Somerset Care Limited

Carrington House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 January 2017 and was unannounced. The service was last inspected on the 2 October 2013. We found no concerns at the last inspection.

The service is registered to look after 44 older people who may be living with dementia. On the days we inspected there were 36 people living at the service. The service offers residential care without nursing. Nursing care is provided by the community nursing team.

There was a registered manager employed to manage the service. 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 were not protected from abuse from other people living at the service. Not all staff understood how to identify abuse. There were also not enough staff with the provider's required training to keep people safe. Staff had not received appropriate training, supervision and support to carry out their role effectively; safeguarding training was one of the topics staff were not all completing. Staff were recruited safely.

People were not always being assessed in line with the Mental Capacity Act 2005 (MCA). Where they had been completed they were not completed correctly. Applications to deprive people of their liberty had been made without completing an MCA assessment first. There was no one in the service trained to carry out assessments in line with the MCA. All staff had not received introductory training in the MCA so all staff did not understand their responsibilities under this law. This meant people's human rights were not being respected.

Medicines were not always managed safely. Staff were administering insulin without the training and competency checks being in place. Stocks of medicine were not always recorded and one person's medicine stock was seen to be out of date. The administration of insulin was taken over by the district nurses during the inspection. Following the inspection, the provider was ensuring a full medicines audit was undertaken.

Risk assessments were not always in place to manage people's risks. People's health, behaviour and risks associated with their medicine were not being risk assessed and care plans did not give staff the information required to deliver care safely. People living with dementia did not have care plans in place to meet their needs. People were not having their needs reviewed to assess whether the service could still meet their needs as they became more complex.

People's health needs were identified but the system of making timely referrals was not operating effectively. Health professionals told us how systems to ensure staff were up to date with people's health needs for non-urgent visits caused issues for them as they were unable to check people's records and

ensure continuity of care.

People's records were written in a personalised way. However, people's end of life care was not being planned with them. Treatment and escalation plans were completed by the person's GP. No other advanced planning was in place to support people to make decisions about how they wanted to be supported by the staff at their end of life.

People had their nutritional needs met. People liked the food and the kitchen was well organised in meeting people's dietary needs, likes and dislikes. There were systems in place to prevent cross contamination where this was required to keep people safe.

People spoke highly of how staff treated with them. People said staff treated them with respect and ensured their privacy and dignity were maintained. Staff were observed speaking with people with respect and supporting people in their own time. Staff missed the opportunity to support a person who became distressed at lunchtime. Staff were also task focused and did not respond and support people when they were saying they were bored. Activities were provided by activity staff but outside of this, little happened to stimulate and support people. Health professionals we spoke with felt the staff were caring.

The provider and registered manager had a number of audits and checks in place to review how the service was running. These had not identified the concerns on this inspection. Staff raised concerns about the management of the service. Staff did not feel listened to. People were asked their view of the service. Relatives were also contacted to request their opinion.

We have found breaches of the regulations. You can read at the back of the full report what action we have told the provider to take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from harm and abuse. Staff did not always know how to keep people safe.

There were not enough staff to meet people's needs safely.

Medicines were not always managed safely. Staff were administering insulin without the training and competency in place.

Risk assessments were not always in place to manage risks for people.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always being assessed in line with the Mental Capacity Act 2015 as required.

Staff were not being trained and supported to ensure they remained effective in their role.

People's health needs were identified.

People had their nutritional needs met.

Is the service caring?

Requires Improvement

The service was not always caring.

People's end of life choices were not being recorded.

Staff were task focused. Staff did not always identify or respond to people who were distressed.

People were positive about the staff though some people felt there was not enough staff time.

People said staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People needs were not always being reviewed to ensure the service could still meet their needs.

People's needs were not always documented in their care plans to inform staff about their healthcare requirements. Significant events in people's lives were not being clearly recorded in the daily records.

Activities were provided but not all needs were being met by staff. People's faith needs were met.

People's complaints were taken seriously and investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider and registered manger were not ensuring the quality of the service. Action was taken by the provider to start putting this right.

Staff raised concerns about the management of the service. The registered manager was approachable. Staff could suggest new ideas but this was not acted on.

