Alpha Care Management Services Limited

Grenville Court Care Home

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 was unannounced and took place on 18 February 2016.

Grenville Court Care Home is a care home that provides accommodation and personal care for up to 64 people. Although the home is registered to provide nursing care, this was not being provided at the time of our inspection. There were 53 people living in the home, all of whom were living with dementia.

During our last inspection in January 2015, we found that improvements were required in some areas. These included improving people's access to regular drinks, staff knowledge regarding how to support people effectively who were unable to consent their own care, the frequency of staff supervision and the provision of personalised activities and care to meet people's individual needs. We found that sufficient improvements had not been made in all of these areas and that other concerns were found during this inspection visit. These concerns resulted in six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

There is a manager at the home. They started working at the home in October 2015. They were not registered with us but we have received a registration application form from them. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run. The manager was not present during our inspection.

The provider had failed to make sure that the required improvements identified during the last inspection had been made. There were a lack of effective systems in place to make sure that all of the staff working within the home had the necessary skills to engage with the people living there effectively and safely. Regular assessments of staff's practice had not taken place and issues with current care practice that had been identified had not always been acted on in a timely way. These contributed to some people receiving poor quality care that was not always responsive to their needs.

The principles of the Mental Capacity Act were not always being followed when making decisions for people who lacked the capacity to consent to their care. Therefore, people's rights may not have been protected.

People received their medicines when they needed them. However, the provider had not followed the appropriate guidance where people were being given their medicines covertly (medicines that are hidden in food or drink without the person's knowledge). This placed these people at risk of not receiving their medicines safely.

People who could provide us with feedback felt happy living at Grenville Court Care Home. This was reflected by the majority of relatives we spoke with. The staff were kind and most were content working at

Grenville Court Care Home. However, the culture within the home required improving to make sure that it was open and transparent and that the staff worked together to provide people with the care they needed.

People received enough to eat and drink and they were supported to maintain their health. The equipment that people used and the premises they lived in had been well maintained.

The provider had made some initial improvements to the environment to make it appropriate for people who were living with dementia. They had consulted best practice guidance within this area and further plans were in place to make more improvements.

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.

The staff knew how to protect people from the risk of abuse but some were not confident to raise concerns so they could be investigated.

The staff were not always deployed effectively to meet people's needs in a timely manner.

People received their medicines when they needed them. However, sufficient guidance had not been sought where medicines were being given to people without their knowledge.

The premises and equipment that people used were safe.

The necessary checks had been conducted to make sure that the staff who worked at the home were of good character.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not always being followed to protect the rights of people who could not consent to their care.

Staff had received training to perform their role but improvements were needed in respect of caring for people living with dementia.

Staff's competency to perform their role safely and effectively had not always been assessed.

People received enough food and drink to meet their needs and were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring but on occasions, people's privacy

and dignity were not respected.

Relatives and representatives were involved in making decisions about their family members care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always responsive to people's needs and people were not always offered choice about the care they received.

People had access to activities that complemented their hobbies and interests.

Written complaints had been recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not taken timely action to make sure that people received safe, high quality care.

Not all of the systems in place to monitor the quality and safety of the care provided were effective.

A number of improvements to the care being provided had been identified and were being worked on.

Grenville Court Care Home

Detailed findings

Background to this inspection

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

This inspection visit took place on 18 February 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection we reviewed information that we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

Most of the people living at the home were unable to provide us with feedback regarding the care they received. Therefore, we observed how care and support was provided to some of these people using 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 spoke with four people living in the home, seven visiting relatives, 11 care staff, the cook, a domestic member of staff and the provider's operations director. The manager was not at the home on the day of the inspection.

The records we looked at included five people's care records and other records relating to people's care. We tracked the care and support that four people received. We also looked at six staff recruitment files, six staff training records and records in respect of the management of the home. These included records regarding the premises and equipment that was used by people and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection visit, we had received a concern from the local authority safeguarding team that one person had been given their medicine covertly (hidden in food or drink without the person's knowledge) in a process that was not in line with current guidance.

