Life Style Care plc

Minster Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 April 2016 and was unannounced.

Life Style Care plc operates Minster Grange Care Home and this was the first inspection since the provider registered in May 2015. The home is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for up to a maximum of 83 people. There were 72 people living at the home at the time of this inspection.

The home is situated in York and there are six units currently open within the home. Care can be provided for young disabled adults and older people and those with nursing and dementia care needs. The ground floor has two units, Ash and Aspen, and provides nursing care and care for young people. The middle floor has two units, Beech and Briar, and provides care for people living with a dementia related condition. The top floor has two units, Copper and Chestnut, and is for people living with dementia and people requiring residential care. There is a safe garden for people to use and a car park is available for visitors.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified some concerns about the way that peoples consent to care and treatment was obtained and recorded. It was not always clearly recorded how the registered provider ensured that individuals had been consulted with about their care needs, and that people had agreed and consented to the care and support being provided for them. We found the registered provider had audits in place to check that the systems at the home were being followed. However, we found these had failed to detect omissions in recording and there was a lack of documentation in relation to obtaining peoples consent in their care plans. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the Mental Capacity Act 2005 (MCA) guidelines had been followed. We found staff had a basic awareness around the principles of the Mental Capacity Act (MCA) (2005).

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff deployed to meet people's needs. Staff had been employed following safe recruitment and selection processes and we found that the recording and administration of medicines was being managed appropriately at the home.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses deemed by the registered provider as both essential and service specific. Staff told us they

completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity.

People's nutritional needs were met. People told us they enjoyed the food and that they had enough to eat and drink. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day. However some aspects of the dinging experience could be improved and the registered manager was taking action to address this.

People spoken with said staff were caring and they were happy with the care they received. They had access to a wide range of activities provided in the home.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. People who lived at the home received additional care and treatment from health professionals based in the community.

We saw people's complaints had been responded to appropriately using the registered provider's complaints policy and there were systems in place to seek feedback from people and their relatives about the service provided. We received mixed responses about how effectively the registered provider responded to people's concerns. We discussed these comments with the registered manager at the end of the inspection who agreed that further work was needed to respond to concerns and provide more thorough feedback to people.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were processes in place to help make sure the people who lived at the home were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adult's procedures.

Assessments were undertaken of risks to the people who lived at the home and written plans were in place to manage these risks. Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Medicines were managed safely so that people received them as prescribed.

Is the service effective?

Good

The service was effective.

We saw staff had been trained in the Mental Capacity Act (MCA) and were working within the principles of the MCA.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience and gave encouragement when supporting people.

We observed good interactions between people who used the service and the care staff throughout the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw people were encouraged and supported to take part in a range of activities.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered provider had systems in place to monitor and improve the quality of the service. However, they had failed to detect omissions in recording and there was a lack of documentation in relation to obtaining peoples consent in their care plans.

Staff and people who visited the home told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who lived at the home and their relatives to express their views about the care and the quality of the service provided.

Minster Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 April 2016 and was unannounced. The inspection team consisted of two Adult Social Care (ASC) inspectors and a Specialist Advisor (SPA) on the first day and three ASC Inspectors and a SPA on the second day. A SPA is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. The SPA who supported this inspection had knowledge and experience relating to older people, nursing care and medicines management.

Before this inspection we reviewed the information we held about the service, such as safeguarding information and notifications we had received from the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought relevant information from the City of York Council (CYC) safeguarding and commissioning team. They informed us that earlier in 2015 they had some concerns about the service, but recent visits by the commissioning team at CYC had shown the service was improving. The registered provider submitted a provider information return (PIR) in October 2015. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 12 people who were living at the home, seven visitors/relatives, one visiting healthcare professional, 17 staff, the deputy manager /clinical lead, the registered manager and the area manager. We looked at six people's care records, medication records, staff rotas, complaints records, meeting records, staff training records and other records about the management of the service. We also spent time observing the interaction between people, relatives and staff in the communal areas of the service and during mealtimes and activities.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Minster Grange, comments included, "Yes I feel safe here, the staff look after me," "I'm not so bad at all" and, "Oh yes, I am well looked after."