People's opinion of the service was requested. Action was taken on this.

There were contracts in place to ensure the equipment and building were maintained.

Carrington House

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 the 12 and 13 January 2017 and was unannounced.

The inspection was completed by two inspectors.

Prior to the inspection we reviewed the records we hold on the service and the Provider Information Return (PIR). This was completed by the registered manager in December 2015. The PIR 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 spoke with 14 people. We reviewed four people's care in detail to check if their care was being given as planned. We also reviewed records about people's hygiene, people's care plans in respect of their medicines and all medicine administration records (MARs). We observed how staff spoke and interacted with people. We also used the Short Observational Framework for Inspection (SOFI). A SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 staff and read four personnel records. We reviewed how training was planned and monitored for all staff. We also reviewed how staff were being supported to remain up to date in their skills. The registered manager was available to support both days of the inspection. An operations manager attended the second day of the inspection on behalf of the registered provider.

During the inspection we spoke with two health professionals. Following the inspection we spoke with a GP and received feedback from two other health professionals.

There were no family or visitors available to speak with us during the inspection, we therefore suggested to the registered manager that they might like to ask family members to give us their feedback following the

inspection. We did not receive any feedback.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, our records detailed we had been told about three occasions when people living at the service had physically assaulted another person. On this inspection, we reviewed how the service was keeping people safe from harm.

People were not always protected from abuse. We observed one person over both days we were at the service acting in a way that made others feel uncomfortable. For example, one person living with dementia, was continually told by them to "shut up" and was shouted at on several occasions. They were also told they were "stupid" by this person. The person who received the comments was observed as part of SOFI to change their facial expressions from a passive face to fearful. Other people present were also observed to be uncomfortable with the interactions taking place. We also observed that staff did not intervene when hearing the negative communication. When we raised this with staff and the registered manager over both days we were told this person always behaved liked this. It was described to us as their normal state.

Despite it being known that the person we observed was reported to have a negative impact on people, and one person in particular, there was no evidence that plans had been put in place to keep people safe.

Training records detailed some staff were not trained in safeguarding to ensure they understood how to keep people safe from harm. Some staff did not demonstrate to us they understood how to keep people safe from harm. One staff member said, "I wouldn't know about abuse – not had safeguarding training." Another staff member said, "I would go and see [the registered manager's name]" and when asked if something would be done they said, "I can't be sure". This member of staff knew to go higher internally if nothing was done at manager level. However, they told us they had to sign a confidentiality agreement when they started and were not sure they could go to external parties such as CQC or local authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider stated annual safeguarding training was mandatory for all staff and those staff who had not received the updated training, this had been planned to take place. Also, staff had confused its data protection policy (which prohibits staff from disclosing people's confidential information) with its safeguarding policy, which encouraged the reporting of safeguarding concerns to management and the local authority. They aimed to speak to all staff to ensure this was made clear.

Medicines were not always being managed safely. The service used an electronic medicine system which we were told reduced the possibility of errors. The system would not allow medicines that required administration outside of the set specific times to be given early. It also flagged any issues that could then be reviewed by senior staff. However, medicine stock checks were not ensuring all medicines were in date, in their original packaging and accounted for. One person had a box of medicine prescribed in February 2015 with an expiry date of November 2016. The person continued to have this medicine administered. This meant the medicine was out of date and it could not be assured that the person's needs were met.

Stocks of insulin were not known. There were no records about what quantity in stock and no audits completed of the stock. This meant it could not be assured the service was ensuring the management of this medicine was safe. One person had five months of their medicine not in the original packaging and in unsecure dosing containers. This had been dated by the pharmacist in August 2016. A member of staff told us the person had arrived at the home with their medicines like this so "were using them up". Staff had not checked with the prescriber the medicines were still prescribed. By not being in their original packaging their expiry date was unknown. During the inspection staff contacted the pharmacy for advice to ensure they could identify what the medicines were. The registered manager was requested to follow this up with the prescriber to ensure the person was receiving medicines appropriate to their current needs. Both these actions were completed.