We found that there were a number of people receiving their medicines covertly at the home and that current guidance on this had not been followed. It is important that when medicines are being given this way, that expert advice is sought. This is to make sure that the medicine will still have the desired effect when given in a different format such as crushed or within food or liquid and would be absorbed at a safe rate. The staff we spoke with told us they had spoken to the pharmacist about how to provide people with their medicines to make sure that the way they were doing this was safe. However, there were no records available to confirm this and the operations director was not aware whether this had been discussed with a pharmacist or the GP. There was no guidance within people's care or medicine records to advise staff how they should prepare people's medicines when they were being given covertly. Therefore, there was a risk that people were receiving their medicines in an unsafe manner. The operations director had sought advice from the local GP, pharmacist and NHS England following the concern that was raised and was working with them to improve their current process.

Some supporting information was available alongside medication administration record charts to assist staff when giving medicines to individual people. This included personal identification and information to guide staff on how and when to administer medicines that had been prescribed for occasional use. However, there were no details of people's preferred methods of taking their medicines or any allergies the person had within these records. Therefore, there was a risk that staff may not be aware of important information when giving people their medicines. We also found that staff authorised to handle and administer people's medicines had received training, but that their competence to do this safely had not been assessed.

Prior to this inspection, we had received a concern that staff were using incorrect techniques when assisting people to move which placed them at risk of harm. During our observations, we observed on one occasion this to be the case. We saw two staff using a medium sized sling when supporting one person to move from a chair to a wheelchair. The moving and handling assessment within the person's care record stated the staff should use a small sized sling. Therefore, the use of the incorrect sling was a risk to the person's safety. We had identified a concern during our previous inspection in January 2015 where staff used a sling that was the incorrect size when helping one person to move. We raised this with the operations director who agreed to investigate the matter.

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

Prior to the inspection, we received some concerns that people were not being adequately safeguarded against harm. One concern raised stated that some staff were not reporting incidents to the manager where they had found unexplained bruising on an individual. In response to this concern, we had written to the

manager who provided us with a copy of their investigation. They had not been able to substantiate the concern and had found that the bruising had been correctly reported and recorded as is required. They had also reminded the staff about the importance of reporting such incidents to themselves. We saw that this issue had been raised in a meeting that had recently taken place with the staff. A number of the staff we spoke with told us about what actions they took to safeguard people from harm or the risk of abuse which included reporting unexplained bruising.

All the staff we spoke with were able to demonstrate to us that they understood what constituted abuse and that they were clear on the correct reporting procedures if they suspected that any form of abuse had taken place. However, three of the 11 staff we spoke with told us they felt hesitant to raise issues with the provider or manager in relation to safeguarding people. This was because they were not confident that the issues raised would always be taken seriously by the manager or the provider. Improvements are therefore required to make sure that all staff feel confident to raise concerns with the manager or the provider if they feel the need to.

The majority of relatives we spoke with told us they did not feel that there were always enough staff available to meet people's needs. One relative told us, "I will say though that they could do with more staff at times. Sometimes I visit and it is quiet here and there seem to be plenty of staff but at other times the staff seem very busy and you do not see them so much." Another relative said, "No I do not think that there are enough staff always. Many people take two or three staff to help them with their personal care or to have a bath. This leaves very few staff with people in the lounge and they are sometimes left alone because staff are busy."

The staff we spoke with told us they felt there were enough staff to meet people's needs and for the majority of the inspection, we found this to be the case. However, during lunchtime on the ground floor, we observed that some people had to wait for a long time to receive their lunchtime meal.

The operations director told us they were not aware how the current staffing levels had been calculated. They advised however, that staffing levels were being reviewed and that a new process was being put in place from March 2016 to make sure that the current staffing levels were adequate.

The operations director told us that they were currently fully staffed and that any unexpected staff absence was covered by the existing staff or a bank of staff. The staff we spoke with confirmed this and added that the manager also assisted them with providing care when needed. We have concluded that improvements are required to make sure that staff are deployed effectively to make sure that people receive care to meet their needs in a timely manner.

All of the people we spoke with told us they felt safe living in Grenville Court Care Home. One person told us, "I do not have to worry about anything." Relatives also told us that they felt their family member was safe. One relative told us, "I have been here when a person has become upset or angry. Yes, the staff responded quickly and spoke to the person taking their mind off what was upsetting them. They soon calmed the person."