Relatives we spoke with said they felt their relative and other people using the service were safe in the home. They told us, "All the staff are very friendly and we have no concerns" and, "[Name] is definitely well looked after, any problems that arise they [staff] take care of them."

People's care plans included details of risk assessments which helped them to live their lives safely; these included the risks associated with moving and handling, falls and choking. Various clinical assessments had been completed including continence and nutrition, and nationally recognised risk assessment tools, for example, Waterlow scores and malnutrition universal screening tools (MUST) were used to assess people's needs. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given patient and MUST is a five-step screening tool to identify adults who are at risk of malnutrition or obesity It also includes management guidelines which can be used to develop a care plan. We saw these were reviewed regularly and that they helped to identify people's needs and risks.

Prior to the inspection we reviewed the information we had received about the home in relation to the safeguarding of vulnerable adults, which included consulting with other professionals. We received information that indicated there had been an increased number of safeguarding concerns, and concerns in relation to staff's understanding of the procedures to follow. During this inspection we saw the registered provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse. When we spoke with staff they were confident they would raise any potential safeguarding concerns with more senior staff and that these would be handled appropriately. Comments included, "I would report any incident to my manager, it could be physical abuse or someone speaking to a person in a verbally inappropriate way," "I have a level two in safeguarding training. I look out for any bruising or something a person may say. If there are any marks or anything out of the ordinary I would report it to the managers" and, "I know about two or three months ago I saw an incident occur and I went straight to [Name of registered manager] and the person was asked to leave the premises immediately. I have had safeguarding training and I would always go to [Name of clinical lead] or the nurse in charge." Staff also told us and records held at the home confirmed they had undertaken training in relation to the safeguarding of vulnerable adults. This meant people were supported by staff who were trained and who had access to information on how to support someone should an allegation of this nature be raised.

The registered manager was able to describe the local authority safeguarding procedures. This consisted of phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about an investigation. There had been instances when alert forms had been completed and when the Care Quality Commission (CQC) had been notified. These were completed appropriately and in a timely way. We noted that there was no clear evidence of any verbal discussions held with the local authority safeguarding team in relation to any concerns or advice given. We discussed this with the registered manager who implemented a 'monitoring log' for this purpose during this inspection.

This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We observed that the home was busy, but organised and staff worked in and around the communal areas throughout the day and we found that the call bells we heard were responded to promptly. When we asked people who used the service, staff and relatives if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were times when the service had been short staffed. Comments included, "There is enough staff," "There have been times that there have been no staff in Briar lounge" and, "When I first started staffing wasn't great and we used a lot of agency staff." When we asked people to qualify what they were saying they told us, "There have been times when people have had to wait for support. It has got better and I have noticed that more staff are in the lounges and it's better now than it was" and, "The staffing has definitely improved now and we have more staff."

The registered manager told us there were currently 72 people living at the home and said, "We usually have 22 care staff and four nurses on during the day and 11 care staff and two nurses on duty during the night." They told us that they used a 'dependency tool' to assess the needs of people who used the service and to identify the levels of staff required to meet those needs. We saw that the dependency levels for the service were calculated each month and duty rotas were prepared one week in advance. We saw copies of the duty rotas were displayed on the staff notice boards and details of staff on duty were displayed on a 'white board' that was present in each unit of the home.

The registered manager told us they were, "Currently recruiting staff and awaiting the return of safety checks to bring staffing numbers up to 11 permanent night staff to reduce the reliance on agency staff." From the records we checked during this inspection we could see that no agency staff were used during the day at the home, only during the night. When agency staff were used these were people who regularly worked at the home. A relative told us, "They do get agency staff when they need them, but it is difficult with strangers [agency staff] as it caused [Name] to be a bit less relaxed. Lately they seem to use regular agency staff." Staff and a visiting healthcare professional told us, "The staffing situation is good now and no agency staff are used," "Staffing levels are good, the residents get looked after first" and, "The management team have really pushed for staff and Beech and Briar units now have eight staff across both."

