Care Quality Commission

Garden House Rest Home Limited

Garden House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Overall summary

The inspection took place from 5 August 2015 to 11 August and was unannounced. The home is a residential care home and provides support, assistance and personal care for up to 14 older people. The care home is established in the main house with an extension to the property named Trudy's Cottage. All rooms apart from one are on the ground floor. One room, situated on a lower level of the home has steps and a stair lift fitted. At the time of the inspection there were 12 people living at the home and in an adjacent building.

Garden House was last inspected on 30 September 2014. The home was found to be not meeting the required standards in care and welfare, management of medicines, assessing the quality of the service and not always notifying us of incidents. Improvements had been made to the care of people and managing medicines. However, further improvements were needed in the governance and sustainability of assessing the quality and monitoring of the service.

Summary of findings

People were not being protected because the recruitment of new staff was inconsistent. The manager was unaware of the importance of procedures like checking staff references before they were employed.

While risks to most people were identified, some people were not kept safe because risks had not been fully assessed. Oxygen was in use but the risk assessment did not include the risk of fire or how to store the cylinders correctly. The assessment did not include the risk posed to other people using the service.

Staff understood how to protect people from abuse and bullying. They explained the circumstances which could lead to people being abused or neglected and the actions they would take. There was sufficient staff to support people and meet their individual needs. One relative said, “There is plenty of staff about and they are always willing to help”.

People received the medicines they needed on time. Medicine charts were checked before medicines were administered to each person and the record was signed as given.

The service was not effective. Staff were not fully aware of the relevant requirements of the Mental Capacity Act 2005 (MCA) and how this could impact on care. Most people living at the service had capacity to make day to day decisions, although it was unclear how staff were assessing people’s mental capacity as their mental health and medical conditions changed.

People received health support through referrals to healthcare professionals including audiologist (hearing specialists) community nurses and from regular contact with their GP. People received sufficient food and drink to meet their individual needs. People told us they had enough to eat and drink and that food was hot.

Staff were trained to provide care and support to people living at Garden House. They attended a variety of training including medicine management, food hygiene and safeguarding adults.

People were cared for by staff who demonstrated understanding and consideration for people’s needs and their circumstances. Staff made time to attend to important aspects of people’s care like cleaning their glasses and checking they had enough toiletries and other resources. One person said, “Staff are caring, they look after me very well, the same ones, and the same staff.”

Several people wished to remain as independent as possible and staff provided examples of how they understood what this meant to people.

The service was responsive to people’s needs. People told us they felt they could talk to staff and the manager if they had concerns or wanted to discuss anything. People and their families were involved in regular opportunities to provide feedback and the results were used to make changes to the service that people received.

Adjustments were made where people’s needs changed following discussion with them and their families. Staff were aware of the individual and varying abilities of people and provided examples. These included where people used walking frames to assist their movement around the home and became tired, then wheelchairs were made available.

The service did not have a registered manager. When we visited there had not been a registered manager in post for the last 22 months. 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.

The lack of a registered manager impacted on the support, leadership and guidance to staff. Improvements made since the previous inspection were unlikely to be sustained. Staff felt there was a lack of leadership from the manager and they were unsure on how management decisions at a senior level were made. Responsibility for the leadership of the home was unclear as management support was being provided by a relative of the provider.

The provider had not submitted a Statement of Purpose to the Commission. Services registered with the Commission are expected to supply an up to date Statement of Purpose for our records.

Summary of findings

We found a number of Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the end of the full version of the report.

Summary of findings

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 safe. People were not being protected because recruitment procedures were inconsistent. The manager was unaware of the importance of checking staff references before they were employed.

Risks to people were identified. However, oxygen was in use and although risks had been assessed this did not include the risk of fire, safe storage of the cylinders and risks to others.

Staff understood how to protect people from abuse and bullying. They explained the circumstances which could lead to people being abused or neglected and actions they would take.

People received their medicines on time, these were checked before being given and charts were completed and signed.

There was sufficient staff to support people and meet their individual needs.

Is the service effective?

Requires improvement

The service was not effective. Staff were not aware of the relevant requirements of the Mental Capacity Act 2005 (MCA) and how this could impact on care. Most people living at the service had capacity to make day to day decisions, although it was unclear how staff were assessing people's changing mental capacity.

