Farrington Care Homes Limited

Palace House Care Home

Inspection report

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Date of inspection visit:
30 October 2018
31 October 2018

Date of publication:
27 November 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Palace House Care Home on 30 and 31 October 2018. The first day was unannounced.

Palace House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Palace House Care Home provides accommodation and care and support for up to 33 people. The service provides nursing care. There were 30 people living in the home at the time of the inspection.

Palace House Care Home is an extended detached older property which has retained many original features. It is situated on the main road between Burnley and Padiham and is near to shops, churches, public transport and local amenities. Accommodation is provided on two floors with a passenger lift. Car parking was available to the rear of the house.

At the time of our inspection, the registered manager was no longer managing the service. A new manager had been in post from August 2018 but had not yet applied to register with CQC. A registered manager is a person who has registered with CQC 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.

At the last inspection on 1 and 2 November 2017, our findings demonstrated there was a continued breach of the regulations in respect of staffing; the service was rated Requires Improvement. The service had also been rated Requires Improvement following the inspections of March 2016 and March 2017. Following the last inspection, we asked the provider to complete an action plan to show what they would do to improve the service to at least good and to identify the date when this would be achieved.

During this inspection, we found improvements had been made. However, we found a breach of regulation 12 in relation to medicines management. Therefore, this is the fourth consecutive time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report.

People's medicines were not always managed safely. The clinical commissioning group medicines optimisation team were supporting management and staff with making improvements. However, we found there were still some shortfalls in medicine management practices in the home and further improvements were needed. People received their medicines when they needed them and staff administering medicines had received training and supervision to do this safely.

Quality assurance and auditing processes were in place to help the manager to effectively identify and

respond to matters needing attention. We saw evidence of regular monitoring that had identified shortfalls in the service and appropriate action had been taken to address the shortfalls. However, the audit tools had not identified the shortfalls found during the inspection in relation to medicines management. The manager addressed this following the inspection. People's opinions on the quality of care provided were sought. The provider had good oversight of the service.

We found people's care records and staff members' personal information were stored securely in locked cabinets and were only accessible to authorised staff. The manager could describe the improvements being made to systems and records in response to shortfalls found during the audits.

Risk assessments had been developed to minimise the potential risk of harm to people. They had been reviewed in line with people's changing needs. The manager was currently improving the incidents and accidents recording and monitoring systems.

Safeguarding adults' procedures were in place and staff had received training. Staff understood how to protect people from abuse and how to report any concerns. People told us they felt safe in the home and that staff were caring. People appeared comfortable in the company of staff and it was clear they had developed positive trusting relationships with them.

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's consent to various aspects of their care was considered and was being included in the care records.

People's care and support had been kept under review and, where possible, people and their relatives were involved in decisions and reviews about their care. Relevant health and social care professionals provided advice and support when people's needs changed.

Recruitment checks were carried out to ensure suitable people were employed to work at the home. Improvements were being made to the recruitment and selection procedures to ensure a robust and fair process was followed. Arrangements were in place to make sure staff were supported, trained and competent. People's opinions about the staffing levels varied; some people considered there were enough staff to support them when they needed any help whilst others felt there were at times insufficient staff. The manager was monitoring this.

The environment was clean and adaptations and decorations had been adapted to suit the needs of people living at the home. Equipment was stored safely and regular safety checks were carried out on all systems and equipment. Some areas of the home needed attention; there was a development plan to support this.

People told us they enjoyed the meals and their dietary needs and preferences were discussed and met. People were offered a choice of meal and food and drinks were offered throughout the day. People were encouraged to participate in activities of their choice. We observed staff spending time chatting to people, listening and singing to music, taking part in exercises and watching movies.

People and staff were happy with the service provided and considered the service was managed well. People felt they had been involved in decisions and were happy with the care and support they received; they made positive comments about the staff and the manager and about their willingness to help them. People knew how to raise their concerns; the manager was making improvements to increase people's awareness of the complaints process.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure people's medicines were managed in accordance with safe procedures. Medicines were administered by trained and competent staff.

The deployment of staff had improved and sufficient numbers of staff were available to meet people's needs at all times.

People felt safe in the home and were protected against the risk of abuse.

Accident and incident monitoring and reporting and the management of risks was being undertaken to ensure people's safety. The manager was making further improvements in this area.

Is the service effective?

Good

The service was effective.

Staff were provided with training, support and professional development. People felt that staff were competent and could support them effectively.

The environment was safe and comfortable for people to live in. There was a development plan to support planned improvements; a system of reporting required repairs and maintenance was in place.

People enjoyed the meals and their dietary needs and preferences were met. People were supported with their healthcare and were referred appropriately to community healthcare professionals.