Staff were able to explain to us what actions they took to support people when they became upset. They told us that they did not use restraint. We saw an example of staff effectively supporting a person who had become upset. The staff member used distraction techniques which calmed the person, keeping the person, the member of staff and others living in the home safe.

Risks in relation to the premises had been assessed and regularly reviewed. We saw that fire doors were kept

closed and that the emergency exits were well sign posted and kept clear. Testing of fire equipment and the fire alarm had taken place. The staff we spoke with demonstrated to us that they knew what action to take in the event of an emergency such as a fire or finding someone unresponsive within their room. The equipment that people used such as hoists had been regularly serviced to make sure they were safe to use. Staff told us and we saw from team meeting records, that issues such as the importance of the safety of equipment before using it was regularly discussed and highlighted.

The required checks had been completed when recruiting new staff to the service such as obtaining character references to ensure that the staff member was of good character.

All of the medicine records that we checked indicated that people had received their medicines as requested by the person who had prescribed them. Medicines were stored securely so that they could not be tampered with or removed. We observed a staff member giving some people their medicines. This was completed correctly and followed best practice guidance. People's medicines were regularly reviewed by their GP who communicated any changes to the staff that was required to people's medicines.

Requires Improvement

Is the service effective?

Our findings

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 are called the Deprivation of Liberty Safeguards. We checked whether the provider was working within the principles of the MCA. We found that the provider was not always working within these principles and that therefore, people's rights were not always protected.

The operations director told us that most of the people who lived at Grenville Court Care Home lacked capacity to make decisions about their care. It was detailed in people's records whether they lacked capacity to make decisions about their care. However, we found that this was a general statement about people's overall ability rather than being in relation to a specific decision. Although the information provided staff with guidance that they needed to act in people's best interests, it did not detail under which circumstances this should take place or how the staff could support people to make specific decisions.

Most of the staff we spoke with had an understanding of the MCA and how it affected their daily practice but we observed that this was not always being consistently applied. Some staff were seen supporting people to make decisions about their care and asking them for their consent before performing a task. However, other staff did not do this. They did not always ask people for their consent before a task was performed and assumed that the person lacked capacity to make the specific decision.

Where medicines were being given to people covertly, no record was in place to show that a full and proper assessment of their capacity in relation to this had been completed. Some people had sensor mats in place that would alert staff to their movements or a deprivation of liberty application had been made to the local authority to restrict some people's freedom. In both these cases, again no assessment of these people's capacity had been undertaken. There was no evidence to show that the provider had tried to support these people to make decisions themselves. We saw some evidence to show that people's GP's and their family had been consulted when making a decision about a person's care in their best interests, but this had not been consistently applied.

The provider had made applications in respect of all of the people living in the home to the local authority for permission to deprive them of their liberty in their best interests. However, this had been a blanket approach and people's ability to consent to the aspect of their care that was believed to be depriving them of their liberty had not been individually assessed. There was no evidence to show that the provider had considered any less restrictive means before making the applications.

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

Most of the staff we spoke with told us they had received enough training to provide them with the skills and knowledge they needed to provide people with effective care. However, four of the staff said they did not think that the training was of good quality. We found that staff had received the majority of their training via e-learning. This included basic dementia training. We saw during the inspection that some staff did not always engage effectively with people who were living with dementia. Staff we spoke with were not always able to demonstrate to us that they understood this condition well. The operations director told us that they were aware of this and that therefore, they were sourcing alternative methods of training for staff within this area.

We received mixed views from staff regarding whether their competency to perform their role was checked regularly. Some staff told us that the manager regularly checked this and took action when they found poor care. However, others said that their competency had not been checked. We saw an example of poor practice where two staff members used the wrong sized sling when assisting someone to move with a hoist. We saw no records in the staff files we looked at to demonstrate that staff practice was regularly assessed.