Staff employed by the service were administering insulin to one person. Staff were not having their competency checked and were not being trained sufficiently to ensure the person was safe. Staff also did not know how to calibrate the blood sugar test machines to ensure the readings on which the insulin dose was being given were accurate. The person's care plan and Medicine Administration Record (MAR) did not have a record of the current dose required. When we asked what dose the person was on, we were given differing accounts. Although there was no record of ill effects for the person, this meant the person's insulin dose could not be guaranteed as accurate. We requested this was addressed during the first day of the inspection and resulted in the community nursing service taking over this task on the second day of the inspection.

There was a policy and practice in respect of the use of 'as required' medicines. However, staff at this location were not following the policy and current guidance to ensure 'as required' medicines were correctly managed. Some people were prescribed 'as required' medicines used to alleviate pain or reduce anxiety. There were people living with dementia who would not be able to tell staff when they required their 'as required' medicine. Staff were not carrying out an assessment of needs such as a pain score to know if these people needed their pain relief, for example. Staff told us they "just knew" if the person needed them based on behavioural observations. Another member of staff told us there was no information to follow on the electronic medicine administration record in relation to 'as required' medicines. People's care plans had no guidelines to help new staff. The deputy manager told us they would make sure guidelines were written for 'as required' medicines.

One person was seen chewing their tablets and capsules instead of swallowing them during a medicine round. We spoke with the member of staff who said, "They have chewed tablets for a long time. A year. Always chewed tablets". The member of staff told us they did not think alternatives had been looked for. We spoke with the registered manager who confirmed no referrals to a pharmacy or doctor had been made to look for alternative medicine. They were able to tell us at least one of the person's medicines could come in liquid form. By not seeking alternative forms of medicine for the person the effectiveness could be reduced.

People's medicines were administered by staff who had their competency assessed on an annual basis to make sure their practice was safe. One member of staff said, "[The registered manager's name] observes me giving medicine". By completing these checks senior staff were able to ensure staff competency. However, one member of staff was observed pouring tablets from a pot into their bare hand prior to administering them. By doing this there was a risk of contamination to and from the medicine. The provider's policy stated, "Tablets and capsules should never be dispensed into your hand". Staff were also not telling people what medicine was being administered, just how many tablets. This meant people could not have information and control over their medicines and select if there was medicine they did not want to take.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Following the inspection, we were advised by the service that a full medicines audit was to be completed by the provider's nurse practitioner. Action was taken immediately following the inspection to ensure staff administering medicines understood their responsibilities. Also, the provider explained that it had a policy on pain management, which sets out a variety of methods which can be used to assess the pain of people who are not able to articulate their level of pain verbally. They would follow up with staff why this was not being used at this location.

People were not always supported by sufficient numbers of staff to meet their needs. Whilst people told us they thought there was enough staff, staff did not. A member of staff was asked if there was enough staff they said, "No". They continued, "The afternoon is terrible".

Staff on duty at the weekends stated it was harder to complete other tasks such as cleaning and getting people's laundry back to them.

During the inspection we observed on several occasions that staff were silencing call bells in the corridor but not immediately going to see what the person needed. We spoke with the registered manager about this practice as we were concerned other staff would then assume the person's needs had been met. The registered manager agreed to review this practice.

Two members of staff told us that the number of people needing two staff to support them had increased and there were now five people requiring two staff at a time for assistance. The view of staff was that staff numbers had not been increased in respect of people's increased needs and dependency on staff for their care. When we discussed this with the registered manager, they stated they would follow up this concern with staff.

We asked the registered manager how they were ensuring there were enough staff and that staffing of the service was flexible around people's needs. For example, reviewing how dependent people were on staff, auditing falls and accidents, reviewing call bell response times and checking with staff how things were going. The registered manager told us they had no systems to identify if there were adequate staff levels in the home. They also told us the provider had no systems in place to gauge safe staffing levels. A member of staff told us when they asked for more staff the registered manager responded by saying there was, "No more money to give more hours".

A member of staff said, "Some people have a strong aroma because of not having a wash" and, staffing for one person resulted in their having their dignity compromised. Another member of staff told us by not having enough staff people were not washed correctly. Records showed gaps when people had a bath. A member of staff said of these records , "It is difficult to do when not enough staff about". They continued to tell us they had last given a bath a couple of months ago.