People's capacity to make safe decisions had been assessed although the manager was aware people's consent to care needed further development. Authorisations to deprive people of

their liberty had been submitted where required.

Is the service caring?

Good

The service was caring.

Staff responded to people in a friendly, caring and considerate manner and we observed good relationships between people, management and staff. We observed some caring interactions from staff.

People were encouraged to maintain relationships with family and friends. There were no restrictions placed on visiting.

Staff respected people's rights to privacy, dignity and independence and were protected from discrimination. Where possible, people could make their own choices and were involved in decisions about their day.

Is the service responsive?

Good

The service was responsive.

People had been provided with appropriate meaningful and interesting day time activities and stimulation both inside and outside the home.

People were not clear about the complaints process but felt confident raising their concerns and complaints with the manager or staff. Improvements were being made to ensure people were aware of how to raise their concerns and complaints.

Each person had a care plan which included details about their needs and preferences. Care plans and associated records had been kept under review.

People, or their relatives, had been involved in discussions about their care and some had been involved in the review of their care plan.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager was not registered, and had not forwarded an application to register with CQC. It is a condition of the provider's registration that there is a registered manager in post.

There were systems to assess and monitor the quality of the service. There was evidence that shortfalls had been identified and acted on. However, we found a breach of regulation with regards to medicine management.

People made positive comments about the manager and staff. They felt the service was well managed and they were happy with the recent changes and improvements made.

Records were managed safely and stored securely. Further improvements were being made in line with shortfalls found.

Palace House 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 checked 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.

An unannounced comprehensive inspection took place at Palace House Care Home on 30 and 31 October 2018. The inspection was carried out by an adult social care inspector and an expert by experience on the first day, and by one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit we checked the information we held about the service and the provider and included this in our inspection plan. We considered the previous inspection report and obtained the views of the local authority safeguarding team and local commissioners. We analysed information from previous complaints and safeguarding alerts and incorporated the themes into the planning of this inspection. We reviewed information from statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

We did not ask the provider to send us a Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, such as what the service does well and improvements they plan to make.

During our inspection visit, we spent time observing how staff provided support for people to help us better understand their experiences of the care they received. We spoke with five people living in the home, four visitors, four care staff, the activities coordinator, a bank nurse, the clinical nurse lead and the manager. We also spoke with a visiting healthcare professional.

We had a tour of the premises and looked at a range of documents and written records including four people's care plans and other associated documentation, three staff recruitment and induction records,

staff rotas, training and supervision records, minutes from meetings, customer survey outcomes, complaints and compliments records, medication records, maintenance certificates, policies and procedures and records relating to the auditing and monitoring of service. We also looked at recent reports from the local commissioning medicines optimisation team (April and October 2018), the community pharmacist (March 2018), the fire and rescue service (October 2018) and the local commissioners.

Following the inspection visit, we asked the manager to send us additional information; this was promptly provided.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 1 and 2 November 2017, we found the provider had failed to ensure there were sufficient numbers of staff deployed. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found the availability of staff varied and was inconsistent. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection, we found improvements had been made. We observed people's calls for assistance were promptly responded to; staff were attentive to people's requests and were available in the main lounge.

Prior to the inspection we received concerns that staff were taking their breaks at the same time which left people unattended. We discussed this with the manager and were told she was aware of this. Staff rotas now recorded which area of the home staff were working in and when they would be able to take their breaks. The manager would continue to monitor this.

People's opinions varied; comments included, "There are enough staff generally. Occasionally people have to wait" and, "There is always somebody here within a minute or two. And there is always someone around to comfort or calm people." Visitors said, "I think there should be more staff" and, "People wait far too long for someone to come. It's staff shortages, they are just dealing with someone else at the time, not ignoring the call bell." Staff confirmed there were sufficient staff. They said, "Staffing is better; we know what we are supposed to be doing now. We are organised better", "We have enough staff so we can spend time with people" and, "We have enough staff to look after people."

We looked at the staffing rotas and found there was a registered nurse with six care staff on duty throughout the day, a registered nurse and five care staff on duty in the evening and a registered nurse and two care staff on duty at night. There were sufficient ancillary staff such as cooks, kitchen assistants, activity, maintenance and domestic staff. The manager worked flexibly in the home and provided out of hours support as needed. In addition, the clinical nurse lead worked three supernumerary shifts. A dependency tool was used to provide guidance about the recommended numbers of staff. We were told any staff shortfalls were covered by existing staff or by agency staff. Records showed the same agency nursing staff were used to provide some consistency for people.

We looked at how the service managed people's medicines. We were aware the manager and staff had been working with the Medicines Management Team (MMT) from East Lancashire Clinical Commissioning Group to make improvements in the way medicines were handled. We saw the improvement plan that the MMT had drawn up for the home to follow in October 2018 and the progress that had been made. We also looked at the audit undertaken by the community pharmacist in March 2018; an action plan was in place and a further visit was planned. However, we found there were still further improvements needed to ensure the safe management of medicines.