People received health support through referrals to healthcare professionals including visiting community nurses, opticians and hearing specialists.

People had enough to eat and drink to meet their individual needs. People told us they enjoyed the food which was hot and tasty.

Staff were trained to provide care and support to people living at Garden House. They attended a variety of training including medicine management, and food hygiene.

Is the service caring?

Good

The service was caring. People were supported by staff that were caring and considerate.

Staff provided care that met people's individual needs. They assisted people who needed support and where people wished to remain independent, staff understood what this meant to people.

People were involved in making decisions about their care. Staff were knowledgeable about people's life experiences, their level of ability and was aware of, and sensitive to, people's wishes and concerns.

Summary of findings

Is the service responsive?

Good

The service was responsive. People told us they felt they could talk to staff and the manager if they had concerns or wanted to discuss a complaint.

People and their families were involved in regular opportunities to provide feedback and the results were used to improve people's experiences.

Changes in care were discussed with people and adjustments were made where people's needs changed. These included where people used walking frames to assist their movement around the home and became tired, wheelchairs were made available.

Is the service well-led?

Requires improvement

The service was not well led. It was unclear from our inspection how leadership of the organisation was being addressed and managed.

The service is required to have a registered manager in post to manage and lead the home and this had not been met. There had been no registered manager at Garden House for 22 months.

We received conflicting comments from the staff about the leadership and management of the home.

The quality of the service was monitored to improve the care people received. Staff had been given new responsibilities and these had improved the overall quality of the service. However it was not clear how these developments would be sustained without consistent leadership.

Garden House

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.

The inspection was carried out by a single inspector on 5, 7 and 11 of August and was unannounced.

Before the inspection we reviewed all the information we held about the service. This included statutory notifications sent by the service. We requested a Provider Information Return (PIR) from the service before the inspection, however this was not returned to us. A PIR is a Pre-Inspection questionnaire that asks the provider to give key information about the service, what it does well and the improvements they plan to make. Its purpose is to assist in inspection planning and to help identify areas to explore in more detail on a site visit.

We spoke with six people living at the home and three visiting relatives. We spoke with eight members of staff including the manager. We talked to the owner and their daughter. We contacted five health care professionals involved in the care of people at the home to seek their views on the service. We observed care and practice and looked around the home throughout the inspection.

We carried out observations of meal times, medicines administration and general service observations. We reviewed three people's care records and five Medicine Administration Records (MAR) along with the care people received. We checked records relating to the running and management of the service such as health, safety and hygiene checks, accident and incident reports, a fire officer's report, environmental assessments, and quality assurance checks.

Requires improvement

Is the service safe?

Our findings

People were not being protected or kept safe because recruitment procedures were inconsistent and the manager was unaware of the importance of following recruitment procedures. Some staff had provided curriculum vitae to illustrate their work skills and previous experiences while others were recruited through personal contacts. Application forms were brief and only included the applicant's basic name and address details. There were inconsistencies in how employment history was gathered and presented. Some had limited information and an absence of details about employment dates or reasons for leaving their previous posts.

References were not always followed up. The manager told us that not all posts were advertised and that some staff had made direct contact for employment. Some references had been sourced for some staff but there was no reference records for one applicant recently employed. The manager told us they had attempted to collect staff references and that one referee had not responded but this had not been recorded. In other cases there were no records that references had been checked or that conversations by telephone about applicants' suitability from previous jobs references had been recorded.

This was a breach of Regulation of 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3).

Other employment checks, including Disclosure and Barring Service checks and proof of identity and address were completed before staff began their employment.

The environment was well maintained and people's living spaces were kept clean and accessible. However, a relative told us that although no one had come to harm they felt that some areas of the grounds were unsafe; including the pathway leading to the home, noting the edge of the path was hazardous with no hand rail to steady people with a drop to the side of the path.

People were not protected from risks associated with the use of oxygen. While some risks had been assessed we noted that oxygen was in use and although risks had been assessed this did not include the risk of fire or how to store the cylinders correctly and safely, and did not include the wider risk to other people using the service. We brought this to the attention of the manager.

People did not have safe exit from the building in the event of an emergency and their safe evacuation had not been considered or assessed. Chairs had been placed outside people's patio doors in the event they could not leave the building through the main fire exits. However, we noticed that one person did not have a chair outside of their patio doors. We also noted there were no Personal Emergency Evacuation Plans for people living at the home. We were unable to discuss this directly with the manager as they had completed their shift for the day.