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

Following the inspection, we were advised by senior staff at the provider level that staffing of the service should be judged against a number of audits. We were informed all registered managers were able to staff their services within agreed budgets and could seek further funding to meet exceptional circumstances. Post the inspection we were advised action would be taken to address this at Carrington House.

Risk assessments were not always in place to mitigate those faced by people living at the service. There was a lack of risk assessments in place for people in respect of their specific health and behaviour needs. Risk assessments were not always clearly linked to people's care plans and a lack of reviews meant these were not always updated. There were no risk assessments in place for people at risk of choking, complications from diabetes and for people prescribed blood thinning medicines (warfarin).

One person had an increase in falls resulting in serious bruising on their face and arm. A member of staff had identified when they lay on their bed, they may fall off again. They were heard to say to the person, "You are going to tumble off again". No information had been updated in their care plan about the risk of falls and no referral had been made to the falls team. This meant this person's risk of falling was not being addressed and every effort made to prevent a further fall. The registered manager advised they would follow this up for this person.

Two people were identified as having MRSA. Systems were in place for managing their personal care and laundry but there was no risk assessment in place and one person's care plan did not mention they had MRSA. The provider had a policy in respect of MRSA to prevent the cross contamination to other people and how other health professionals were told about the MRSA risk at the service. For example, how to communicate with hospitals a person's MRSA status should they be admitted to hospital.

We found the kitchen staff were ensuring people were free from cross contamination when required. However, there was no risk assessment process in place for people with food intolerances which could place that person at risk. For example, one person required a gluten free diet and another needed precautions to prevent an adverse reaction to nuts. Also, a staff member had informed the kitchen of the person with a self-declared nut allergy but the registered manager was unaware of this so there was no record kept, their GP had not been informed, and there was no emergency medicine on standby in case this person had a reaction to nuts. We requested the latter was acted upon immediately and adrenaline was requested from their GP by the registered manager. Staff were informed by senior staff of the need to prevent cross contamination during their work and advised of the importance of communicating information to keep people safe.

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

A risk assessment in place for a person who smoked needed updating to reflect current guidance. For example, it needed to address their capacity to understand the risks and have more detail as to where the ignition source was being kept, where the nearest extinguishers were, and how the person was being observed to ensure potential fire incidences could be responded to quickly.

Personal emergency evacuation plans (PEEPs) were not in place for everyone. We were told by the registered manager that the provider had told them PEEPs were not required for everyone other than those requiring physical support to evacuate safely. We advised the fire service of this who agreed to communicate with the provider. The service ensured their fire alarm system and extinguishers were maintained. Regular fire evacuations and practices took place. There was a need to ensure people who were physically mobile were aware of the service's evacuation procedures and where to gather in the event of the fire alarm being sounded.

During the inspection we found stock contained in the first aid kits were out of date. This was addressed on inspection.

Staff employed by the service were recruited safely. Checks on their history were made to ensure they were safe to work with vulnerable adults. Staff confirmed these checks were in place before they started to work at the service. During the inspection some of the required information had not been documented correctly. We spoke with the registered manager and operations manager who were unaware there were gaps. They told us they would check all the staff recruitment records and ensure they were completed in line with the provider's policies.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager had received training in the MCA however, they did not feel this gave them the skills to carry out MCA assessments. When we asked, we were told no one working at the service therefore was trained to complete assessments of people's capacity to consent or refuse care and treatment. People living at the service were identified to us as having conditions such as dementia that meant they may have no or reduced capacity to give consent to living at the service and receiving care and treatment. However, people who lacked capacity were not having their capacity fully assessed. Where records included an assessment of capacity, best interest decisions or who had been involved with ensuring people's rights were being respected these were not correctly completed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS had been applied for to restrict people's liberty without first completing an assessment of their capacity to consent or refuse treatment. This meant people's human rights could be being contravened.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider have been unable to provide the necessary evidence that staff had received the training required for them to be effective in their roles. The training records we were initially showed had significant gaps. Training records covered the training for staff in those areas as identified as mandatory by the provider and in other areas to meet specific people's needs. We were told that this could not be accurate as Somerset Care had a structured training programme. The provider was given time for staff training to be reviewed so it could be checked whether the records had not been filled in but the training had taken place. We had further confirmation on the 27 January 2017 that staff had not received a significant amount of the provider's mandatory training. This meant that training for staff in respect of health and safety, fire safety, manual handling, safeguarding, end of life care and mental capacity and DoLS was not in place.

