Methodist Homes

Berwick Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 30 January 2018. The first day of the inspection was unannounced.

Berwick Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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.

Berwick Grange offers both residential and nursing care for up to 52 older people and people living with dementia. Accommodation is provided over three floors, each of which has separate communal facilities. Residential care is provided on the ground floor and nursing care is provided on the upper floors. At the time of our inspection there were 52 people living at Berwick Grange, 32 of whom required nursing care.

There was a registered manager in post. A registered manager is a person who has registered with the 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. The registered manager was available and assisted on both days of the inspection.

At the last inspection on 22 December 2015, the home was rated Good. At this inspection we found standards had not been maintained and required improvement. This is the first time the service has been rated Requires Improvement.

We found breaches of Regulation 12 (safe care and treatment) and Regulation 17 (good governance) of the Health and Social care Act 2008 (Regulated Activities) 2014.

Staff were not consistently following the provider's medicine policy and this meant people were at risk of not receiving their medicines safely. For example, medicines that required cold storage were not always stored at the correct temperature. Arrangements were not in place to ensure people's topical medicines such as creams and ointments were well managed. There was limited specific written guidance for the use of 'as required' medicines to enable staff to provide a consistent approach to the administration of this type of medicine.

Risks to people were identified and assessed but care plans to reduce those risks and guide staff on how to manage specific risks were not always established. This meant people were at risk of receiving unsafe or inconsistent care.

Management systems were not always effective in identifying shortfalls in the quality of the service. Some records were not complete or well maintained and staff training was not fully embedded or supported by effective supervision and support. This had led to inconsistency in some areas of practice across the home.

Staff were recruited safely. Whilst there were enough staff on duty to care for people safely, the availability of staff sometimes impacted people's care. This was identified as an area that needed to improve.

Staff had received training but our observations were that staff did not always apply their learning in practice. We saw staff who were confident, polite, well-mannered and accommodating however we also saw examples of inappropriate staff responses. We have made a recommendation about staff training on the subject of dementia.

People received a varied diet. However our observations were that some people did not always receive the consistent help they needed to eat their food. This was identified as an area of practice that needed to improve.

Arrangements were in place to maintain the cleanliness of the home but these were not always effective in practice. We found some areas, which required updating. We made a recommendation that the provider seeks further information about best practice in the use of colour and design within the environment to help people with dementia to orientate themselves in time and place. Environmental risks were assessed and monitored and the home and equipment were well maintained.

While we found that people did not always receive consistent care and support relatives spoke highly of the staff and said they were caring and compassionate. Relatives and volunteers were actively involved in people's daily care and activities. We saw that this involvement, together with that of the home's Chaplain and the music therapist promoted people's spiritual needs and enhanced their sense of wellbeing. People had maximum 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.

Staff supported people to access health care services and we saw that a range of health care professionals had contact with people at the home. One visiting health care professional told us that staff always made appropriate requests and complied with any guidance provided about people's health conditions.

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

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.

Medicines were not always managed safely.

When risks were identified suitable risk management plans had not always been established.

The provider had effective recruitment procedures in place. Although there were enough staff to meet people's needs safely, staff deployment was not always consistent.

Appropriate infection control procedures were in place although these were not always effective in practice.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training but they were not always applying their learning in practice. Some people did not receive the help they needed at mealtimes.

Environmental adaptations did not follow best practice guidance on good dementia care.

People's capacity and consent was documented. Deprivation of Liberty Safeguards applications were made appropriately. People received support to access health care services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

While people valued their relationships with the staff team staff did not always have sufficient time to spend with people. Care was task focused.

Reasonable adjustments had not always been put in place to ensure people's wishes were taken into account in the way care was provided to them.

People told us they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Records were not used effectively to ensure people received person centred care. The registered manager had recognised improvements were needed to care planning and recording and was planning to introduce new recording systems.

People could maintain relationships that were important to them. People's spiritual wellbeing was promoted. People had access to a music therapist.

Staff supported people to plan for care at the end of their life.

