New Care West Bridgford (OPCO) Limited

The Grand

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 3 May 2017 and was unannounced. The Grand is registered with the Care Quality Commission to provide accommodation, personal care and nursing care for up to 82 people. There were 69 people staying at the service at the time of our inspection. The service comprised of four floors and included a unit which catered for people who were living with dementia and a short stay rehabilitation unit which was run in partnership with a local health authority.

The service did not have a registered manager in place at the time of our visit. The previous manager had deregistered in January 2017. A new manager had been appointed and was registered with us shortly after our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who were aware of the risk of abuse and were knowledgeable and confident about when to report any concerns. Risks to people's health and safety were identified and assessed and measures introduced to keep people safe if required. We found that some of these measures had not always been fully implemented and the manager took swift action to address this concern. Sufficient numbers of staff were planned to meet people's needs and action was being taken to minimise the impact of staff absences. There was a risk that people may not receive their prescribed medicines as required and improvements were needed to ensure these were managed safely.

People were supported by staff who received training and support to carry out their roles effectively. People were asked for their consent before care was provided and staff were knowledgeable about how to support people who may lack capacity in their best interests. The service was in the process of ensuring that relatives who consented on behalf of their relation had the authority to do so. People were supported to maintain their health and to eat and drink enough.

People were cared for by staff who were kind and gentle and took swift action to relieve people's distress. Staff were knowledgeable about the people they supported and respected their choices and decisions. People were supported to be as independent as possible and their privacy and dignity was upheld. People and their relatives were involved in planning their own care.

People received care which met their individual needs and respected their preferences. Staff told us that communication systems used at the service were effective in ensuring they were kept up to date with any changes in people's needs. The service employed dedicated activity co-ordinators who worked hard to ensure that people were provided with meaningful activities and supported to maintain their interests. People could be assured that complaints would be responded to appropriately.

People were cared for by staff who worked well as a team and were supported and encouraged to provide a

good service by management. People, relatives and staff were complimentary of the manager who understood their responsibilities. Quality monitoring systems were in place and continued to be developed to ensure they were effective in identifying and acting on areas of improvement. Swift action was taken by the management team in relation to issues identified during our inspection.

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 entirely safe.

There was a risk that people may not receive their prescribed medicines as required and improvements were needed to ensure these were managed safely.

Risks to people's health and safety were identified and assessed and measures introduced to keep people safe if required. We found that some of these measures had not always been fully implemented at the time of our visit.

People were supported by staff who were aware of the risk of abuse and were knowledgeable and confident about when to report any concerns.

Sufficient numbers of staff were planned to meet people's needs and action was being taken to minimise the impact of staff absences.

Is the service effective?

Good

The service was effective.

People were supported by staff who received training and support to carry out their roles effectively.

People were asked for their consent before care was provided and staff were knowledgeable about how to support people who may lack capacity in their best interests. The service was in the process of ensuring that relatives who consented on behalf of their relation had the authority to do so.

People were supported to maintain their health and to eat and drink enough.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and gentle and took swift action to relieve people's distress.

Staff were knowledgeable about the people they supported and respected their choices and decisions. People were supported to be as independent as possible.

People and their relatives were involved in planning their own care and people's privacy and dignity was upheld.

Is the service responsive?

Good

The service was responsive.

People received person centred care which met their needs and respected their preferences. Communication systems used at the service were effective in ensuring staff were kept up to date with any changes in people's needs.

The service employed dedicated activity co-ordinators who worked hard to ensure that people were provided with meaningful activities and supported to maintain their interests.

People could be assured that complaints would be responded to appropriately.

Is the service well-led?

Good

The service was well led.

People were cared for by staff who worked well as a team and were supported and encouraged to provide a good service by management.

People, relatives and staff were complimentary of the manager who understood their responsibilities.

Quality monitoring systems were in place and continued to be developed to ensure they were effective in identifying and acting on areas of improvement. The management team were responsive to feedback.

The Grand

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.