We sampled four people's medication administration records (MARs). A photograph identified people on their MAR and any allergies were recorded to inform staff and health care professionals of any potential hazards of prescribing certain medicines to the person. We were told further work was being done with the community pharmacist to ensure all allergies were correctly recorded and to improve the labelling to boxed items. We were told no-one was managing their own medicines however, people had not consented to their medicines being managed by the service.

During this inspection, we found some protocols had been put in place for medicines prescribed to be given when required (PRN) or 'as needed', to ensure they were given safely and consistently. However, we found two people were prescribed PRN medicines but did not have any protocols in place; this had been identified by the MMT and included as part of the action plan. The clinical nurse lead told us this was currently being actioned. We saw evidence to support this.

We looked at four people's records to support the administration or application of external and internal creams; the records were stored in people's bedrooms. We found the directions on the records were insufficient to guide staff where to apply creams or how often they should be applied; directions stated to be applied 'when needed' or 'as directed'. There were also gaps on the cream records without any recorded reasons for non-administration. The manager told us a member of care staff was now responsible for checking the accuracy of all records in people's bedrooms; this had commenced the week of the inspection and the system's effectiveness was being monitored.

We completed a random count of three people's boxed medicines. We found the amounts for two people's medicines were incorrect; this meant the medicine had not been given but had been signed for. We were unable to check this for other people as any amounts carried forward from the previous month had not been recorded. Records showed medicines that were no longer needed were safely stored and disposed of. However, two staff signatures were needed on the returns records to improve the safety of the process.

Our findings demonstrated the provider had failed to ensure people's medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

People and their visitors had no concerns about the way their medicines were managed. There was a robust ordering system in place and everyone had an adequate supply of their medicines to ensure they could be administered as prescribed. The stock level of medicines was under control. Where thickener was prescribed, to be used in drinks to prevent choking, there was guidance available and this was stored safely.

Appropriate arrangements were in place for the management of controlled medicines, which are medicines which may be at risk of misuse; we checked two people's controlled drugs and found the amounts to be correct. Nursing staff administering medicines had undertaken medication training and assessments of their competency, in relation to medicines management, were completed. Staff had access to a full set of medicines policies and procedures. There was a system to ensure people's medicines were reviewed by a GP to help ensure people were receiving the appropriate medicines. The temperatures of medicine storage areas were recorded. However, we noted limited lighting was available as light bulbs needed replacing and the medicine cabinet bases were rusty and needed attention.

The manager told us the MMT had provided them with a more detailed audit which was due to be used this month; this would help the manager to identify and respond to any shortfalls. We were told a further visit was planned by MMT to follow up progress made with the improvement plan.

We looked at how the risks to people's health, safety and wellbeing were being managed. Risk assessments

were in place including those relating to falls, moving and handling, skin integrity and nutrition and hydration. Assessments included information for staff about the nature of the risks and how staff should support people to manage them. They were updated regularly and information about any changes in people's risks or needs was communicated between staff during shift changes.

Records were kept in relation to accidents and incidents that had occurred at the service, including falls. Referrals were made, as appropriate, to the GP, the falls team and the district nursing team; we also observed alarm mats and sensors in use for people who had been identified at risk of falls. The manager was made aware of any incidents and accidents and shared this information with local commissioners and with the provider. However, we noted staff had not been completing sufficient detail regarding any incidents; the manager had recently identified this and appropriate documentation was now in place. The manager carried out a monthly analysis of falls but not of other incidents or accidents occurring in the service; this information was needed to help identify any patterns or trends. The manager showed us a new record that would be used to support her with the monitoring process.

Financial protection measures were in place to protect people. Staff were not allowed to accept gifts or assist in the making of, or benefiting from people's wills. We noted there were systems in place to respond to concerns about staff's ability or conduct.

During the inspection, we observed people were comfortable in the company of staff. We observed staff interaction with people was kind, friendly and patient. People told us Palace House Care Home was a safe place, was free from abuse and free from any bullying. People told us they could tell someone if they felt unsafe about anything or anyone. They said, "I always feel safe" and, "The place itself is a nice place. Safe enough for me." Visitors said, "Safe, absolutely. The staff do keep any eye open for them" and, "[Family member] is safe; they have an alarm mat set up in their room now. They also have an hourly check, plus passing traffic. I feel more comfortable with [family member's] safety and wellbeing now."