New staff who started working for the home completed induction training. One new staff member told us how they had shadowed a more experienced member of staff before they started to work on their own. The operations director told us that new staff's competence was evaluated before they started working on their own. We saw some records to verify this, but this had not been consistently applied with some staff induction competency records being blank. We also found that for those staff whose first language was not English, that their competency to converse effectively with people had not always been assessed before they started providing care to people independently. Prior to the inspection, we had received a concern regarding this matter and we observed one staff member on the day of the inspection who was unable to converse effectively with people they were providing care for. Therefore, staff competency to perform their role had not always been assessed by the provider to make sure that their practice was safe and appropriate.

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

Some staff refresher training was overdue. This included in areas such as fire safety, moving and handling and infection control. The operations director was aware of this and we saw that training sessions within these areas had been booked for the staff to attend. Most staff told us that the manager was making sure that the staff completed the training that they needed. One member of staff had completed a 'train the trainer' course in relation to moving and handling and the operations director told us that plans were in place for them to receive in depth training in other areas. This was so they could deliver further training to the staff.

The operations director told us that they were keen to improve the staff's knowledge in a number of different subjects by holding 'bite size' training in team meetings. Some of the staff we spoke with confirmed this and said they had received further training recently in relation to safeguarding, hydration and pressure care. The operations director also said that the staff were to complete more practical training. This would include training where staff would experience what it was liked to be hoisted or assisted to eat so they could empathise with the people they provided care for.

At our last inspection in January 2015, we found that people did not always have sufficient access to drinks and did not always receive the prompting they required to drink enough. We found during this inspection visit that improvements had been made. People had access to regular drinks including hot and cold drinks throughout the day. Water machines had been installed to enable people to help themselves to fresh water when they wanted. People received assistance and prompting to have a drink regularly.

The people we spoke with told us they enjoyed the food. One person told us, "The food is good and yes, there is plenty to eat." Another person said, "They always bring me a cup of tea in the evening." Relatives said that the food was good. One told us, "The food here looks really good. People have a choice and are encouraged to eat the meals. Yes, they can have what they like from the menu." Another said, "The food is nice, they make good tea cakes." When people received their food, they looked to enjoy it. We saw that those people who required assistance to eat their meals received this.

Where there were concerns about people not eating and drinking enough, their intake was being monitored so that actions could be taken if needed. Other healthcare professionals such as dieticians and speech and language therapists had been contacted for assistance when people needed extra support with their calorie intake or they had swallowing difficulties. We saw that people were encouraged to eat independently and that meals were cut up for people when required. Those with specific dietary requirements received these in line with healthcare professionals' recommendations. We saw that the home had received the maximum five star award from the local authority environmental health team for food hygiene during their inspection of food safety in September 2015.

People were supported to maintain good health. We saw that the staff referred people to healthcare professionals in a timely way when required. For example, one person was quickly referred to their GP when they had showed signs of being unwell. One relative told us that their family member's medication had been altered accordingly since they first went into the home. The relative added that they had always been informed of any changes to their family member's health or GP visits. Staff and relatives told us that a person with variable continence needs was being assessed by the continence team the following week. Staff also advised that other healthcare professionals such as physiotherapists, district nurses and chiropodists regularly visited people. We were therefore satisfied that people were supported with their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

Most of the relatives we spoke with told us that their family members were treated with dignity and respect. One relative said, "Yes, staff are kind and respectful to people." Another told us, "Staff are good and know how to treat people well." Some staff were able tell us how they would preserve privacy and dignity whilst carrying out care, and used examples such as shutting doors and keeping people covered when providing personal care. We observed in the main that this occurred. Staff knocked on people's doors before entering their room and toilet and bedroom doors were closed when people were being assisted with their personal care. However, we did see one example where a person was being supported to move in a hoist in a way that did not protect their dignity.

The person was not provided with a blanket and therefore, this manoeuvre was not carried out in a dignified way. We also saw that in one of the dining rooms, the names of people who required a specialist diet was written on a whiteboard. This did not respect people's privacy or dignity. We also observed during the inspection, that some people were not asked before a task was carried out or given choices. We told the operations director about this who advised that they would investigate into these matters. The subject of dignity and privacy was a regular item on the staff meeting agenda and we saw that staff were reminded regularly within these meetings of the importance of treating people with dignity and respect at all times.