This inspection took place on 3 May 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a 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 care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition to reviewing the PIR we also checked the information that we held about the service such as previous inspection reports, information we had received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our visit we spoke with 16 people who used the service and the relatives of four people. We spoke with four care workers, a nurse, an activity co-ordinator, the care manager, the maintenance person, deputy manager and manager. We observed care and support in communal areas. We looked at the care records of eight people who used the service, medicines records, staff training and recruitment records, as well as records of safety checks and some quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe as the environment was secure and they felt able to approach staff with any concerns. One person told us, "The place is secure" whilst another commented, "There is a lady who I can (approach with any concerns), she said to me, 'If you're worried any day you can contact me', she was very nice. She comes in and has a little chat with me." People's relatives also thought their relations were kept safe. The relative of one person told us, "There's good security. When you come in, someone's on the reception to greet you. There's people around. [Relation] has a pressure mat because [relation] wouldn't know to press a button (to ask for support.)"

Systems were in place to minimise the risk of abuse. The majority of staff we spoke with told us they had received training in safeguarding adults from abuse since commencing work at the service. Staff were informed about the different types of abuse people could be exposed to and what action they would take in response to any allegations or concerns. One member of staff told us, "I would stop it (abuse), report it to the manager and record it." Staff were confident that any concerns they raised with the management team would be dealt with properly. Two members of staff told us about concerns they had raised or safeguarding incidents they had been involved with. Both of these issues were being or had been addressed. Records confirmed the manager had taken appropriate action in response to concerns and made referrals to the local safeguarding adult's team as required.

People and their relatives felt that risks to people's safety were managed. One person's relative told us, "[Relation's] very safe. [Relation's] unable to get out of the doors because they change the codes regularly. They've recently put a sensor on the wall by [relation's] bed in case [relation] wanders at night."

The staff we spoke with were able to describe the measures they took to ensure that risks to people's safety were reduced. One member of staff told us of the actions they took to reduce the risk of falls. These included ensuring people had good fitting footwear, safe walking aids and checking their eyesight. Another member of staff told us told us they had recently been updated with moving and handling training and were able to read people's care plans which contained different risk assessment tools which helped them to understand the risks to people.

People's care plans contained risk assessment tools in different areas of care. These had been reviewed monthly and measures to keep people safe were recorded in their care plans. However, these measures were not always fully implemented. For example, records stated that a person who was at risk of recurrent urine infections should have their urine output monitored but we found no records to evidence this was being done. However, we were informed that the person had experienced one urine infection since they moved to the service and this had been recognised promptly by staff.

We also checked the daily records of three people who required support to change their position to reduce the risk of developing a pressure. We found this was not always recorded as being provided at the intervals specified in people's care plans. Although staff were aware of the risks they did not always know how often support was required. This meant that, although people had not suffered harm there was a risk that

measures identified to keep people safe may not be fully implemented. Swift action was taken by the management team following our feedback to ensure care was provided as required and the necessary records were kept.

We observed that mobility aids were available to support people with their mobility and reduce the risk of falls and sensor equipment was used if required to alert staff that the person may require support. People who had been assessed as being at risk of developing pressure ulcers were provided with suitable equipment to reduce the risk, such as, pressure relieving mattresses and cushions. We saw this equipment was being used as specified in people's care plans.

People had care plans to describe the support they needed to ensure their safety and wellbeing in the event of an emergency situation which would require evacuation. Equipment and safety checks were in place to reduce the risk of harm to people in the event of a fire. We also found that regular checks were carried out to reduce the risk of legionella, scalding and faulty equipment.

People told us there were usually enough staff to ensure they did not have to wait long for support although this was not always the case, particularly at night and over the weekend. One person told us, "In the morning I press the buzzer and they (staff) come up to get me. Yes, they come quickly whenever I buzz." However another person commented, "I have waited thirty minutes after ringing the bell. Someone comes to turn it off and leaves saying they will be back in a minute. Also at night when wanting to be helped to get ready for bed."