Although some people felt that their complaints were not always taken seriously at a local level, senior managers kept complaints under review and responded appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some management systems and processes were not effective in identifying shortfalls and omissions in the quality of the service.

There was a clear leadership structure with identified management roles.

Staff understood their roles and responsibilities. The registered manager had submitted notifications to CQC in a timely way.

People who used the service, relatives and staff members were asked to comment on the quality of care and support. Although meetings were routinely held these were not always being used effectively to promote continuous improvement.

Berwick Grange

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.

CQC was aware of a past injury sustained at the location. We explored particular aspects of current care and treatment during the inspection regarding how the provider assessed and mitigated risks for people living with dementia.

The inspection took place on 24 and 30 January 2018. The first day of inspection was unannounced. The inspection team consisted of an inspection manager, two adult social care inspectors, a specialist advisor who was a registered nurse, and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On 24 January 2018 two inspectors visited, together with the inspection manager and the specialist advisor. On 30 January 2018 one inspector visited the home with the experts by experience.

As part of planning our inspection, we contacted the local authority safeguarding and quality performance teams to obtain their views about the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We used this information to inform the inspection.

We spoke with 15 people using the service, six relatives and 12 staff, including the registered manager, an area manager, nurses, care staff, an activity coordinator, domestics, the home's Chaplain and a music therapist.

We looked at care plans and associated medicine records for six people. We observed medicines being administered in two areas of the home. We used the Short Observational Framework for Inspection (SOFI).

SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the lunchtime experience and the way people were supported in communal areas and we looked at records relating to the management of the service. These included recruitment files for four staff , daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Following the inspection we asked the registered manager to send us a sample of policies and procedures, training and supervision records, and the home's improvement plan. This was sent us within the required timescale.

Requires Improvement

Is the service safe?

Our findings

We checked the arrangements for the management of medicines. We found medicines were not always stored or handled safely. Records showed medicine fridge temperatures were outside the safe recommended temperatures on 23 occasions in November and December 2017. This meant that the quality of medicines that required cold storage may have been compromised, as they had not been stored correctly.

Staff used an electronic medicines record (eMAR) to record medicines administration. The application of topical medicines such as creams and ointments was recorded on supplementary topical medicines administration records (TMARs). These did not include instructions regarding the frequency of application and the area of body where creams were used so we could not be sure these medicines were appropriately managed and used.

A relative told us staff did not always wait to make sure people had taken their medicines. They said, "Sometimes I've seen people with tablets in their chairs after they've been given out." We observed instances of medicines left unattended in resident areas on three separate occasions, which we raised immediately with the deputy manager.

Where people were prescribed 'as and when required' (PRN) medicines protocols were not always in place for staff to follow. For example, for one person they were prescribed anti-anxiety medicine. A detailed plan which told staff what steps to follow before administering their PRN medicine was not in place. This meant they were at risk of receiving medicines before other, less restrictive, methods were fully explored.

Medicine audits had not picked up on the issues we found. Where shortfalls had been identified, such as in the pharmacist report of December 2017, a consistent action plan was not in place to address the issues and we found similar concerns at our inspection.

Staff were not consistently following the provider's policy and procedures for managing medicines safely and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were used to determine the level of risk and action taken to mitigate the risks to the health, safety and welfare of people. Risk assessments were completed for moving and handling, mobility, falls, nutrition and hydration, continence and skin integrity. For one person who was at risk from diabetes there were no risk management plans in place to show how their health was to be maintained. The weight loss for this person had not been calculated correctly meaning their weight loss had not been recognised and referred to the GP in line with the provider's policies and procedures. The deputy manager told us that this person required a high calorie diet but records were not in place to monitor their food and fluid intake.

The food record chart for another person recorded they had refused breakfast on the second day of our inspection. At 2.15 pm we observed the person was still in bed. There was no record of further food or drink

being offered during the day. Staff said that it was the person's choice to remain in bed. Records were not in place to guide staff on how they could encourage this person to eat and drink. For example, by offering finger foods or other snacks and drinks between meals. The above matters place people at potential risk of harm and was further evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment process to ensure appropriate checks had been made to establish the suitability of each candidate before they were employed. Relevant references and a result from the Disclosure and Barring service (DBS), which checks if people have any criminal convictions, had been obtained. Records of checks with the Nursing and Midwifery (NMC) to check nurses' registration status were available and up to date.