The people we spoke with told us that the staff were kind and caring. One person said, "Nice staff. They are lovely people." Another person told us, "The staff are kind to me." We were also told by a person living at the home, "Yes, they [staff] are friendly. My relative likes them and they [staff] remind me when they [relative] are coming to see me. I forget."

The relatives we spoke with also told us that the staff were kind, friendly and helpful. One relative said, "The staff here are so friendly and cannot do enough for the people who live here. They are really kind, friendly and helpful." Another told us, "The staff do their best for everyone and seem to understand my relative." Another relative said, "There are dedicated and friendly staff working here who make me feel welcome when I visit."

Although at times we did not observe staff interacting well with people who were living with dementia, we did see other positive interactions between people and staff. This was seen in general conversations that people had with some staff and when people became anxious. When this occurred, gentle reassurance and distraction was used to good effect to calm the person and to make them feel happier. One staff member was seen to help a person move into the lounge. They spoke to the person kindly. The staff member told us that they treated people as if they were their own family.

The staff we spoke with told us they felt they knew the people they cared for well. Books regarding people's past lives were in the process of being completed for each person who lived in the home. This was so that staff could have conversations with people about their past lives. One person told us, "They [staff] wrote about my life and where I worked. It is all in this book" which they proudly showed us.

One person we spoke with told us that they felt actively involved in making decisions about their care. The relatives we spoke with echoed this in relation to their family member's care. One relative told us, "Yes, I am asked my opinion about the care and support my relative receives and about six monthly I take part in a review of the service provided." Another relative said, "Yes there are resident's meetings where we can join in and comment." A further relative told us that they felt included in all decisions about their family member's care.

Relatives had been involved in an initial assessment of their family member's care and then they were invited to participate in reviews of care every six months which also involved the person receiving the care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2015, we found that people did not always receive care that was responsive to their individual needs. At this inspection we found that the necessary improvements had not been made.

Although we saw some staff being responsive to people's needs during the inspection, such as assisting them with personal care or providing them with a drink when they wanted it, this did not always occur. Staff were not always responsive to people's needs in a timely manner and people's preferences were not always sought regarding the care they wanted to receive.

During the lunchtime meal on the ground floor, we found that some people had to wait for an unacceptable amount of time before they received assistance to eat their meal. This concern had been identified by us during our last inspection visit in January 2015.

At least 14 people required assistance to eat their meals. We saw that six people who were seated at the dining room table had to wait for an hour to receive this assistance whilst others around them were eating their meal. This meant that some people had to wait for their meal whilst watching another person eating theirs. This may have been frustrating for people if they had been hungry and did not promote their dignity. Four people who remained in their lounge chairs asleep did not receive assistance to eat a meal until 1.45pm although lunchtime commenced at 12.30pm. Two people who had been provided with their meal were not encouraged to eat it when it was placed in front of them. They were finally assisted after thirty-five minutes by which time the meal was cold.

A staff member was observed to take two meals on the same tray to assist two people who remained in bed. Although the meals were covered, the second meal remained on the tray until the first person had been assisted to eat by the staff member. This resulted in the second person being provided with a cold meal. We also saw that six meals were dished up and left on the kitchen hatch for 10 minutes before the cook noticed this and placed them on top of the hot plate to keep them warm.

Staff did give the people they were assisting attention but people who had eaten their lunch had to wait 20 minutes for their dessert. Two people became restless and got up from the table three times resulting in one person tripping on their walking stick and falling onto a dining room table. The cook eventually intervened and gave people their dessert as there were no staff available to do this as they were assisting other people at the time.

We saw one person continuously walking up and down the corridors throughout the inspection but we did not see them offered anything meaningful to do. This again had been identified as a concern during our last inspection in January 2015.

One person we spoke with and the majority of relatives expressed their concern about how difficult they often found it to communicate with some staff. One person told us that although staff were kind, some were difficult to have a conversation with. A relative told us, "There are a lot of staff from overseas working here.

We struggle to understand them sometimes so I do not think the residents do." Two other relatives told us that they were worried about people's safety due to lack of understanding and expressed anxiety as they were unable to converse with many staff on the phone due to lack of mutual understanding. They added that they had made a complaint to a member of staff but said that the staff member could not speak and understand English well enough to talk to them about it.