Our observations on the availability of staff to respond to people's needs varied throughout the service. The service is large and divided into four floors. In most areas we observed there were enough staff to maintain a presence in communal areas and provide reassurance and support to people when it was needed. However, we observed that people who spent their time in one area of the home would have benefitted from more staff presence during one of the mealtimes as some people waited up to thirty minutes for their meal.

The staff we spoke with told us when planned staffing levels were met they felt there were sufficient staff to meet the needs of the people they cared for. However, they told us of occasions when planned staffing levels were not met due to short notice absences and this tended to be at weekends and at night. We spoke to the manager about staffing levels. The manager described the tools they used to determine the amount of staff required. They told us they did have issues with high sickness absences and told us about the plans they had to address this to help ensure required staffing levels were met. They told us they routinely monitored call bell response times to ensure these were answered in a timely way and would continue to do so as part of their daily checks.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicant's suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

People could not always be assured they would receive medicines as prescribed by their doctor. People and their relatives told us that medicines were administered in a safe and timely manner but one person told us their medicines had not been available. Whilst action had been taken when people's medicines had not been available, we identified improvements were required to ensure the safe management of medicines.

The pharmacy supplier of medicines for the service was changed three weeks prior to our visit and the

service had moved from an electronic medicines management system to a paper system on a temporary basis. We saw there had been problems with the supply of some medicines and there were records to indicate staff had contacted the pharmacy regularly about missing medicines for some people using the service until the issue was resolved.

We found several gaps in people's medicine administration charts which meant either the medicines had not been given or staff had not recorded when they had given them. We checked these and found it was not always possible to identify whether the person had been given their medicine as there were inaccuracies in the recording of stock totals. We were able to ascertain that three people had not received their medicines as required. This meant that people were at risk of not receiving their medicines as required which could result in unnecessary harm.

Medicines were stored securely however regular temperature checks required to ensure medicines were safe to use were not always being completed on one floor of the service. However, this issue had been identified in the homes audit and the temperature monitoring improved. When the temperate of rooms and refrigerators were recorded these were within acceptable limits. We also found that liquid medicines and creams were not labelled with the date of opening. This meant that staff could not always be assured that the medicine remained effective.

Staff who were responsible for the administration of medicines told us they had completed medicines training and had their competency assessed to ensure they were safe to do so. The manager provided information about the action they had taken following our feedback which included daily and weekly checks and a competency update of all staff who administered medicines.

Good

Is the service effective?

Our findings

People and their relatives told us they thought the staff who cared for them were competent. One person told us, "They have the right, good quality people on the whole," whilst another person commented, "Can't fault the care." A relative said, "I don't know if they (staff) are trained in dementia but they're very good at dealing with [relation]. They understand [relation]."

People were cared by staff who received an induction when they commenced working at the service. The provider told us in their PIR that, 'The initial induction period for staff covers all the required mandatory training.' One staff member we spoke with told us they found the induction to the service supportive and stated, "We got a checklist of things to go through such as Health and Safety, Fire and Moving and Handling." Another member of staff told us they had shadowed a more experienced member of staff prior to working on their own and felt this enabled them to feel confident and safe when providing care and support.

The staff we spoke with confirmed they had received training relevant to their role. Staff were supported to complete the Care Certificate. The Care Certificate is a nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. Records showed staff were provided with other training which the provider had identified as being mandatory such as fire safety, moving and handling and safeguarding. We identified some gaps in training and instances where some staff members training was highlighted as being out of date. The manager provided us with dates of training which had been arranged to address these gaps following our visit.

All of the staff we spoke with told us they could request additional training and this would be considered. Although some staff had completed training in dementia awareness, other staff members had not and felt this was would be beneficial. We discussed dementia training with the manager of the dementia unit who told us they provided practical training and advice on an ongoing basis. They told us that staff had recently asked about additional training at a staff meeting and there were plans to provide this.

Most of the staff members we spoke with told us they had recently received supervision from a member of the management team. Staff told us they found this to be positive and helpful. The frequency of supervision reported by staff was variable. The manager acknowledged that not all staff had received regular supervision prior to their arrival at the service in November 2016. However since this time, records showed that all staff had received supervisions.