There was no written evidence of staff having received additional training in respect of caring for people with dementia and other health needs. Although, one staff member said, "I go to all training. Had dementia and health and hygiene". However, there was no record of this training having taken place. Some staff told us they felt there could be more specific training to meet people's care needs. For example, one staff

member said they attended diabetes training but felt dementia training would have been more appropriate for their work.

Records provided to us by the registered manager and provider showed staff were not receiving supervision and appraisals as expected by the provider. These are mechanisms which support staff. The records showed some staff had not been supervised and there was no set pattern. Some staff had been supervised more often and others had months when no supervision had taken place. Staff could not tell us how often they were expected to attend supervision sessions. There was confusion amongst staff about the difference between an appraisal and supervision. When supervisions had identified concerns about staff practice, there was no information about the actions taken to improve the situation.

Staff new to the service told us they had shadowed more experienced staff before working on their own. The registered manager advised us the Care Certificate had been introduced. A new member of staff said they had started the Care Certificate. The Care Certificate was introduced nationally to ensure there was a standard of care among staff new to care. Staff gave us a mixed view of the quality of the induction to the service they had completed. One staff member said management had, "Organised an induction day and two shadow shifts [with a staff member]; I don't think [the staff member] was good at induction. It was a general chit-chat rather than induction".

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

All staff were able to tell us about a six-week and 22-week review to ensure their continued suitability for the role once they were employed to work in the service. Following the inspection, we were advised by the provider that the training of staff was being addressed with all staff booked on their mandatory training. Also, the provider said new staff were expected to complete the 15 modules of the Care Certificate as part of their induction and the staff member we spoke with appeared not to have realised that this was part of her induction.

People's view was that staff were responsive to their health needs and they could see their GP and other health professionals as needed. However, people's records were kept electronically and there was no record of professional visits outside of the person's daily records. This meant following through on a concern or health professionals' advice was very difficult for staff and it was not clear this advice had been taken through to people's care plans.

We found people were not always being referred to other health and social care professionals for assessment and advice. For example, one person was embarrassed about the way they ate their food. We asked the member of staff if any referrals had been made for advice and supportive equipment. The staff member told us they thought prior to moving in the home they had seen someone. However, this had not been reviewed so this person's needs could be looked at.

People told us they liked the food. Comments we received included, "The food is tremendous. We have enough choice and always have drinks", "The food is very good" and, "I always get what I want". Any concerns in respect of people's weight and eating were referred to other professionals for an assessment. For example, people had seen the speech and language therapist if it was identified they were struggling to swallow their food. The kitchen had clear systems in place to ensure people's food was prepared as the assessment showed. Also, kitchen staff were informed of people's likes and dislikes and were flexible in providing food people enjoyed. People could have drinks and snacks when they wished. For example, three people were observed sitting in the dining room between meals and were provided with cups of tea and

biscuits as they chatted to each other. People were supported to eat and drink as needed. People received their food supplements as prescribed.

Seven people were noted as having weight loss on the information provided to us at the start of the inspection. However, we were told by the registered manager that no one was having their food and fluid intake monitored. We asked them to review these people to ensure the correct monitoring of their food and fluid intake was in place as required.

Requires Improvement

Is the service caring?

Our findings

There was no record in people's care plans of how people wanted their end of life needs met. Some people had their treatment and resuscitation choices recorded but other advanced decisions were not being obtained. For example, people's choices in line with their faith and who they wanted with them were not recorded. Staff had not received any training in this area either. Staff did not therefore, have the information required should a person's condition deteriorate suddenly.

Generally, people were positive about staff and the way they related to them. There were times though, through observation, and lack of staff time for people, that we were concerned about how people's needs were being met in a caring way.