Five of the staff we spoke with also felt that this was an issue. They told us that communication with some staff was very difficult as they didn't understand English well which they felt made it difficult to communicate well as a team and to delegate tasks. They added that they often witnessed some staff with poor English skills carry out personal care tasks without any interaction with people. One staff member we tried to speak with was unable to converse with us or answer our questions due to language barriers.

Although we observed some staff asking people's preferences about the care they wanted to receive and interacting with them well, we witnessed on some occasions that this did not occur. For example, we saw a member of staff move a person in their wheelchair without offering them a choice about this. The member of staff did not interact with people other than to ask basic questions such as asking people if they wanted a drink. Some other staff were observed hoisting people into wheelchairs to take them to the dining area for lunch without consulting them first. One person was hoisted into a wheelchair who was still asleep. Tabards were put on some people without asking them if that was what they wanted.

Our findings constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection in January 2015, we found that improvements were required in the provision of purposeful activities for people. At this inspection, we found that some improvements had been made and that plans were in place to continue to improve the provision of activities for people.

We received mixed feedback from the people, relatives and staff we spoke with. One person told us, "I sometimes do a puzzle or we play 'catch the ball' with staff. Yes they chat to us and help me if I forget things." A relative said, "There are some activities but they need more I think. People get bored." Another relative told us that there were things for people to do on some days but that the activities provided could be more varied. Some staff said they felt there had been improvements in the variety of activities for people to take part in whilst others said that often, activities did not take place.

We saw some people taking part in activities such as completing a jigsaw and colouring. Staff were seen playing skittles and throwing a ball for people to catch. The people involved in this were smiling and laughing and we saw some relatives also become involved. A weekly plan of activities was seen to be displayed on the notice boards and included such activities as, colouring, game of skittles and nail care. Daily exercise classes had been introduced for those who wanted to take part.

The provider employed an activities co-ordinator who worked for three days per week. They had recently employed another member of staff so that a variety of activities could take place seven days per week.

Care records were in place to provide the staff with guidance on the care that people required. These had clear information within them about people's needs and how staff could meet these. Care plans covered areas such as continence, diabetes, moving and handling and eating and drinking. We saw that these records had been regularly reviewed to make sure that the information within them was up to date and an accurate reflection of people's current needs. The staff we spoke with told us that the care records contained enough information in them to enable them to provide people with the care they needed.

The operations director had recently put a new way of allocating work into place. This was to give staff more information about people's current needs and included issues such as who had received care and when, if there were any issues that needed to be discussed at handover meetings and whether people needed further assistance to drink more fluids. Staff were allocated to different tasks so had a clearer understanding of what was expected of them. The staff we spoke with about this told us that they felt this system was working well and that they were clearer about their individual roles and responsibilities. The operations director told us they were looking to improve this further by including a two page laminated sheet for staff that would help them to easily understand people's care needs and preferences at a quick glance.

We saw that any complaints that had been received had been fully investigated and that feedback had been given to the person who raised the concern. We were therefore satisfied that people's complaints were investigated and responded to effectively.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in January 2015, we told the provider that they needed to make improvements to how the quality of the care that was being provided was monitored. At this inspection we found that the provider had failed to make the required improvements.

We again found concerns within some of the areas that we had previously identified during the last inspection in January 2015. These were having an impact on the quality of care that some people who lived at Grenville Court Care Home received. We also found other concerns during this visit regarding the management of people's medicines where they were given to them covertly, protecting the rights of those people who were unable to consent to their care, staff training and competency to perform their role safely and effectively and treating people with dignity and respect.

The operations director told us they had recognised some of the issues we identified during this inspection visit. These included people not receiving their meals in a timely manner and that some staff were unable to converse effectively with people in English. Although we saw that all of the staff had been reminded of the need to always treat people with dignity and respect in the regular staff meetings that had been held, this was found to still be a concern during this inspection. No immediate action had been taken to make improvements on the other issues. The issue in relation to people not receiving their meals in a timely manner had been raised by us as a concern following our previous inspection in January 2015.