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 told us they were given choices about how they spent their day and their decisions were respected by staff. One person told us, "They (staff) let me get up when I want to", whilst a relative said, "They (staff) ask

[relation] and then ask me if [relation] can't answer, so they try." During our visit we observed staff asking for people's permission before providing care and support, for example people were asked what they would like to drink and whether they wished to take part in an activity.

The staff we spoke with demonstrated a good understanding of the need to obtain consent from people before providing care and the principles of the MCA. One staff member told us, "Yes when we go in to people we ask what they want us to do" whilst another commented, "We should always assume people have capacity." They discussed that people's capacity fluctuated but they made sure people were given support to make choices for themselves whenever they could. They went on to say, "It's about giving people choices and trying to act in their best interests."

People's care plans contained evidence that people had consented to their care if they had the capacity to do so. If there was doubt as to whether people had the mental capacity to make specific decisions, an assessment of their capacity had been carried out and a best interest decision made. For some people who lacked capacity to consent to their care we saw that relatives had done so on their behalf and it was stated that they had the legal authority to do so. There was no evidence that one person's relation held power of attorney as stated in care records. The manager told us the service had previously asked to see records but not kept copies. They told us the guidance regarding this had changed and they had written to all families who held power of attorney to request a copy for their records. This is important as it shows that a relative has the legal authority to make decisions on their relation's behalf.

A number of people had 'do not attempt resuscitation' orders in place. Those which we reviewed had been completed appropriately by an external health professional and had been discussed with the person and their family.

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 on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate.

People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were care plans in place informing staff of what may trigger the behaviour and detailing how staff should respond. They provided information about the person's interests and things which might be used to calm or distract them. We observed staff applying this knowledge when supporting people.

People told us they got enough to eat and drink and were offered choices. Most of the people we spoke with were very complimentary of quality and choice of food. One person told us, "Food is excellent," whilst another person said, "The food is good and staff are very concerned with you getting food."

During our visit we saw that people were supported to eat and drink enough. People were offered a choice of meals and there were snacks and hot or cold drinks available throughout the day. We observed a member of staff sitting with a person to discuss the meal options for the lunchtime meal. When they indicated they were not sure about any of the options on the menu the staff member said, "You can have something else. What would you like?" At lunchtime we saw staff providing assistance to those people that required it and chatting to people creating a relaxed and homely atmosphere.

People's nutrition and hydration needs were met. Nutrition assessments were completed and eating and

drinking care plans were in place. People were weighed regularly to ensure that any changes in their weight were identified. During a meeting which was held on the day of our visit the chef discussed a person who had been losing weight and shared strategies to try and increase intake such as fortifying meals and tailoring meal sizes to meet needs. Staff told us that when people's weight had changed they had referred people to external healthcare professionals for advice, such as speech and language therapists and dieticians.

People were supported with their healthcare needs. People were complimentary of the way in which the health service and care staff worked together at the home. One person's relative told us, "If the GP is needed he is called out. He does his rounds every Tuesday and they add [relation] to his list if [relation] needs it." On the rehabilitation unit we observed care staff had a close working relationship with the health team who worked with them. Care records indicated people had access to a range of professionals including GPs, the dementia outreach team, dieticians, speech and language therapists, chiropodists and opticians.

We spoke with a visiting healthcare professional during our visit. They told us that staff accompanied them when they saw people and provided support when it was required. They told us staff took their advice on board and they had not observed any issues with staff competence of knowledge in relation to people's healthcare needs.

Good

Is the service caring?

Our findings

People were supported by staff who were kind, friendly and gentle. One person told us, "There's some lovely carers. They're all really good but [care workers name] is particularly nice," whilst another said, "Staff are caring and they listen and are respectful." People's relatives also told us that staff were caring towards their loved one. One person's relative told us, "Yes, above all, they do care and they are kind. [Relation] has never said anyone has been unkind."