During our observations at lunchtime we saw most interactions were task based. This included serving and clearing food away. Also during lunch, staff missed an opportunity to support a person who became distressed on both days. Staff did not appear to notice this person's behaviour. This person was observed running out of the dining room in a distressed state and not eating their food. On the second day we spoke with the person and asked staff to attend to them. There was some reluctance from staff as the task of serving lunch was in process. The staff member who did respond spoke to the person was appropriate and comforting. The same staff member was observed trying to tempt the person with other food during the day. However, when we checked with the registered manager if this information had been passed to them or was being looked at, they confirmed it was not. This meant this person's needs were not being reviewed and a way forward planned to find out why they were becoming distressed.

A further time of observation in a lounge showed people had little positive or no staff interaction. A staff member started a game with one person without engaging them then left to answer calls bells twice. After the last time they left, the staff member did not return so the person put the game away and dozed in the chair. Another staff member spoke to a person in a tone of voice which was not respectful of talking to an adult. People told us during this time that this was usual in that, they were "bored" and had nothing to do for significant amounts of their time. One staff member told us, "[People] are not getting care they deserve" due to the staff level issue.

A third member of staff spent time chatting with a person at lunch and having a bit of a joke whilst supporting them to eat. On another occasion a person reached out and a staff member held their hand. The member of staff told us afterwards this was because the person could become distressed and could grab people and holding their hand alleviated their distress. Another person was supported after lunch to move in their own time to the lounge; lots of reassurance was given by staff as they patiently guided the person.

Positive comments we received included, "The staff are marvellous. We get looked after; all staff are very good"; "Staff are nice. This is one of the nicest places to be in. The staff are so nice"; "The staff are very helpful and all very kind" and, "All staff would help if I needed it".

People appreciated when a staff member on their day off brought their dog in to see them. The staff

member told us, "Once a month I come in with my dog". We saw people greeting the dog in lounges and their bedroom and reminiscing about their own dogs. This was observed to have a positive effect on people's moods.

People said staff ensured their dignity and privacy was respected. One person said, "Staff do respect my privacy" and another, "Staff always knock on my bedroom door". One member of staff told us how they respected people's privacy when undertaking intimate care. They said, "I always knock on the door. People are covered up; we cover them and dress from the top. I use a towel or blanket to cover them and keep the door shut."

Two members of staff explained how they offered choice to people living with dementia who had communication difficulties. They told us they would describe the food on offer such as an omelette. They would describe this being "round and made of eggs". They did not have pictures to show people but thought it was a good idea and wanted to liaise with the activities staff to make cards to achieve this. The second staff supported people to choose between objects so they could have their food as they liked. For example, staff got the jam and marmalade jars so the person could point at them and decide how they wanted their toast made.

All the health professionals we spoke with told us that the staff always presented as caring. One health professional added that should a family member require residential care, they would consider Carrington House an appropriate place.

Requires Improvement

Is the service responsive?

Our findings

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. People's care was recorded in a personalised way which detailed their wishes and preferences. However, systems were not in place to ensure people's needs were reviewed. During the inspection, health professionals raised with us on more than one occasion that the service was not reassessing people's needs to ensure they still had the ability to meet their needs. Staff also told us they were looking after people whose needs had become more complex with some having behavioural support needs. Staff said they were struggling to look after those with increased need. We identified a number of people who we were concerned needed reassessing to ensure the service was able to meet their needs. For example, we saw on day one a person living with advanced dementia had very dirty nails and mixed clothing with patterns that clashed. This person had poor sight and was heard to be shouting for staff to help them. We called for staff so their immediate needs could be met. We were told by staff they could scratch and injure staff hence, their appearance. There was no evidence this person's needs had been reviewed, and with the absence of any capacity assessment, it was not possible to say how the staff were being supported to act in their best interests.

A staff member told us, "I think there are some people whose needs we are not able to meet anymore. Their needs have advanced and I feel they are not reassessed quickly enough when their needs have changed." For example, one person was highlighted as not being safe to relocate with their current equipment. They told us this had been raised with management and they were concerned if this was not sorted, it may result in injury. The same staff member also highlighted three people who hit out at staff and there was no management plan available for staff to know how to manage this.