There was a lack of effective systems in place to make sure that all staff had been assessed as being safe and competent to perform their role. Whilst the service specialises in dementia care, only basic training had been received by the staff in relation to this condition.

Some audits were undertaken by the manager and senior staff to monitor the care provision that was delivered. These included audits of people's medicines, accuracy of care records and the environment. However, these were not all found to be effective. Therefore, as a result of the concerns we have identified during this inspection, it was apparent the provider was not effectively assessing and monitoring the quality of service provision being provided.

Incidents and accidents had been recorded by the manager. We asked the operations director for information on how this data had been analysed and what if any, actions had been taken to reduce the risks of the incidents from re-occurring. However, this information could not be found and therefore we were not provided with it.

These issues constitied a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found that we had not always been notified by the provider when the local authority had granted the home authorisation to deprive people of their liberty in their best interests. We found for two people that this had been the case.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations) 2009.

The provider was not displaying their rating on their website from our last inspection in January 2015.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The last registered manager left the service in September 2015. A new manager was recruited in October 2015. Their application to register with us has been received and is currently being processed.

Most of the staff we spoke with told us that the new manager was approachable and that they had observed they were trying to change the culture within the home so that people received care that met their individual needs and preferences. However, we received differing views from staff as to whether they felt confident that issues they raised would be listened to and acted on. We found that there was a clear difference between the teams who worked within different areas of the home. Seven staff told us that they could raise concerns and that these would be acted on. They added that they were happy in their role, that morale was good and that they felt listened to.
However, four staff we spoke told us they were not happy in their role and that morale was poor. They said they had raised issues about the standard of care provided but had not witnessed that any improvements had been made. Some said they now felt hesitant to raise concerns directly with the operations director or the manager because of this.

We observed that although some teams of staff worked well together, others did not. Where this happened, there was little interaction and communication between the staff. Therefore, improvements are required to ensure that staff work well as a team to enable them to provide effective care and that there is an open and transparent culture within the home.

The relatives told us that they found the manager approachable. One relative said, "There has been lots of change in the managers over the three years I have been visiting. Yes, this one seems a nice chap. You know, approachable and eager to make things better here for my relative and everyone else." Another relative told us, "The manager is very approachable. He has offered a chat several times. He's easy to talk to." Another relative told us how they felt their relative was given all the care and attention they needed.

The operations director showed us that some improvements had been made to the environment of the home to help people living with dementia to orientate themselves around the home more easily. These included repainting the home and placing photographs that were important to the person in display cabinets by their room. There was a programme in place to refurbish people's rooms and televisions had been provided that could take USB sticks. The manager was working with families so that the USB sticks could facilitate the playing of photographs on the television that would help stimulate pleasant memories.

The operations director told us they had recently visited an organisation that specialised in providing people who were living with dementia with outstanding care. This organisation used current best practice and research evidence to demonstrate how outstanding care could be provided. The operations director told us they had taken away many ideas from this visit and were planning to make further improvements to the environment. This included sensory items for people to look at and touch and the addition of a reminiscence room for people to use. They were also planning to turn another area into an old fashioned pub for which they had already purchased an old juke box. A cinema and family room were also to be created.

We saw that relative's views on the quality of the care being provided had been sought and that action had

been taken in response to their suggestions on how to improve care. There was a notice board in reception that was entitled 'you said, we did' which detailed the changes that had been made in response to feedback. This included the employment of a further member of the activities team, displaying photographs of the staff member who was responsible for monitoring the care of their family member and to have more regular reviews of their family member's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Commission had not been notified of some notifiable incidents. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment service users received was not always appropriate or met their needs. Regulation 9 (1) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always delivered with the consent of the relevant person. The Mental Capacity Act 2005 principles had not always been followed. Regulation 11 (1) (2) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way and action was not always taken to mitigate risks. People's medicines were not always managed safely. Regulation 12 (1) (2) (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider's performance rating was not being displayed on their website. Regulation 20A (1) (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support and training to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor, and improve the quality and safety of the care provided or to mitigate risks to people's safety. Regulation 17 (1) (2) (a) (b) and (c).

The enforcement action we took:

We have sent the provider a warning notice and told them they must be compliant with this Regulation by 30 April 2016.