The staff we spoke with also felt that the service was caring towards people who stayed there. One member of staff told us, "Yes I feel there is a caring attitude among staff, seniors have a good attitude and it rubs off." Another member of staff told us, "Yes definitely (caring attitude among staff) I see that."

During our visit we observed good rapport and positive relationships between staff and people who stayed at the service. We observed staff engaging with people in a friendly and compassionate way as they were providing care and support. For example, one member of staff supported a person to move position from their wheelchair to a chair. The member of staff spoke to the person throughout, providing gentle and reassuring support and ensured the person was comfortable before leaving. We saw another member of staff providing a person with a drink and advising them where it was and that it was hot. The person was visually impaired and the staff member made sure the person knew who was speaking to them and where their drink was before moving away.

Some people staying at The Grand were living with dementia and could be anxious and distressed at times. We observed staff responding to people's distress and spending time engaging with people individually, walking with them and talking. We saw that people responded positively when provided with this support. We accessed the care plan of a person which compassionately explained the impact their deteriorating health was having on their mental wellbeing. The care plan described how staff should respond to the person's distress and low mood. When we met with this person they told us they had been referred to an external health professional who came to talk to them about how they were feeling.

People were involved in their care plans if they had capacity and we saw that people had provided their consent to care where they were able. Care plans contained information about people in the form of a 'life story'. We saw evidence that staff had spent time with people completing these documents. Care plans also contained details about what was important to the person, for example, it was recorded that it was important to one person they wore their watch every day. During our visit we observed that staff knew people well and it was clear they had a good knowledge of people's support needs and their likes and dislikes. Staff routinely checked with people about their preferences for care and support and people were offered choices and their decisions respected. People's relatives were involved in planning their relation's care where appropriate. One person's relative told us, "Yes, we were (involved in planning their relations care). They (staff) wrote our ideas into the care plan."

People were supported to be as independent as possible. One person who was staying on the rehabilitation unit told us, "Physios and carers make you do things for yourself. Good progress with the care and physio

and own effort." The provider told us in their PIR, "Residents are encouraged to have as much independence as they are able whilst feeling supported in an environment that is safe." Records provided evidence to support this. One person liked to go out into the community and this had been planned for to help them retain independence whilst ensuring their safety. There was information in people's care plans about what they were able to do for themselves and areas in which they needed prompting or assistance and we saw that staff display a good knowledge of people's skills and abilities.

People had access to advocacy. An independent advocate visited the service each month. From this visit, the service was provided with a monthly briefing on people's likes/dislikes and any issues regarding communication which were then acted upon. Advocates are trained professionals who support, enable and empower people to speak up.

People's rights to privacy and dignity were respected. People told us the staff treated them with dignity and their rights to privacy were respected. People described staff talking to them respectfully and asking permission in addition to being able to lock their rooms and meet with friends and family in private. When asked if staff treated their relation with dignity, one person's relative responded, "Definitely, and with love. They don't treat [relation] like a customer."

Throughout our visit we observed that all staff treated people with dignity and respect. Staff knocked on people's doors and waited to be invited in, greeted people warmly and provided clear explanations before providing any support. During our visit staff talked about people respectfully and were discrete when discussing people's needs. The staff we spoke with were able to describe how they treated people with dignity and respect such as talking to people when assisting them and ensuring people are covered up when providing care. Staff described how the service used a 'green light system' which was a system to show a light outside a person's door if they were receiving personal care. This system helped to ensure that people's privacy and dignity was maintained.

Good

Is the service responsive?

Our findings

People and their relatives told us that care staff understood their or their relations needs and responded in timely way. One person told us, "Overall staff are supportive and attentive. I ring (the call buzzer) and they (staff) come." People told us that most of the time staff responded to their requests for support quickly although at 'busy' times they may have to wait. However, people felt staff knew them well and how to support them. A person who was staying on the rehabilitation unit told us, "I've made good progress. Staff know what they are doing."