Staffing levels were kept under review using a recognised staffing tool. People told us there were enough staff but their availability sometimes impacted on the quality of care people received. A relative told us, "Sometimes there is enough staff and other times there is no one about. I think it is when they have a break they all seem to go off for a break at the same time. That could be managed better. It would be better if they staggered it so that there were some staff around all the time." Another relative said, "Staff are reduced in the evenings and there can be a lack of supervision at these times." We observed there were times that staff were not obviously present in certain areas and noted that this corresponded to times when staff went for breaks. While we found enough staff were employed staff deployment needed to improve.

Arrangements were in place to maintain the cleanliness of the home but these were not always effective in practice. We saw that some areas such as sluice rooms required repair and refurbishment to allow for effective cleaning. We showed the registered manager dirty furniture in one person's room and we saw bedding that was of poor quality and was stained. This showed a lack of cleanliness and respect for people using the service. The registered manager explained this was due to recent malfunctioning of laundry equipment, which had resulted in the staining. They could not explain why these items had not been taken out of circulation.

Risks in relation to the safety of the building were assessed. People had personal emergency evacuation plans (PEEPs) so that staff knew how to support people in an emergency. We saw equipment had been regularly tested and certificates were in date. Staff told us they had received training on health and safety issues including fire safety awareness training and records confirmed this.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider supported staff to develop their knowledge and skills. Training records showed that staff received training in a wide range of topics depending on their experience and role within the organisation. Examples included moving and handling, safeguarding, fire safety, dementia awareness, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

A consistent theme relatives raised was that the quality of care was variable and dependent upon who was on duty. Comments we received included, "By and large the staff are competent but some staff are not up to scratch;" and, "Some of the carers are excellent and really know what they are doing and follow procedure, but others don't;" and, "I think some of the staff know [Name] very well, but some wouldn't know what assistance [Name] needs."

During our inspection we observed examples of inconsistent practice and approach that we had been told about. We saw staff who were confident, polite, well-mannered and accommodating. We also saw negative staff responses, which appeared to arise from a lack of understanding and misinterpretation of behaviours. We discussed this with the registered manager who agreed to take further action with the staff concerned. The registered manager told us that one staff member had attended a 'train the trainer course' to cascade dementia training to improve staff awareness and knowledge about good dementia care.

We found care was task based, which could impact the wellbeing of people living with dementia. While structured activities were offered daily not all staff had the knowledge and skills to keep people's interest stimulated and engaged at other times. Staff told us they received supervision but they demonstrated limited understanding how these could be used to explore new ways of working or to develop reflective practice. A relative told us they had recognised the problems facing less experienced staff and had suggested a system of mentoring to the registered manager. We have identified that this is an area of practice that needs to improve.

We recommend that the provider reviews best practice guidance and uses this to develop staff knowledge and skills about good quality dementia care.

A lack of colour around the building made it difficult to identify specific areas and could be disorientating for people living with dementia. There were limited adaptations or appropriate signage to meet the needs of people to move around the home or access an outside area independently. Where adaptations were in place staff were not routinely using these for their intended purpose. One example was the empty 'memory boxes' and nameplates at bedroom doors, which were designed to help orientate people to their surroundings. This demonstrated a lack of attention to detail and highlighted staffs' lack of underpinning knowledge about dementia care, which we had already identified. While there was a well-equipped sensory room limited items were provided elsewhere to help engage people's interest.

We recommend that the provider seeks further information about best practice with regard to environmental design for people who are living with dementia.

Care plans included people's dietary needs and recorded individual preferences. Records included notification to the kitchen regarding specialised diets. For one person, their care plan stated, 'diabetic diet - to be offered a varied diabetes diet'. There was no specific information regarding what this consisted of and to guide care staff to support the person's nutritional well-being. The deputy manager told us that they would seek additional evidence-based guidance from the Diabetes UK organisation to include in the person's care file.