We looked at the duty rotas from 15 April to 12 May 2016 and we saw these indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rotas. The duty rotas showed us there was sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of registered general and mental health nurses, team leaders, day and night care staff, administrators, activity co-ordinators, catering staff and maintenance personnel.

The provider information return (PIR) we received told us, 'Accidents are recorded and investigated and lessons learnt shared with appropriate staff with improvements resourced as required.' The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed that a monthly quality report on all accidents was collated and broken down into areas such as skin tears, time of day the accident occurred, bruising, pressure ulcers, admittance to accident and emergency, equipment failure and witnessed / unwitnessed falls.

The registered manager told us that in response to an incident at the service the whole staff team was in the process of receiving further training on first aid and cardiopulmonary resuscitation (CPR) and where people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) orders in place, these were made clearly

visible to all staff. We saw from training records and certificates held at the home (provided after this inspection) that 89 staff had completed training in first aid and a further 53 staff were booked to attend the course. Peoples DNACPR orders were clearly visible in their care plans, on staff handover sheets and recorded in red on the white boards in each nurse's office within the home. This meant the registered provider had taken steps to increase staffs knowledge and skills in the event of an emergency.

Staff told us how they kept people safe. Comments included, "I have recently done first aid and CPR training and we have a white board in the office with residents initials in red and it is recorded in red on handovers and in people's care plans to let us know if they have a DNACPR in place," "People have sensors in their rooms and doors alarms which helps us to keep them safe," "We have moving and handling training" and, "If there is a fire we are not to use the lift and use the fire doors." We found that the fire risk assessment was reviewed in August 2015 and we saw the registered provider's business contingency plan; this advised staff on the action to take in the event of a fire, power failures, flood, severe weather, gas leaks and other emergency situations, and included the telephone numbers for people who staff may need to contact in an emergency.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place to ensure that equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm and the nurse call bells, moving and handling equipment including hoists and the passenger lift, portable electrical items, water systems and gas systems. We saw that the registered provider also had regular checks of the electrical wiring carried out and we were shown a copy of the five year electrical wiring certificate for the service. This showed that maintenance of the environment was important to the registered provider and resources were available to ensure its upkeep was dealt with effectively.

We looked at the recruitment files for six members of staff and we noted in one staff members file that only one reference was present. We discussed this with the registered manager who sent us evidence of the second reference for the person immediately after this inspection. We saw application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council (NMC) to ensure that the nurses employed by the service had active registrations to practice and we saw that 14 nurses employed by the registered provider had checks that were carried out in 2016.

There were systems in place to manage medicines safely and we saw from the training records held at the home that staff had completed medication training. The registered provider's policy had been reviewed in December 2015 and contained clear information on safe ways of managing medicines in line with best practice guidance. Additional medicine procedures were available for staff to follow that recorded specific instructions, such as protocols for people that required 'as and when' (PRN) medication.

We saw that people's medication was ordered via a local pharmacy on a 28 day cycle and each ordered prescription was seen and checked by staff. This meant there was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was stored securely in a well-equipped clinical room on each floor of the home. Medication was stored in locked medication trolleys and supplied in blister packs; this is a monitored dosage system where tablets are

stored in separate compartments for administration at a set time of day. We saw that the temperature of medication rooms and medication fridges were taken and recorded on a regular basis to ensure medication was stored at the correct temperature.

Some people who lived at the home had been prescribed controlled drugs (CDs); these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was a suitable storage cabinet and staff were recording the administration in a CD record book.

We observed the administration of medicines and saw that this was carried out safely; the staff member did not sign peoples medication administration records (MARs) until they had seen people take their medicine, and people were provided with a drink so that they could swallow their tablets or medicines. We observed one person refuse their medication and saw this was respected by staff, who recorded the refusal appropriately on the person's MARs.

There were specific instructions for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. Some people had been prescribed PRN medication (medication given when necessary) and the MARs had only been signed when this medication had been administered.

We checked a sample of MARs and saw that there were no gaps in recording. There was a list of sample signatures for staff so that records of administration could be checked and creams were recorded on the persons MARs and on body maps to record where on the body the cream should be applied; those we saw were up to date. We saw that medicine systems were audited regularly by the staff and the clinical lead.

