staff to feel motivated and valued for their hard work. Regular directors' meetings were also held. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Regular residents' meetings were held and we saw records of these. Minutes from the meetings showed people were asked for their ideas, for example in relation to activities and entertainment and menu planning. The registered manager discussed whether it may be appropriate to remove a television from the conservatory, as it was hardly used, and replace this with an entertainment centre. People were asked to think about this and to let the registered manager know their thoughts. This showed people's views were actively sought.

Quality assurance questionnaires had been sent to different groups of people, in order to try and obtain their views. Of the questionnaires which were sent to health professionals, one comment included, 'Staff are always very polite, friendly and efficient on welcoming GPs. They are obviously caring with their residents.' Another questionnaire indicated a concern regarding, 'Appropriateness of requests for home visits.' The registered manager had ensured this concern was acted upon and responded by writing to all local GPs, outlining actions the registered manager intended to take and inviting further feedback from GPs. This showed the registered manager sought and acted upon feedback from relevant health professionals.

Visitors were also asked for their views and we saw the results of this on the notice board. This included information such as, 'What you told us,' and 'What we did.' This showed any areas for concern, such as laundry systems for example, had been addressed and this information was shared with people and their relatives.

We saw resident questionnaires were also completed. In October 2016, 33 resident questionnaires were returned, with all of those completed stating they, 'Feel happy,' living at Carleton Court Care Home. The results of the most recent survey were displayed on the noticeboard for people, visitors and staff to see. This further demonstrated the registered manager was seeking and acting on feedback from people who used the service.

Regular audits were undertaken to help ensure improvements were sustained and continued to develop. Regular medication audits took place which had helped to improve systems in relation to medicines management. Maintenance audits regularly took place and we saw, where areas for improvement were identified, these were actioned. There was a clear system in place for the regular auditing of care plans. An audit tool was used to assist the staff member responsible, and checks were undertaken such as whether entries were signed and dated, preferred names and religious and cultural details were included, relevant medical details were included, risks had been assessed and whether the information recorded provided adequate information for informed care planning.

Records showed regular discussions and observations of staff practice took place. Where any areas for improvement were identified, action was taken. For example, where a staff member had been observed not following the infection prevention and control procedure, this had been raised with the staff member and appropriate action was taken. By completing these observations and feeding back findings to staff, the directors showed they were continually improving the service and being proactive in developing the home and staff.