Staff had safeguarding vulnerable adult's procedures and whistle blowing (reporting poor practice) procedures to refer to. Safeguarding procedures are designed to provide staff with guidance to help them protect people from abuse and the risk of abuse. Staff had received safeguarding training and understood how to protect people from abuse; they were clear about the action to take if they witnessed or suspected abusive practice. They told us they would have no hesitation in reporting any concerns either to the management team or to other agencies and were confident the registered manager would listen and respond appropriately to their concerns.

The manager was clear about their responsibilities for reporting incidents and safeguarding concerns to the appropriate agencies. Action to be taken and lessons learned from incidents had been discussed with staff during meetings and shared with the provider. Arrangements were in place to respond to external safety alerts to ensure people's safety.

We looked at how new staff were recruited. We looked at three staff recruitment records and found checks had been completed before they began working at the service. This included an enhanced Disclosure and Barring Service (DBS) check, which is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Proof of identification and suitable references had been obtained. However, a full employment history had not been obtained and health records were not available; the manager showed us a revised application form and reference request form to be introduced for any new applicants. Employment checks would ensure that staff employed were suitable to provide care and support to people living at the home. Regular checks on the registration status and fitness to practice of all nursing staff had been completed. When agency staff were

used, confirmation was received that they were fit and safe to work in the home.

We looked at the arrangements for keeping the service clean and hygienic. We found all areas to be clean; we did note some slight odours on areas on the first floor; these were attended to as part of the cleaning schedule. People told us, "The home has got good cleaners now, two of them" and, "The home is clean." There were infection control policies and procedures for staff to refer to and staff received training in this area. Staff were provided with protective wear such as disposable gloves and aprons and, suitable hand washing facilities were available to help prevent the spread of infection. The service had designated domestic staff; cleaning schedules were in place and reviewed each week by the manager. At the time of the inspection, there was no designated infection prevention and control champion. However, the manager was responsible for conducting checks on staff practice in this area, attending local forums and for keeping staff up to date. The laundry had sufficient equipment to maintain people's clothes.

Equipment was stored safely and we saw records to indicate regular safety checks were carried out on all systems and equipment. People had access to a range of appropriate equipment to safely meet their needs and to promote their independence and comfort.

There were arrangements in place for ongoing maintenance and repairs to the building. A system of reporting any needed repairs and maintenance was in place. We were told new fire doors and a door for the first-floor stairway were on order to keep people safe. We suggested this was risk assessed and shared with staff. Records showed repairs were undertaken promptly.

Training had been provided to support staff with the safe movement of people. We observed staff using safe practices and offering kind re-assurance when supporting people to move around the home. Records showed staff were trained to deal with healthcare emergencies.

Records showed staff had received fire safety training. Regular fire alarm checks had been recorded to ensure staff knew what action to take in the event of a fire. Each person had a personal evacuation plan in place in the event of a fire, that assisted staff to plan the actions to be taken in an emergency. The fire safety officer had visited in October 2018 and recommendations had been made such as the replacement of fire doors; action was being taken to address the shortfalls.

The environmental health officer had visited in September 2018 and had awarded the service a five-star rating for food safety and hygiene; we noted that any recommendations made during the visit, were being acted on. There was key pad entry to the home and visitors were asked to sign in and out which would help keep people secure and safe.

Good

Is the service effective?

Our findings

People told us they were happy with the service they received and felt staff were knowledgeable and competent in their work. They said, "The staff know what they are doing and they do have training. I don't see them doing anything wrong." Visitors said, "I've never seen a problem with regards to staff competence. They all appear to have a sympathetic ear with regards to communicating with people. They know how to ask the right way so people understand."

Before a person moved into the home, a thorough assessment of their physical, mental health and social needs was undertaken to ensure their needs could be met. The assessment was based on good practice guidance in areas such as falls, skin integrity and nutrition; this ensured best outcomes of care, treatment and support were achieved for people. Most people, or their relatives, were enabled to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff could determine whether the home was able to meet their needs.

We looked at how the service trained and supported their staff. The training plan showed that staff received a range of training that enabled them to support people in a safe and effective way. We noted there were gaps on the training matrix; the manager was aware of the shortfalls and additional training updates were planned. All staff had achieved or were working towards a recognised care qualification. The service had started to participate in training provided by the local commissioners, which would help the staff to provide people with safe, effective and consistent care. Nursing staff were provided with additional training and support to maintain their registration and to meet the specialised nursing needs of people living in the home.

Staff were provided with regular one to one supervision and told us they were supported by the manager. Supervision provided staff with the opportunity to discuss their responsibilities and to develop their role. Staff were also invited to attend regular meetings and received an annual appraisal of their work performance.