Any medication that was returned to the pharmacy was recorded and a receipt confirmed that the pharmacy had received it. This meant the arrangements in place for returning unused medication to the pharmacy were satisfactory.

Good

Is the service effective?

Our findings

People and their relatives reported that the home provided effective care overall. Relatives told us, "The communication is good, I ask the nurse how she is and they are very forthcoming" and, "The staff ask [Name] what they want to do and they [staff] do listen." One person living at Minster Grange told us, "The staff are pretty good."

Staff we spoke with told us they had supervision meetings with their line manager and we looked at the supervision records for three care staff and six nurses which indicated that sessions took place regularly with discussions that included safeguarding, recording of documentation, confidentiality, training and professional boundaries. We saw that an issue had occurred in the home around professional boundaries and that this had been discussed in the relevant group of staff in supervision meetings. We also saw that 18 staff had been encouraged to complete a quiz about boundaries and also to re-visit the Code of Conduct for healthcare support workers and adult social care workers. The Code of Conduct sets the standard of conduct expected of all adult social care workers and healthcare support workers in England. It helps workers provide high quality, safe and compassionate care and support, and outlines the behaviours and attitudes that people who use care and support should rightly expect. Staff told us that overall they found the supervision sessions beneficial as they could talk about their concerns. They told us, "Yes, our boss comes and does spot checks regular with us," "I have not had supervision, but if there are problems the line managers will speak to you directly," "I am new to the home and have had one supervision," and, "Yes, we are supported better now."

We looked at induction and training records in detail for six members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the home. Staff we spoke with confirmed they completed an induction and training programme before starting work at the home. They said, "Yes, I'm trying to do lots of courses and I feel competent in supporting people," "I am offered plenty of good training, I enjoyed the dementia training and I am interested in more training," "During my induction I completed health and safety training, fire, safeguarding, moving and handling and person centred care training," "The training was really good and interesting" and, "New staff do shadowing shifts and continue until they feel confident." A visitor told us, "Staff are usually in good spirits and keen to learn."

We saw induction documentation that indicated new staff were orientated to the home and that training covered information such as accident reporting, emergency situations, call bell system, laundry, food handling and corporate policies and procedures at the start of their employment. The maintenance person told us, "I am qualified to deliver all the health and safety, safeguarding, infection control, food hygiene, nutrition and fire training. I base the learning on examples I have seen in the home. The fire safety is delivered every six months to day staff and every three months to night staff and I take people on a complete tour of the building showing them where the call points are, the nurse call system and the fire assembly points. All of this training is completed with the person before their police checks come back." As staff gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity.

The registered manager told us that there was an on-going programme of training for dementia care and person centred care at the home and we saw from the records we looked at that collectively 102 of the 150 staff employed had completed this training at the time of this inspection.

We asked staff about how they used the training they received around dementia care in their everyday working practices, and received some good feedback. One member of staff said "[Names] were together and one of them would not come out of the room and was becoming distressed. I took a step back from the situation and gave the person time to calm down and some space and they came out when they were ready." Other staff told us, "People are always given choices and you get to know people, for example, [Name] cannot verbally communicate but I know they will smile or make a noise if they like something" and, "People are in charge of their own lives."

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 (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. Records showed that 36 DoLS were in place and 8 further applications had been submitted at the time of this inspection. We saw a written record of the date DoLS authorisations expired and the details of any conditions. The registered manager told us that potential DoLS were identified as part of pre-admission assessment and we saw the guidance available on identifying DoLS. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility in relation to the MCA/DoLS.

The service training record we looked at showed 67 staff had completed training on MCA/DoLS awareness during the last two years. However, staff we spoke to during this inspection had a basic understanding of the principles of MCA, but did not always understand that MCA and best interest are time and decision specific.