People's needs had been assessed prior to them being admitted to the service and were regularly reassessed throughout their stay. The provider told us in their PIR, 'All residents have a care plan which is person centred, this is written initially from the pre admission assessment, and it is reviewed and updated on a monthly basis or as required.' Records showed this to be the case. Staff had completed a pre-admission assessment and a range of care plans had been developed in relation to each person's health and care needs. The vast majority of the care plans we looked at were detailed, up to date and contained information about the person's personal preferences in relation to their support needs. We identified one person's care plan which required further information about their health need and received confirmation from the manager this had been updated following our visit.

People who were receiving support on the rehabilitation unit had care plans in place which were not as detailed as in other units. Whilst this was to be expected due to the short term nature of the unit, it was felt that further explanation of some of the medical abbreviations would be useful to staff. This would ensure that staff would properly understand people's needs. We asked staff on the unit how they understood about people's needs. Staff told us that communication on the unit was good. We were told there were three meetings with health staff each week and that staff shared information at these meetings and via a communication book. The staff working on the unit were complimentary of communication on the unit. An external health care professional working on this unit told us, "The care staff are here 24 hours a day seven days a week. We rely on them to feedback changes to us and they do."

The staff we spoke with were aware of people's needs and preferences. One staff member we spoke with, when asked how they got to know people and their needs, told us, "From care plans or family. We talk to people and get to know them. People are given choices and can express preferences. People do as they chose." Another member of staff told us they documented how they met people's needs. They said, "Yes we are kept up to date. We complete daily records and daily charts." We found that records and charts were in place and mostly completed as required. We did identify some gaps in some people's monitoring charts. Following our visit the manager told us they had introduced daily checks of charts to ensure staff were completing these as required. This would help ensure that people's needs were being responded to as required.

People were offered the opportunity to take part in social activities and to maintain their interests. People and their relatives were very complimentary of this provision at the service. One person commented, "We're having some sort of entertainment this afternoon. Every week we get one of these. Yesterday we had a little

church service here, which happens once a month. The activities people are very good; they go round and do your nails. They're very good. There is no problem if you ask the activities people, they'll do it. Very much more of a personal service. They fill in where needed."

One person showed us their talking book which was on loan from the library service. They told us this had been arranged by staff to support their love of reading. Another person told us, "They (staff) get me a paper. I can just about read the paper with my magnifying glass." The activity co-ordinator we spoke with also gave an example of tailoring activities to people's individual preferences. They told us, "[Person's name] asked for a pianist and we arranged a duo. [Person] used to play the violin and was really happy when they played."

People described a range of activities which took place at the service which included outside entertainers, cheese and wine tasting, cooking and sensory sessions and trips to the local community. The provider employed activity co-ordinators who had responsibility for planning and delivering activities for people using the service. We observed the activity co-ordinators to be enthusiastic and motivated. One of the activity co-ordinators told us, "We research their (people's) interests before coming in and add it to the interest's booklet." They explained how they had researched ideas for activities and as a result had changed working patterns to try and support as many people with their interests as possible.

People and their relatives told us that they felt comfortable approaching staff or the manager with any concerns or complaints. Some of the people and relatives we spoke with had made complaints and told us their complaint had been listened to and positive changes made as a result. One person's relative told us they approached the manager or deputy manager with any concerns. They explained, "They're very approachable. You can go in guns blazing and they'll say 'Yeah, I agree. You're right. Let's sort it." Another person's relative confirmed this view and said, "I complained about not enough chairs in the lounge when they moved some people upstairs and more chairs arrived. I complained there were not enough footstools and they appeared."

People could be assured that complaints would be taken seriously and acted upon. Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. One member of staff told us, "I would look at things, try and resolve issues and let the seniors know. I would record the issues." Staff told us they were confident that the management team would act upon complaints appropriately. People were made aware of the complaints procedure in the 'Residents services guide.' The guide detailed how complaints should be raised and what action would be taken in response to a complaint.