New members of staff participated in a structured induction programme, which included an initial orientation to the service, working with an experienced member of staff, training in the provider's policies and procedures, completion of the provider's mandatory training and, if new to care, undertaking the Care Certificate. The Care Certificate aims to equip health and social care workers with the skills and knowledge which they need to provide safe, compassionate care. Agency staff also received a basic induction when they started to work in the home; this helped keep themselves and others safe.

Staff told us communication about people's changing needs and the support they needed was good. Records showed key information was shared between staff and staff spoken with had a very good understanding of people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. There were policies and procedures to support staff with the MCA and DoLS and records showed staff had received training in this subject to help improve their understanding of the processes. We were told applications had been submitted to the local authority for consideration and appropriate authorisations were in place and kept under review.

People's overall capacity had been assessed and their capacity and consent to make decisions about care and support was referred to in the care plans. However, we noted people's wishes had not been consistently recorded in areas such as information sharing, personal care, involvement, gender of staff who supported them, medicine management or taking photographs. This meant that people, particularly those with limited decision making, may not receive the help and support they needed and wanted. The manager was aware of this shortfall and action was being taken to review this. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff understood the importance of gaining consent from people. One person told us, "The staff don't do anything you don't want them to do" and, "The staff always ask you if you would like support. There is no pushing you into anything."

We noted people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions in place. Each person's doctor had signed the record and decisions had been taken in consultation with relatives and relevant health care professionals. A DNACPR decision form in itself is not legally binding. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. Where possible, we found people's care plans reflected their decisions and preferences in relation to this. The manager was aware a policy was needed to guide staff with this.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history and any needs related to their health. Appropriate referrals had been made to a variety of healthcare agencies including GPs, dietitians, speech and language therapists, dentists and opticians. The nurse practitioner and district nursing team regularly visited the service and monitored the care and treatment of people living in the home. Staff could access remote clinical consultations which meant prompt professional advice could be accessed at any time and in some cases, hospital visits and admissions could be avoided. People considered they received medical attention when they needed.

Information was shared when people moved between services such as transfer to other service, admission to hospital or attendance at health appointments. People were accompanied by a record containing a summary of their essential details and information about their medicines; where possible, a member of staff or a family member would accompany the person. In this way, people's needs were known and considered, and care was provided consistently when moving between services. Visitors confirmed they were informed

of any changes to their family member's health.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals and that they had been given a choice. People said, "We have fresh vegetables; carrots, peas broccoli" and, "I'm happy with the food. They had something that I didn't want today so they came back and offered something else." A visitor said, "Since [family member] has been here they can't get enough puddings, and it's helping with their weight loss." Another relative made comments about the good quality of the food.

We observed lunch being served. People were asked for their choices earlier in the day and their choices were confirmed again whilst at the dining table. The menus were not displayed and were not available in a suitable format for people living in the home. Following the inspection, the manager told us picture menus were being developed. Some people sat at the dining tables whilst others remained in their bedrooms or in their armchairs; people thought this was because the dining room was too small to accommodate people's wheelchairs. The dining tables were attractively set with napkins, flowers and condiments. Adapted cutlery and crockery and protective clothing was provided to maintain people's dignity and independence. The meals looked appetising and the portions varied in amount for each person. The meals were brought in a hot trolley.

The meals served were nicely presented. We overheard friendly conversations and banter during the lunchtime period and we observed staff patiently supporting and encouraging people with their meals. However, we observed one person supported to eat their meal in bed; we noted the member of staff stood over them rather than being seated on their level. Hot and cold drinks were offered during the meal. People confirmed they were offered a supper and cold, hot and alcoholic drinks were served between meals. One person said, "I'm awake at 5am and a cup of tea always comes at 6am so I don't have to wait for breakfast time."

Information about people's dietary preferences and any risks associated with their nutritional needs was shared with kitchen staff and maintained on people's care plans. Staff provided people with appropriate food and drink in line with their care plan. Food and fluid intake charts had been implemented for those people deemed at risk; records were being monitored to identify any deficits in people's dietary intake and any gaps in the records. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed. This was confirmed by two visitors that we spoke with.

We looked at how people's individual needs were being met by the adaptation, design and decoration of premises. We looked around the home. We found the home was comfortable and warm; aids and adaptations had been provided to help maintain people's safety, independence and comfort. Communal areas were comfortable and spacious.

We found the home to be spacious and bright but found some areas in need of redecoration and refurbishment such as damaged carpets, shabby corridor decoration and faulty glazing. However, the manager could describe what improvements were needed and there was a development plan for the home which was updated each month and discussed with the provider. There were plans to improve the home for people with visual or perception difficulties such as with signage and the use of contrasting colours. Aids and adaptations had been provided to help maintain people's safety, independence and comfort. We noted people using the corridor handrails to help with safe mobility.