We identified some concerns about the way the service obtained and recorded consent. It was not clearly documented how the registered provider ensured that individuals had been consulted with about their care needs, or that people had agreed and consented to the care and support being provided for them. In three care plans that we looked at people were deemed to lack capacity to make decisions about their health and well-being. There was no information about their families having power of attorney (POA) but their families had signed to consent to their care and support. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and / or finances). For example, we saw that one person had a valid DoLS authorisation and was receiving their medication covertly. There was evidence in the persons care plan that their family members, GP and pharmacy had been consulted in reaching this decision. However, there was no documented MCA assessment or best interest decision around their use. Covert medication is the administration of any

medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. Another person's care plan indicated in a local authority review that they were deemed to lack capacity but we were unable to see any MCA assessment or best interest decisions made around the care and support they required. We have reported on this further in the well led section.

The staff monitored people's health and wellbeing and people were able to talk to health care professionals about their care and treatment. We saw evidence that individuals had input from their GP's, district nurses, dieticians, physios and community mental health teams. All visits were recorded in the person's care plan with the outcome for the person and any action taken (as required). One relative told us, "The doctor visits on a Tuesday and they phone to tell me if anything's happened, for example if [Name] has got a chest infection."

Assessments, care plans and risk assessments recorded a person's particular needs in respect of eating and drinking including people's likes and dislikes or any specific dietary requirements. Care plans also showed that staff took advice from dieticians and the speech and language therapy team (SALT) when they had concerns about a person's nutritional intake or the risks involved in swallowing / choking.

Everyone we spoke with said the food was good. They told us, "I have no complaints, it has improved a lot," "The food is good, there is enough variety and choice," "The food is good especially the puddings. We had a meeting with the manager recently, I complained that we were being offered too much foreign food, and since then the food has greatly improved."

Visitors to the service were also able to enjoy a meal with their friend/relative if they wished. We saw one person's relative helping them to eat their meal and enjoying a meal themselves in one of the dining rooms. Visitors told us, "I get asked most times if I want some lunch" and, "The food is good, they've got to try and suit everyone, but there is plenty of variety over the week, maybe two choices at each meal and more than enough to eat."

We observed the lunchtime meal in four of the units during this inspection and we saw lunch was held in bright, clean dining rooms with space for people who used mobility equipment to move around. From our observations we saw that people received mixed experiences in the dining rooms; during two of the meals we saw staff and people were engaging and chatting with each other and lunch was a sociable event. People who required support with eating their meal were assisted by staff and were not hurried. We saw staff asking people what meal they would like to eat; in one of the dining rooms this was a choice of shepherd's pie or salmon.

Progress with eating was at various speeds as might be expected and some areas of the home were relaxed and unhurried. However, during other observations we saw that some people lacked support from staff and we identified some practice which could be improved. For example, we saw one person needed support to eat their food and was attempting to do this themselves using their knife and a beaker. Staff were busy providing food for people in their rooms, at the tables and in their chairs which meant there was no one to support this person to eat their meal. We asked for someone to support the person and this was responded to immediately. Another person requested to use the bathroom at lunchtime and was supported to do so; however we saw the person's lunch was left uncovered on the table for approximately seven minutes and when they returned the temperature of the meal was not checked to see if it was still warm enough or to offer a fresh meal.

We observed another person to be drowsy during lunchtime and only ate a small amount of food. Staff were eating with other people and did not offer any prompt or encouragement to the person to eat until they had

finished their lunches which was approximately 15 minutes later. We then observed staff to only offer brief encouragement for the person to eat in passing. They were not offered any alternatives or any meaningful encouragement or support to eat more. We checked the persons care plan which recorded, '[Name], may need help eating especially if [Name] is tired. [Name] may need prompting to eat food and food and fluid intake should be recorded.' We were unable to see any food or fluid monitoring in place for the person and during discussions with staff we were told these were not necessary as the person's weight was stable which we saw was correct.

Discussions with the registered manager indicated that work was still continuing to provide a positive dining experience for all people living at the home and from discussions we held with relatives we could see there had been improvements made. One relative told us, "The food is great now, in the past I felt I had to bring food in as [Name] could not eat much of what they were offered. I don't need to complain now."

Good

Is the service caring?

Our findings

Everyone we spoke with told us they felt staff at Minster Grange cared about them. People commented, "It's a lovely home, I've lived in this area all my life" and "It's probably as good a place as any." Relatives told us, "[Name] is content and quite happy here, they don't worry and say isn't it beautiful here nearly every day" and, "Staff are helpful and compassionate – our minster family, that's what we call them."