We reviewed records of complaints made over the last few months and we saw that they had been recorded, investigated and addressed. Responses to complaints contained details of the investigation, action taken to reduce the risk of reoccurrence and an apology was issued if appropriate. People confirmed their feedback about the service was sought and the provider told us in their PIR about plans to further develop this.

Good

Is the service well-led?

Our findings

People were complimentary of the management and staff team at the service. One person's relative said, "I have no issues. Staff have been fantastic. [Relation] thrives. It's great for [Relation]." Although people told us that the manager was very busy, they found her approachable and also mentioned other senior members of staff they felt able to approach with any concerns or issues. One person told us, "[Manager] is very good if you can catch her," whilst another person said, "We've got a good manager at the moment. She talks to people and she means what she says. The others never used to appear out of the office. She's very approachable."

People benefitted from clear leadership within the service. The staff we spoke with felt that the service had developed an open culture and the staff team were responsive and worked well together under the leadership of the management. They told us they had regular staff meetings and felt able to discuss issues openly and without fear of recrimination. One member of staff told us, "It is a relaxed culture. It gets busy but there is a good balance. I like working here," whilst another member of staff said, "They (manager) are one of the best managers I have had. I can talk about anything." The staff we spoke with told us they would feel comfortable to whistle blow if they witnessed abuse or poor care at the service and felt this would be responded to fairly and swiftly. The manager also sent us information about what action had been taken in response to issues identified during our visit. This included daily checks of people's care records and additional training in the administration of medicines for those staff who were responsible for this.

Staff told us they received feedback about their performance and were able to discuss training and development needs. One member of staff told us they knew what was expected of them within their role and that the management team went through this regularly with them. They told us they had received supervision and had also attended group supervision in relation to specific issues such as documentation. Another member of staff described the supervision they received from the deputy manager and told us, "we talk about our progression." Records from monthly staff meetings also showed that staff were able to raise issues and discuss their support needs and that managers talked about their expectations of staff.

The service did not have a registered manager in place at the time of our visit. The previous manager who had been registered with us had left the service and deregistered in January 2017. A new manager had been appointed and was registered with us shortly after our visit. The manager was aware of their responsibilities and were aware of which specific events which occurred at the service they were required to notify us about. They had identified that the system to notify us of events may not have been fully effective in the past and had taken steps to reorganise this system to ensure we received notifications as required.

People who stayed at The Grand service confirmed they were able to make suggestions with regards to the running and development of the service. People and their relatives told us they were aware of resident and family meetings. The provider told us in their PIR that in addition to meetings, 'we will implement a resident survey. This will enable us to know what our residents need and how our services can deliver an outstanding service. We will identify people's feedback about the effectiveness of our service.' We spoke to staff about some issues that people raised during our visit. We found that staff were aware of these issues and in the

process of responding to them.

Systems were in place to monitor the quality and safety of the service. On the whole these were effective in identifying issues at the service and we saw that actions were recorded to address these. The manager confirmed the range of audits carried out by members of the management team on a regular basis. This included audits in relation to infection control, medication and care plans. However we found that the medicines audit had not been fully effective as it had not identified all of the issues we found during our visit or that required improvements had not always been sustained. The manager told us that some of the issues with medicines were due to recent changes in supplier and management system. They confirmed the action they had taken following our visit to ensure improvements were made which included increased checks and audits.

In addition to the above audits, the manager completed regular spot checks, including checks at night. They also maintained oversight of accidents and incidents which occurred in the service. A previous quality assurance check which had been carried out by the provider had identified that this oversight would benefit from further analysis of trends and the manager was in the process of implementing this.

The Grand worked in partnership with other agencies with a view to developing the service and improving outcomes for people. The rehabilitation unit was run with Nottingham NHS Trust and Age UK. The staff at the service worked with a wide range of health and social care professionals to provide rehabilitation to the people staying on the unit. In addition the service participated in projects with outside agencies. For example, the service had implemented new audit tools as a result of involvement in these projects which enabled them to analyse information and reduce the amount of common care problems in care home settings, such as falls and pressure ulcers.