Communal areas were bright and comfortable with additional seating areas available on the corridors. People told us they were happy with their bedrooms and some had arranged their rooms with personal

possessions that they had brought with them; this promoted a sense of comfort and familiarity. Some bedrooms had personal items displayed outside, such as photographs or names which would help people with a sensory disability to recognise their individual bedrooms. We were told further work was underway to make the home more suitable for people living with dementia. Some bedrooms had en-suite facilities and bathrooms and toilets were located within easy access of bedrooms; commodes had been provided where necessary.

The gardens and decking areas were safe, and people had enjoyed sitting out in the warmer weather. However, the garden paths and the driveway needed attention to make them safe and accessible for people and their visitors.

Good

Is the service caring?

Our findings

People spoken with were happy with the care and support they received. They told us they were treated with care and kindness and were treated equally and fairly. They said, "I do think the staff care, they are kind to you and help you" and, "The staff are kind and very caring. I can overhear them when they are helping someone in their room and they talk very nicely to them."

People made positive comments about the staff at Palace House Care Home. They said staff were kind, friendly and caring. We saw a number of compliment cards that highlighted the caring approach by staff. People had commented, "We can never express our gratitude for the love and care you have shown" and, "You gave us comfort knowing she was in your care." We also noted a comment from an independent review site, "The home and care staff are brilliant, well caring and are very dignified. I have been a resident for almost three years and I am still as happy as I was when I came."

People were encouraged to maintain relationships with family and friends. Friends and relatives confirmed there were no restrictions placed on visiting; we saw they were made welcome and some could dine with their family member and join in with the activities. One person said, "My friends can visit anytime I want them to. We can be private if we want to be."

People appeared comfortable in the company of staff and it was clear they had developed positive trusting relationships with them and with their relatives and friends. We observed staff interacting with people in a caring, affectionate and respectful manner and observed good relationships between staff and people living in the home. Where possible, people could make their own choices and were involved in decisions about their day. One person said, "I do more or less what I want really. People seem quite free to choose here" and, "We are free to choose; I do everything for myself but I could ask for support if I wanted."

We observed people were treated with dignity and respect and without discrimination. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. People were dressed comfortably and appropriately in clothing of their choice. We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills. During the inspection, we noted caring interactions and encouragement. A member of staff noted a person was unsteady. They said, "Are you alright? That's it, use your walker. Don't fall, take your time and I'll get the door." The member of staff continued to monitor the person whilst encouraging them with their independence. The person was appreciative of the staff member's patience and kindness.

People told us the staff respected their privacy and all staff were bound by contractual arrangements to respect people's confidentiality. We observed personal care interventions being carried out behind closed doors in the person's bedroom or bathroom. People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms and they could spend time alone if they wished. However, we noted care posters and guidance for staff was displayed on the wardrobe doors which detracted from the homeliness and comfort of the rooms. We discussed this with the manager.

People's wishes and choices with regards to spiritual or religious needs were recorded; religious services were held in the home or people could attend the local place of worship. Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and members of the management team, we were satisfied care and support was delivered in a non-discriminatory way and people's rights, protected characteristics and individuality were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality. However, to fully embed the principles of equality, diversity and human rights we recommend the service consults the CQC public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.

People were encouraged to express their views by means of daily conversations and during residents' and relatives' meetings. The meetings helped keep people informed of proposed events and gave them the opportunity to be consulted and make shared decisions. We found people's views had been listened to and acted on in areas such as the provision of activities and meal choices.

Useful information was displayed on the notice boards and informed people about how to raise their concerns, also included was information about safeguarding, activities and events in the local community. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

The manager told us that people had not been routinely provided with a brochure or guide to the service on admission to the home. People needed information about the services and facilities available in the home and what to expect when they moved into the home. Following the inspection, the manager sent us a copy of the new service user guide; we were told this would be shared with people living in the home and with prospective residents and their relatives. The manager told us the information could be made available in other formats to ensure it was accessible to everyone.

Good

Is the service responsive?

Our findings

People were happy with the personal care and support they received and made positive comments about the staff and about their willingness to help them. People said, "The staff are very good, they are lovely; they listen to me and do things the way I want", "It is a first class service" and, "The staff are helpful and nothing is too much trouble; I am looked after very well and I like living here."

We looked at whether people received personalised care that was responsive to their needs. We looked at four care plans and associated records and found improvements had been made to the way people's care was planned and managed. The care records had been developed, where possible, with contributions from each person and their relatives. People's needs had been assessed before they started living at Palace House Care Home, to ensure that the staff were able to meet people's needs.

The care plans were organised and included information about people's likes, dislikes, preferences and routines which would help ensure they received personalised care and support in a way they both wanted and needed. Some information, in relation to personal choices such as clothing and activities and types of specialist equipment, was not always clear in all the care plans. However, this area was being developed with the collection of 'This is Me' information. Information about people's changing health needs and specialised care needs were recorded and the advice given by health care professionals was documented and followed.