We observed that there were good interactions between the staff and people who lived in the home, with friendly and supportive care practices being used to assist people in their daily lives. Small acts of kindness were noticed several times, for example, during an observation we saw one person who appeared to be distressed and was crying; a staff member quickly bent down to the person and told them, "It's okay" in a calm and quiet manner. The staff member then encouraged the person to join in with the group by asking them if they wanted to sing a song. We saw that staff were consistently pleasant with people who lived in the home; the staff clearly knew them and their personality. One member of staff told us, "Staff definitely care, you can tell by the way they approach them [people using the service] and give them choices. They are genuinely good with them." People who lived at the home said, "Staff are very good to me and they take me to see my friend" and another person told us the staff were kind and caring and they could always get hold of someone if they needed them. Relatives told us, "They listen to [Name] and don't disregard what they say and let [Name] do what they would like to" and, "They [staff] care, it isn't just a job to them. They are full of life and they bounce around."

People told us that staff respected their privacy and dignity. One person said, "They always treat me with respect." Staff told us that they knew how important it was to respect people's dignity and to maintain their confidentiality. They told us, "We treat residents as you treat your family and respect them," "We take them to their room or toilet and assist them there. Nothing is ever done in public spaces" and, "We get residents to be as independent as possible. It's not dignified to do things for people."

We saw that the people who lived at the home were clean, appropriately dressed, had tidy hair and were wearing appropriate footwear. Relatives told us that their family member's privacy and dignity was respected by staff at all times. Bedrooms were spacious and there were also various areas of the home where people could meet with relatives and friends in private, and where private meetings could be held.

We saw that visitors came to the home throughout the day and that they were made welcome by staff. They chatted to other people who lived at the home as well as their relative or friend. Family members told us that they were made to feel welcome at all times and that they were well looked after. Relatives told us, "I'm made to feel very welcome when I visit," "The support they have given me is wonderful" and, "Staff are very caring, I have not seen one that is not, they are always polite." Staff told us they enjoyed working in the home. They said, "I don't think the place is perfect but on the whole yes, I like working here," "Some of the carers are fantastic with the people that live here. I have never seen anyone left without personal care and the staff are really good and take their time with people" and, "The place is sociable and people are clean and well looked after."

Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. This showed that people and their relatives had been involved in assessments and plans of care. However, we noted that peoples care plans in one of the nursing units we looked at were heavily weighted in favour of the person's physical care and did not include much information based on the person centred approach to care. In discussions with the registered manager it was clear that this work was still to be introduced in some parts of the home.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager.

Discussion with the staff revealed there were no people living in the home with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told one person's cultural needs were supported by the home in respect of specific food. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The provider information return (PIR) we received told us, 'A programme called Namaste is being delivered to provide care for residents. This programme will be evaluated, early feedback is very positive; residents are showing less agitation, better appetite and better sleeping patterns. The programme offers interventions in a more intensive way to all five senses. For example, a comfortable reclining chair, in a peaceful room with pleasant fragrances, sweet treats and drinks offered, sounds that the residents may enjoy and a relaxing activity with perhaps a hand massage or reminiscence work.' The registered manager told us they had employed three staff who had completed in house training and were providing the 'Namaste care programme' for a total of 20 hours each week to people who lived at the home. Namaste Care is a stimulating, comforting and person-centred approach to care for people living with dementia that concentrates on meeting all of the five senses and follows core elements such as comfort and pain management, meaningful activity and sensory stimulation. We saw this included one to one care and attention for people with head, feet, hand and arm massages, soothing music and pampering sessions. A staff member told us the programme was aimed at people who were living with dementia and may be at risk of social isolation and involved the completion of a social isolation screening tool with the person which would determine any therapy sessions they may wish to take part in. We observed a 'Namaste' session with one person who lived at the home (with their permission); which was held in a dedicated therapy room. They told us, "I have on-going problems with my feet and I have a foot massage every day which brings me some relief and the music gets me in a trance" and, "I find it eases my pain a bit as I get a lot of pain." We noted that this programme promoted people's well-being.