People's needs were not always documented in their care plans to inform staff about their health and care requirements. For example, one person required regular blood tests due to a medicine they were taking. Their daily logs demonstrated a nurse would visit to do this. However, their care plan contained no detail on the frequency of these blood tests. A member of staff was not aware of how often the person required a blood test. We spoke with the registered manager who could not tell us how often the blood tests should be carried out. This meant the person was at risk of not having their blood test because no information was recorded in their care plan for staff to follow. The staff checked with the GP surgery to ensure the necessary information was recorded; the practice reassured staff that they had the next appointment booked and the person's blood checks would continue to take place as planned.

Guidance would say for two other people that blood pressure checks were required due to one of their medicines. No information was recorded in people's care plan about any medical guidance in this situation. During the inspection a member of staff contacted the GP who confirmed it was not necessary. By not having this information recorded staff were unaware of potential risks to these people.

People living with dementia did not have care plans in place to meet their needs. This meant there was no information for staff to refer to in regards to how dementia was affecting them and what staff could do to support them.

Significant events in people's lives were not being clearly recorded in the daily records. There was no time and date being recorded. Also, the records kept did not need clearly record what was said. For example a recording of a district nurse visit did not detail what the conversation had contained, so when this was queried during the inspection the records were not accurate enough to for the registered manager to respond to. Also, it made following events through to demonstrate people's needs were being responded to virtually impossible.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged and supported to make choices about aspects of their day to day lives. For example, people were able to get up and go to bed when they choose. People had their breakfast when they wanted. Following the inspection we have been advised that everyone's needs had been reviewed with two people in particular being referred for urgent social care reviews.

Activity co-coordinators were employed to support people to remain active. People were able to take part in a range of activities according to their interests. An activity coordinator told us, "I read the paper and do a lot of one to ones". Every morning there were group activities and weekly faith services people could attend if they wanted to. We were also told by staff, "Once a month a friend takes [name of person] to church". There is a librarian who came from the local library to help people choose books they wanted to read. Also, once a month volunteers came from a local school. However, not everyone was having their needs met. When the activity co-ordinators were not there, other staff did not support people to be active when needed. People commented it was always like that when we raised with them that there did not seem to be a lot happening for them to do. One person said, "I prefer to have someone to talk to" and another, "I get fed up sitting somewhere with no one to talk to".

Staff said about one person, "[They] hardly ever do activities. They are always bored. They have nothing to do." Other people told us of times they were very bored. One of the activity co-ordinators said they were constantly taken off activities to carry out care tasks. We have raised the issues about activities with the registered manager and provider and we have been told action was being taken over this.

The provider had a policy to manage complaints people raised. The policy and means of raising complaints was available to everyone. People's complaints were identified and investigated. People were contacted to ensure they were happy with the outcome.

The registered manager collected positive feedback from relatives and visitors to the home. For example, "We would just like to say a huge thank you for all the wonderful care you showed Dad over the last 15 months" and, "I would like to thank you for the care and dignity you have shown [name of person] over her last few years she has been with you". A newspaper article showed when a person had a surprise visit of the lorry they used to drive. Other positive comments included, "A big thank you to all the carers that have been looking after me at Carrington House" and, "I have been very impressed with the way you have cared for [name of person], which I appreciate has not been easy. However, she was very fond of you all".

Requires Improvement

Is the service well-led?

Our findings

Carrington House was owned and run by Somerset Care Ltd which is a large provider of care in Somerset. There was a nominated individual (NI) in place who is a person appointed by the provider to be responsible for supervising the management of the various services. Carrington House had a registered manager employed to manage the service locally. They were supported by a deputy manager, administrator and a team of staff. An operations manager came to the second day of the inspection to support the inspection and represented the provider view in answering our questions and concerns.

The provider had a set routine to ensure audits were undertaken with the aim of these to measure the quality of the service. A range of audits were completed by the registered manager and the provider but these had not identified the concerns raised during the inspection. Where issues had been identified for example when looking at critical incidences, these had been given to other staff to follow up. It was not then clear what happened to that review and what changes were made to the service as a whole.