People's care and support had been kept under review and records updated on a regular basis or in line with any changes. However, we noted some updated information about people's changing needs had not been added to the overall plan from the review information; this meant there was a risk that information about people's needs may not be accurate and known to staff. We discussed this with the manager and the clinical nurse lead who assured us this would be shared with nursing staff and acted on.

People said they were kept up to date with any changes and involved in decisions about care and support. They said, "I think I know enough to sign my care plan", "I sign the paperwork if there is anything to sign" and, "The care plan is being reviewed with me for the first time since [family member] came here about 12 months ago."

At our last inspection, we recommended the provider sought advice regarding people's involvement in the care planning process and in regular reviews of their care and support. During this inspection, we found there had been some improvements and some people, or their relatives, were involved in a review of the care plan and in providing useful information about preferences, interests and routines. Some people participated in the 'Resident of the Day' which meant people, and their relatives, would be invited to discuss and review the content of their care plans; we noted there had been some gaps in the delivery of this process but were told they would recommence. The manager was aware the review process needed further development to ensure a consistent approach; appropriate action was being taken to address this.

Daily records were maintained of how each person had spent their day and of any care and support given;

these were written in a respectful way although the quality of the information recorded was varied. There were systems in place to ensure staff could respond to people's changing needs. This included a handover meeting at the start and end of each shift and the use of handover sheets and communication diaries. Staff told us communication had improved.

We looked at how the service managed complaints. People were not aware of the complaints procedure. However, they told us they would feel confident enough to speak with a member of staff or to the manager if they had a complaint. Visitors said, "I feel listened to now" and, "There was just a minor problem once, and it was sorted out quickly." The service had a policy and procedure for dealing with any complaints, which was displayed in the entrance and was now available in the new service user guide. A suggestion box was also available in the entrance.

We looked at the records of complaints. We found two recorded complaints had been responded to regarding concerns about the changes to management and about care. Following our discussions with people, it was clear one person's concerns had not been recorded. We discussed the importance of recording both minor concerns and complaints; this would help to determine any themes, demonstrate that people's concerns were taken seriously and show that appropriate action had been taken. The manager assured us this would be followed up in line with procedures.

We looked at how people could access meaningful and interesting activities. At our last inspection, we recommended the provider sought guidance from a reputable source regarding the provision of suitable activities for people. People told us, "We sit out in the garden when it's nice" and, "We have entertainment here and we have bingo and things like that. We have videos and CDs; sometimes we sing along to them."

The service employed an activities coordinator. During the inspection, we noted there were generally no planned activities provided but people were asked each day what they would be interested in. We discussed with the manager how a record should be maintained to support activities that had taken place. We observed people participating in chair exercises, watching musicals, participating in Halloween themed movies and activities, one to one and group chats and going out to the shops with staff. One person was planning a shopping trip with a member of staff; they were involved in compiling a shopping list for those people that were not able to leave the home. People were supported to maintain local community links and visited local shops and the park, garden centres, pubs and clubs and cafes either with staff or their visitors. Outside entertainers were booked on a regular basis.

We looked at how the service supported people at the end of their life. The manager told us staff followed guidance from specialist professionals and ensured that anticipatory medicines were in place to keep people comfortable; training had been provided for staff. Where possible, people's choices and wishes for end of life care were being recorded, kept under review and communicated to staff. Where people's advanced care preferences were known, they were shared with GP and ambulance services. There were systems in place to ensure staff had access to appropriate end of life equipment, training and advice.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information for staff. E-learning formed part of the staff training and development programme. Sensors or pressure mats were used to alert staff when people were at risk of falling and pressure relieving equipment was used to support people at risk of skin damage. One person used audio books and films that were translated into a language that they were familiar with. The staff could access out of hours professional advice with the telemedicine services. There was a policy to support management and staff with this.

We asked the manager what actions they had taken to meet the accessible information standard. The accessible information standard was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. There was a policy to support management and staff with this area. The manager told us information could be provided in different formats to meet people's communication needs. We noted information was displayed on notice boards and some of the information was in larger print. We discussed how the provision of information in pictures and symbols could improve people's understanding and accessibility to information such as with the results of surveys, meetings and menus. The registered manager gave assurances this would be reviewed. We found there was information in people's initial assessments about their communication skills to ensure staff were aware of any specific needs.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoken with told us they were satisfied with the service provided at Palace House Care Home and with the way it was managed. One person said, "It's a good place to be in. I think it is managed well." A visitor said, "The manager is in the office on the corridor. A new broom but it takes time", "I really don't think the management is good", "Everybody seems in good spirits", "I have seen a change for the better. [Manager] does listen" and, "[Manager] is always available for a quick word."