Good

Is the service responsive?

Our findings

Everyone we spoke with during this inspection told us the activities in the home were good, comments included, "There are always activities, all different things on. I enjoy the activities, I don't always feel like it, but I get involved," "We have a sing song and a game of bingo, I enjoy that very much" and, "There are loads of things going on. This morning was the choir, there are prayer meetings and phantom of the opera was shown yesterday. Recently we went to the railway museum and Wacker's fish and chip shop." One visitor told us, "There has been a massive shift and improvement in interaction across all three floors here. Today we have put on a show and the staff have gone the extra mile for people. They have been by their side, they have catered for their every need like making sure they weren't in the sun and keeping them hydrated. Staff have embraced the entertainment more and when we tell them the next theme they start planning for it immediately. This is one of the best turnouts we have ever had and people were smiling."

We spoke with one of the activity workers for the service who told us there has been a big improvement in the activities at the home and there was now a structured programme of events for people to take part in if they wish to. They told us, "People would be sat doing nothing and not talking to each other. It is so much better now and everyone gets involved in the events and it's really lovely" and, "One person used to sit in their chair all day and not engage at all. We worked with their family and did work on the person's life story to help us get to know them as a person. Since then they seem happier and will engage more in a group" and, "Since the training on person centred care it has been taken on board to give people more choices such as what clothes they would like to wear."

When we asked staff and relatives about how person centred approaches were used at the home they told us, "[Name] has their own furniture and memory box, we were encouraged to do a life story book and now the staff do look at it" and, "We use person centred approaches now, I always ask people things like if they would like to get up or stay in bed, what they would like to wear and what they would like for breakfast."

We observed the choir activity during the inspection and saw that 18 people joined in with the event. The three staff members supporting the activity were seen to be both engaging and inclusive during the choir making sure that everyone was involved; some people had lead roles by choosing the songs and one person took the role of counting people in before the singing started. People were given the lyrics to the songs and several songs that were clearly known to people were included, which they thoroughly enjoyed singing. We saw visual activities boards in communal corridors that displayed pictures of weekly events including the choir, games morning, Sunday service, makeover mornings, Sunday spas, cooking club, chess, music, coffee mornings and bar nights.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual. Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at six of these files and records evidenced that the information had been gathered from the person themselves, their family and from the registered

person.

We saw that most assessments, risk assessments and care plans had been updated as needed so that they included current information for staff to follow. However, we noted there were some omissions in the recording in people's care plans. For example, one person's professional visits notes recorded in April 2016, 'Dentist detected an abscess.' The person was also reported to be unsettled and in pain as a result of this. We saw the personal hygiene care plan contained no details of any support the person required to clean their teeth and it was only recorded once throughout the month of April 2016 that staff provided assistance to the person to clean their teeth. All other entries recorded this had been declined or not completed. The ABC (Antecedents, Behaviour, Consequences) charts we saw did not provide sufficient information or analyse/explore the cause of the person's behaviour, providing limited use in reducing future incidents or developing a person centred approach to supporting people with challenging behaviour. ABC charts can be valuable tools to assist the development of strategies to manage behaviour. We discussed our findings with the registered manager who agreed that these issues would be addressed in a wider context and recording would be developed further.

The provider information return (PIR) we received told us, "Communication is the key theme that we are addressing. We have improved by providing timely responses to families, dealing with concerns as soon as we hear of them." We received mixed responses when we asked staff and peoples relatives if they felt the service would respond appropriately to any concerns or complaints that were raised. Comments included, "A lot of staff left as they were not getting supported, they raised concerns which were not addressed" and, "The Managers are approachable however I am not sure that they always deal with concerns raised, maybe too many things are swept under the carpet," "Yes people listen to what we have to say and we can always go and have a chat" and, "I feel very comfortable and listened to. They [Managers] would respond to you."