Relatives told us that there was plenty of food and drink available and people's nutritional needs were met. Their comments included, "They offer [Name] different foods when they are not eating," "The food is good. [Name] is a good eater," "[Name] is on a soft diet which is dictated by the hospital and is met," and, "The food looks lovely and varied." One relative however commented, "The meals are not as varied as they used to be." We discussed this with the chef who told us that the menu had been imposed from head office.

We identified areas of inconsistent practice during mealtimes. People seated at dining tables received appropriate staff support to eat their meal. Staff sat alongside people close enough for privacy and to provide individual assistance. Some people were served their meal while sitting in armchairs or in their rooms. In these cases tables were not correctly placed at the right height to support independent eating. For example, for one person the table was too low. Although they were trying to ladle soup from a bowl with a spoon there was a large volume of spillage. Staff did not intervene to help the person and they ended up drinking from the bowl. Another person who was served with soup in a cup, sandwiches and juice was left unsupervised to manage their meal and this went largely untouched.

A number of relatives told us they came in to assist staff and help with mealtimes. One relative told us, "There are not enough staff as the condition of people here has deteriorated. That's why I come to help, it's not convenient but I come so [Name] gets fed."

On our arrival on the first day of inspection we noted that tables were poorly presented. At subsequent meals tables were nicely set with appropriate cutlery, tablecloths and condiments. Menus were on each table with details of both lunch and tea but these were not easy read or accessible. Staff told us that they showed people meals from which they could make a choice and we saw this process being used during our visit.

While we found people were offered a nutritious diet the mealtime experience was not consistent across all areas and needs to improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. People's records contained a pre-admission assessment to assess people's needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort. Consent to care and treatment records were signed by a relative, where people were unable to sign. The registered manager told us new forms took account of relative's legal authority to be able to sign

on people's behalf.

People's care plans reinforced the need to involve people in decisions about their care and to promote their independence. For example, one person's personal care plan detailed their preferred bathing routines and staff confirmed this was followed when planning their day. Care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions and on-going involvement of GPs and health care professionals. A visiting health care professional told us that staff always made appropriate requests and complied with any guidance provided about people's health conditions.

Requires Improvement

Is the service caring?

Our findings

We received differing views regarding staff approach and how people using the service were involved and encouraged to express their views. Staff spoke about the people they supported respectfully. One staff member told us it was a good home with a loving atmosphere but that staff were short of time to spend with people because of increased dependency levels.

Relatives told us that some staff knew people very well and had a good understanding of their needs. People's wishes with regard to their preferences however were not always recorded or taken into account when care was provided. For example, some people speaking with us expressed a stated preference for a staff member of a specific gender to assist them with personal care tasks. This was not recorded in their care plan so that their wishes could be taken into account and met wherever possible. One relative said, "[Name's] dignity is respected yes, but there is no choice of staff and we are not keen on that." Another relative commented, When new staff arrive we are not introduced to them, they just turn up."

Care plans did not always include the specific adjustments people needed to maximise their engagement, involvement and inclusion. Some people had communication difficulties which meant that they could not always express themselves verbally. Information was not always presented to people in a way that made it easier to understand using signs, pictures, symbols or photographs. Not all staff knew how to engage positively with people living with dementia and we observed limited interaction on occasions. For example, we observed one person asked a member of staff to be directed to their bedroom. They conveyed this request by continually repeating the number of their room. The staff member they were speaking with did not answer them or respond in any way. We observed the person was becoming increasingly upset until another staff member stepped in to assist. We raised this with the registered manager who told us that staff were encouraged to help people make decisions about their care.

People's bed linen was generally of a poor quality unless people provided their own. Personal items such as continence pads were not stored discreetly, which could compromise people's dignity and privacy. We brought these points to the manager's attention who told us staff would be reminded of good practice. They said that the bed linen had been newly purchased.