Staff commented, "The providers come and are happy with everything; they take time to speak with staff", "I like [the manager]; she is fair but firm and not overfriendly with staff so she can do her job properly", "Everything is a lot better. Communication has improved and everyone is working together" and, "[The manager] makes things happen. She values us and we are all important."

During this inspection, we found the previous registered manager had left the service. A new manager had been in post from August 2018. We had not received any applications to register them with CQC. It is a condition of the provider's registration that there is a registered manager in post. The manager told us they would be forwarding an application to register with CQC.

Our findings from this inspection, demonstrated there was a breach of regulation in relation to medicines management. This meant that Palace House Care Home had been rated Requires Improvement for four consecutive inspections. In addition, there had been three changes to the management of the home over a two year period; this made it difficult to introduce and sustain improvements and did not provide consistency for people living in the home, their relatives and staff.

The manager had responsibility for the day to day operation of the service and was visible and active within the service. The manager was not a registered nurse and therefore was unable to make clinical or nursing decisions about people's care; she was supported by a clinical lead nurse who was a registered nurse. The manager was regularly seen around the home, and was observed to interact warmly and professionally with people and staff. The manager told us she was committed to the continuous improvement of the service and could describe the planned improvements for the year ahead. There was an improvement plan available that was updated on a regular basis. We discussed how the recommendations made by other agencies such as the fire safety officer and environmental health officer and the findings from regular audits could be recorded in one place.

The manager was supervised and supported by an area manager who visited the service on a regular basis, and by an external agency that was responsible for quality monitoring on behalf of the provider. The manager provided weekly reports to the provider in relation to areas such as accidents and incidents, falls, infection control, admissions, discharges and complaints; this would assist the provider with monitoring the management of the service and would improve their oversight of the service. The provider also visited the service each month. The manager could access support and advice from managers from other homes within the organisation.

During this inspection, we looked at the way the service was being monitored. We found there were systems in place to assess and monitor the quality of the service in areas such as medicines management, staffing, care planning, infection control and the environment. We noted shortfalls had been identified, timescales for action had been set and actions were shared with and monitored by the provider. However, the audit tools had not identified the shortfalls found during the inspection in relation to medicines management. The manager told us checks on all recruitment files would be undertaken and a new medicines audit tool was being introduced for the following months checks. The manager told us an audit tool to monitor falls, accidents and incidents was being developed to provide more analytical information. Following the inspection, we were told this was in place.

The manager was completing quarterly reports for the health commissioners which included an overview of falls, pressure sores, DoLS and infection rates in the home. She undertook a daily walk around the home to monitor standards and to discuss any concerns with staff and people living in the home and had carried out unannounced out of hours visits to monitor quality provision at different times.

We found that records were managed appropriately at the home. People's care records and staff members' personal information were stored securely and were only accessible to authorised staff. Systems and records were being updated in areas such as care planning and review, complaints information, consent, medicines management and accident and incident recording, in response to the findings from the auditing systems.

People were encouraged to share their views and opinions about the service by talking with management and staff, by completing feedback forms and by attending meetings. Regular resident and relative meetings were held; areas discussed included menus, activities, housekeeping and cleanliness. One person said, "They ask if we are getting our washing back alright and about the food etc. They've told us we are getting new chairs soon and new cushions." There was good evidence people's views had been listened to.

An annual satisfaction survey had recently been sent out to people and their families; the results would be analysed and shared with people so they knew what action was being taken to respond to their comments. Staff had also completed a satisfaction survey this year; the results from this were positive.

Staff said they worked well as a team and felt supported to carry out their roles and felt they could raise any concerns or discuss people's care with the manager. There was a clear management structure. Staff were aware of the lines of accountability and who to contact in the event of any emergency or concerns; there was always a senior member of staff on duty with designated responsibilities.

Regular staff meetings had taken place and records showed they discussed a range of issues and had been kept up to date. Staff were provided with job descriptions, contracts of employment, a staff handbook and had access to policies and procedures which would make sure they were aware of their role and responsibilities. Policies and procedures were kept up to date but some such as the safeguarding and whistleblowing procedures needed to be personalised to the service.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC and other agencies. We noted the service's CQC rating and a copy of the previous inspection report was on display in the home and on the provider's website. This was to inform people of the outcome of the last inspection.

We saw evidence that the service worked in partnership with a variety of other agencies. These included

community nurses, GPs, podiatrists, dieticians, speech and language therapists, hospital staff and social workers. This helped to ensure that people had support from appropriate services and their needs were met. The manager had also developed links with the local commissioners to access appropriate guidance and training.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's medicines were managed safely. Regulation 12