We looked at the registered managers audits which were completed each month and included an analysis of concerns/complaints. We saw it had been identified in October 2015 that the registered manager of the home should complete a walk around each of the units every day. When we asked staff if this had been achieved they told us, "You see the managers as they come into the units but you don't always get to speak to them" and, "We are supported better and the managers are trying to be visible in the units more." We discussed these comments with the registered manager at the end of the inspection who agreed that further work was needed to respond to concerns and provide more thorough feedback to people.

There was a complaints procedure in place. We checked the registered provider's complaints log and saw that the folder was divided into months and any complaints or concerns that had been received had been stored accordingly and recorded on the complaints action plan. The PIR told us in the 12 months prior to the completion of the PIR in October 2015; the service had received 18 formal complaints. Our checks of the registered provider's complaints log indicated that there had been one further complaint made in 2016 and we saw evidence that the registered manager had responded to the complaints and where necessary had sent the complainant a written response.

There were other opportunities for people living at Minster Grange and their families to raise concerns or provide feedback to the registered manager. These included monthly resident and relatives meetings and quality assurance surveys. A meeting for residents/relatives was being held on the first day of this inspection and we saw this was advertised on the noticeboard. We were given access to the minutes from these meetings and we saw the last two meetings had discussed the offer of fresh fruit; we saw this had been implemented and fresh fruit smoothies had been purchased.

The most recent quality assurance surveys for people who lived at the home had been carried out in August 2015 and we saw 19 had been returned with 12 positive and 7 mixed responses and the results analysed.

Requires Improvement

Is the service well-led?

Our findings

We found there was a quality monitoring system in place that consisted of daily, weekly, monthly and annual audit checks, meetings and questionnaires, and the analysis of the information collated from these. We saw audits were carried out on a variety of topics such as accidents, infection control, medication, care plans, staff training and safeguarding referrals.

We found during our inspection that although care plans were being audited, those audits had failed to detect omissions in recording for the level of support people required with elements their personal hygiene and we identified a lack of documentation in relation to obtaining peoples consent to their care needs. We identified a lack of clear guidance in care planning for people who may exhibit challenging behaviour and we saw ABC (Antecedents, Behaviour, and Consequences) charts did not analyse or explore the potential causes of the persons behaviour. Not all people felt that complaints were appropriately responded to by the registered manager and feedback to concerns raised by people could be followed up with the person more thoroughly.

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

We sent the registered provider a 'provider information return' (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned with the given timescales. The information within the PIR told us about changes in the service, improvements being made and enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) since 2015; this meant the registered provider was meeting the conditions of their registration. The registered manager told us that they attended regular local care home manager and clinical commission group meetings as well as manager's meetings within the organisation, and that this helped them to keep up to date with any changes in legislation and with good practice guidance.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

The registered manager was supported by a deputy manager/clinical lead and office administrators. When we asked staff if they felt supported by the management team at Minster Grange they told us, "My manager is good," "We have handover every morning and we go into the café and talk about the previous day" and, "I have no problems in going and speaking to my managers and saying what I need. The managers have brought me more into the team and I feel comfortable and listened to."

We saw a variety of meetings were held with staff across the departments at the home including the 'nine at nine' meeting held every morning for nurses and team leaders, a twice weekly meeting between heads of departments and the chef, maintenance and activity workers and care staff meetings. We saw various topics were discussed at these meetings including planned activities for that day, people who were unwell, people with pressure sores, resident of the day (service user whose care files would be audited), feedback from relatives, admissions, appointments, duty of candour and social media usage.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires and meetings. This information was usually analysed by the registered provider and where necessary, action was taken to make changes or improvements to the service. We saw thank you cards and emails sent to the home thanking the service for its support and care. Comments we saw included, 'Thanks to staff that have shown care and consideration,' 'Food is excellent, my [Name] experience of meals is a vast improvement since our meeting,' 'I can never thank you enough' and, '[Name] always smiles when one of you enter their room.'

Staff described the culture of the home to us, they said, "Any problems I can talk to anyone here and the managers door is always open," I enjoy it, I think it's ace," "I absolutely love my job" and, "The manager has not long taken over and it is completely different. [Name of manager] is so approachable."

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have in place complete records in respect of service users decisions taken in relation to the care and treatment provided and effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17 (2) (a) (c)