While we identified areas for improvement we also observed areas of good care practice and staff were kind and gentle when they attended to people's personal care. Feedback from relatives included such comments as, "Overall, [Name] is well cared for, always nicely dressed nice and clean," "They are definitely respectful; they knock on doors," and, "Mum gets looked after well, it's all I care about."

People were dressed individually with clothes of their choosing and their rooms contained their personal belongings and items that were important to them. One person described an extremely positive relationship with a staff member. They said, "[Staff name] has empathy for everybody. They have got to know me and my situation very well, they are very kind." Other comments we received from relatives included, "They are absolutely kind and caring, I have never heard a raised voice even when people are difficult," and, "This is one of the best places for care and compassion. I wouldn't swap it."

Relatives told us they were actively involved in every aspect of their loved one's care. One relative told us, "I am involved in [Name's] care and I am involved in their care plan too." Another relative said, "They keep you informed," and, "I talk to the nurse every three months and more often if needed. I can always go to [Registered manager] the door is always open." One relative told us that staff were approachable, saying, "I talk to the care staff regularly they are all amenable to my suggestions."

Requires Improvement

Is the service responsive?

Our findings

Care plans contained person centred information about people's lifestyle choices and care preferences. For example, the care plan for one person record stated, "Favourites are salmon, brown bread, likes to eat fruit, and occasionally likes a glass of wine in the evening." For another person their communication plan included, "[Name] will answer yes / no when asked a question, needs time to think about what has been asked of them and needs a gentle reminder of the topic of conversation." This approach meant could staff provide responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

However, care plans relating to people's behaviour management were not personalised to include specific triggers for any distressed behaviour so staff could recognise them and offer appropriate intervention. There was also no information on why one person may present with distressed behaviour such as pain, being unwell, being over stimulated or having a low mood.

We found staff were dealing with complex recording systems that were time consuming and did not operate effectively. In practice, staff told us they relied on colleagues to pass on essential information to them verbally and through handover records. These records however did not always follow the principles of good record keeping. We saw frequent use of abbreviations, which can be misunderstood and lead to errors in the standard of care being delivered to people.

Information regarding people's care was kept on different records and these sometimes held incomplete or conflicting advice. For example, one person's care plan stated the person attended to their own toileting needs. However, we saw a monitoring chart in place to record this aspect of their care. When we spoke to the deputy manager they told us that the person did not require the chart and they would remove it. The care plan for another person stated they needed their dietary and fluid intake monitoring but monitoring records had not been put in place.

The failure to maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The registered manager told us about plans to develop an electronic system to record people's care plans, and to improve record keeping overall. They said work to provide people with information in an accessible format was on-going.

People we spoke with were generally happy with the activities offered at the home, although some people felt more activities could be provided. One person told us of plans to start a gardening club when the weather had improved. Comments regarding activities included, "There are some good activities here and a little one to one time. I'm quite sure [My relative] gets a choice in what they want to do and whether they want to join in or not," and, "There are a lot of activities and entertainers." Relatives and volunteers were actively involved in the day to day life of the home and attended the regular services and hymn singing, which the Chaplain led throughout the week. A relative told us, "It is family orientated here. They have

barbeques and we are invited for Christmas lunch."

People had access to dedicated music therapy sessions. For one person, we observed this resulted in a sense of wellbeing and improved their ability to talk and interact with others. The music therapist logged the person's response and rated the person's responses to enable them to measure progress. Staff reported a reduction in the frequency and severity of distressed behaviour for people who attended music therapy. A relative reported that their family member had appeared much happier and more alert after each session. They said they had been concerned when their programme of individual sessions had come to an end. They reported being pleasantly surprised when their relative subsequently retained their skills enabling them to take an active part in the group session, which they enjoyed.

There was a complaints policy in place. People told us they knew how to raise a complaint. One relative reported, "I would complain to [Registered manager]. I think they keep things running well." Another relative told us, "If I had complaints I would speak to the staff, nurses or the registered manager. I have had no complaints but they are always there if you have concerns." A common theme raise with us was that minor concerns and 'niggles' were not always taken seriously and resolved satisfactorily at a local level. One example raised with us was about changes to the joint resident / relative meetings. People felt these changes had been imposed on them without sufficient consultation and when they had raised concerns no further action had been taken. The registered manager told us they had introduced these changes to give everyone who used the service a say in the running of the home.