There was no system to ensure people's health needs were identified in a timely manner. We were told by a range of health professionals that the staff were not organised in passing on concerns about people's health that they wanted reviewed by a GP or district nurse. The service had an allocated call from the GP surgery at 10.30am each week day to discuss people's needs and to see if a visit was required by any of the health professionals. We were told that the service had no system in place to make sure they had the information required by the time of the GP call, so any further calls would be down to something having arisen as a matter of urgency. Staff would call the GP throughout the day asking for other people to be seen. Also, health professionals were asked to see other people when making planned visits. This meant health professionals had not had the opportunity to review the person's records before coming to see them. Attempts had been made to put this right but the service did not seem to be able to maintain an organised approach. We discussed this with the registered manager and operations manager so they could look at improving this situation.

We reviewed the recording of people's falls from July –December 2016 and could see a number of people were having multiple falls but there was no evidence these records were being reviewed to see what lessons could be learnt to keep the individual and everyone else safe.

There was no system to ensure the first aid kits were kept in date and stocked.

During the inspection we raised a number of concerns as we identified issues. However, we found action was not being taken to address the issues as they arose. For example, we raised concerns about the staffing on the first day. The registered manager did not have the current guidance available so we supported them to find this on CQC's website. When we asked the registered manager on day two what their thinking on staffing was, we were advised they had not reviewed the guidance and had no further comment they could make. We spoke about this to both the registered manager and operations manager.

Staff had regular meetings to share concerns and compliments. However, some concerns raised in staff

meetings continued to occur. Staff did not feel listened to when they raised concerns about people's needs. Staff told us they did not think the management of the service was effective. Comments we received included, "[The registered manager] is very approachable. Sometimes takes problem on board and goes through with it" adding, "They need to be more of a manager. Not everybody's friend"; "I don't think the [registered manager] is forceful enough"; "[The registered manager] is nice. You can talk to them" adding, "They listen but not much gets done" and, "[The registered manager and deputy] are very approachable and lovely people" adding, "I like them, but they are not managers. They are too nice. They want to be friends but they are not here to be liked".

People we spoke with found it hard to identify who was in charge of running the service. People, told us they did not see the registered manager regularly walking around the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following the inspection, we were advised by the provider that a different manager and operations manager had been brought in to support the service address the concerns provided in the initial inspection feedback. An initial action plan was provided to the Commission to demonstrate how shortfalls were being addressed. Further contact with the new operations manager and temporary manager demonstrated the provider's commitment to getting it right at Carrington House. The action plan was updated and showed progress has been made.

When people had raised issues at their meeting these had been acted upon. Minutes from residents' meetings recorded comments such as, "Staff are friendly" and, "I am very happy here". During the meetings there were opportunities for people to raise concerns. Actions were then recorded about how they had been resolved. For example, one person said, "Staff speak very loud at night" so the response was, "Have spoken to night staff and care support staff to address this issue". Another person asked for more one-to-one time with staff. It was recorded that more one-to-one time was being offered throughout the home. An activities coordinator confirmed this. The registered manager advised, every month there were telephone satisfaction calls to five percent of the relatives. However, the registered manager was unable to show us any records of this.

The registered manager understood their responsibilities in respect of the Duty of Candour (DoC). The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct. Staff told us they felt confident concerns raised with the registered manager would be addressed appropriately.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that of fire safety equipment took place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1)(2)(3) People were not being assessed in line with the Mental Capacity Act 2005 as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(a)(b)(c)(g) Care and treatment was not always safe for people as risks to people's health and safety were not always assessed; All reasonable steps were not then made to mitigate those risks; staff giving insulin injections were not trained and checked as competent and the management of medicines was not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1)(2)(3) People were not protected from abuse and systems and processes were not operated effectively to prevent abuse of people. When made aware of a concern, this was not investigated and responded to effectively.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) and (2)(a)(b)(c) Systems in place were not operated effectively to ensure quality of the service; risks to people's health and welfare were not mitigated and records were not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) and (2)(a) Sufficient numbers of staff were not deployed who were suitably qualified. Staff had not received the training and support necessary to enable them to carry out their duties.