We looked at six complaints in the past year. Most of these had been well managed and had been responded to appropriately. The registered manager advised that any complaints had to be reported to head office within 24 hours so they could keep complaints under review. One complaint had no date of completion so it was not clear if this was still on-going. We discussed this with the registered manager who agreed to date any letters sent in response to a complaint.

People were supported to make plans for care at the end of their life. One staff member spoke about making sure that practical arrangements were in place such as ensuring all the medicines that might be needed were in place. Staff told us that relatives were involved to ensure they could accommodate the person's wishes and needs. Although people's records contained limited information about specific wishes for people of different faiths, or none, the registered manager could describe the arrangements in place for everyone to receive the spiritual support they required. Staff told us they received the training they needed to support people at this important time and we saw a book of remembrance had been developed to remember people who had lived at the home.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been registered with the Care Quality Commission in December 2016. In their feedback relatives were positive about the ethos of the home, the registered manager and staff. Comments we received included, "We chose this home because it was a Methodist home and we are very happy with it," "I see the manager every day. I have always thought the home was well run," and, "I would definitely recommend this home."

Management systems and processes were in place for the governance of the home. Audits were used to monitor quality and included senior management oversight to ensure that complaints, incidents and accidents were analysed. These systems were devised to help drive improvements.

However, we identified that not all management systems were understood and used effectively. For example, we found audits had not picked up on the issues we identified regarding medicines management and care records. When checks had identified shortfalls suitable action plans had not been put in place to ensure that the root cause was identified, action was taken, progress measured and appropriate lessons were learned. For example, the quality of mealtimes and their management was a recurring concern and theme at staff meetings. Clear goals however were not being set for staff to identify priorities and provide feedback on progress to consolidate and improve their performance. We saw an action plan had been developed in response to a visit, which the provider's internal quality team had undertaken in November 2017. The registered manager had signed off on most of the issues as completed yet we found concerns of a similar nature during our inspection.

Monitoring systems were not being used to ensure the support people received was of a consistently high standard. For example, the registered manager's daily 'walk around' had not picked up on the issues we found with regard to care practice, mealtimes, and the quality of the bed linen and the cleanliness of the home. We found that the impact on people living at Berwick Grange was mitigated to some extent by the care and support, which relatives and volunteers willingly provided each day. However, management systems to monitor staff were not adequate to provide us with sufficient assurance that people received appropriate care and support at all times.
Management systems were in place to monitor accidents and incidents to minimise the risk of re-occurrence. People were monitored following any untoward incident that affected their health and wellbeing and risk assessments were reviewed and updated. Monitoring forms did not detail the exact support staff were to provide, how they should monitor after the incident and who they should contact for additional support if needed. This meant that staff were not provided with guidance so as to manage situations in a consistent and positive way.

The lack of effective systems to monitor and improve the safety and quality of services was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Good governance.

We checked a sample of staff meeting minutes. Meetings followed a set format and topics were repeated at

each consecutive meeting. For example, care planning, training, medicines, health and safety. Some staff told us that they had no difficulty in raising an issue and these would always be addressed. For example, one staff member said they had asked for more hoists on each floor and these had been provided. Meeting minutes read as lists of instructions and were not inclusive of staff attending or focused on their needs, suggestions or aspirations in any way. Not all staff we spoke with said they felt confident to speak up at staff meetings. In these cases, staff said they asked for individual updates.

The registered manager understood their responsibilities to inform the Care Quality Commission, (CQC), of important events that happened. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not always fully assessed so that appropriate measures could be taken to minimise risks. Staff were not consistently following the provider's policy and procedures for managing medicines safely. Regulation 12(1) (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always effective in monitoring and improving the safety and quality of services to ensure compliance with the regulations. A complete and contemporaneous record was not always maintained in relation to each service user's care. Regulation 17 (1) (2) (a) (b) (c).