This was a breach of Regulation of 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3).

There was sufficient lighting and fixtures inside the home to support people moving about their environment safely and fire extinguishers had been checked and serviced. There were fire procedure notices explaining what to do in the event of an emergency and safety notices about hot taps. A recent fire inspection found only minimal changes required which included additional fire evacuation signage and advice on the safest time to use the tumble drier. Staff were advised to contact an independent fire safety company to carry out more regular checks and the manager was awaiting a report.

People were kept safe from abuse and avoidable harm safe because staff understood how to protect people from abuse and bullying. Staff explained the circumstances which could lead to people being abused or neglected and the actions they would take, these included, reporting and completing safeguarding referral forms and informing senior staff. One staff member said, "The forms are in the office". Another staff member said, "We safeguard residents and make sure they are not in danger and are not being bullied by anyone". Staff described warning signs that might mean people were at risk of abuse. Examples given were unexplained bruising and people being unusually withdrawn. One staff member said, "I would check their skin, note anything like finger marks, bruising and if concerned, I wouldn't hold back, I'd report it, if unsure, I would also contact the Care Quality Commission (CQC)". Staff were aware of the Whistle Blowing policy and one staff member said, "There's an internal Whistle-blowing policy; if you can't get through to your manager, then you go higher".

Requires improvement

Is the service safe?

One person said, "I feel very safe living here, I can always talk to the staff if I need to" and another person said, "It's very safe and secure I know staff will respond if I'm worried".

People's safety was maintained. Staff monitored incidents, accidents and injuries and these were recorded and monitored to identify trends and patterns of increased risk. Another staff member explained that hazards in the home had been addressed and gave examples including carpet replacement because of wear and tear. They also told us about how a bath mat had been replaced with a rubber bath mat to improve contact and avoid slips. Staff spoke to us about preventing injuries by making sure that brakes were used on beds and wheelchairs and making sure people had items needed within their reach, like call bells. Staff explained how new risk assessments had been used to identify hazards to people and how this had raised greater awareness. The risk of falls and accidents was supported by new policy guidelines for risk reviews and reporting.

People received the medicines they needed on time. People and their relatives told us they received medicines for their medical conditions and understood what most of the medicines were for. One relative said, "These are given on time for arthritis" and another person understood the condition their eye drops were used to treat.

Medicines were checked, administered and recorded in line with a new policy. The policy outlined that one staff member was responsible for medicines per shift and they kept the key to the medicine cupboard at all times. This was confirmed by three staff members. Medicine charts were checked before being given to each person, and then signed as given. The medicine cupboard was locked between each administration. Medicine records included photographs of each person to aid recognition and known allergies had been recorded. Where people were in hospital, codes were used to record this. Ointments and other medical creams had been labelled indicating the date they were opened and when they would expire. Body map charts made clear how and where creams and topical ointments were to be used and several staff confirmed this. However, we found two skin creams and an eye drop where labels had not been used. This meant it would have been difficult to identify when they were first opened for use or when they would expire, rendering them less effective.

On one occasion a staff member did not attempt to wash their hands or apply gloves before beginning to administer eye care drops. We raised the matter with the staff member before the eye drop was administered and they proceeded to wash their hands and apply gloves. Explanations about people's medicines were provided and people had time to take them. People were given a choice to take pain relief for their symptoms and their wishes were respected.

The manager explained how medicines were ordered, checked, administered and recorded and how pharmacy returned medicines were managed. Some medicines required regular reviews and were dependent on health checks and blood screening. The manager and one staff member both explained the process and safety precautions involved. This was confirmed by a healthcare professional providing treatment to the person.

Healthcare professionals told us they had confidence in staff managing medicines. One healthcare professional said, "I'm confident of how they manage medicines. We had to change one person's medicines recently and the staff showed insight and checked the resident understood". Another healthcare professional told us that one person required injections and checks were made to ensure there was the means for correctly storing the medicines.

There was sufficient staff to support people and meet their needs in a person centred way. One staff member told us that the team worked together to share responsibilities. They said, "Everyone mucks in we share cleaning, care and refreshments" and "Staffing levels are good, we've a good mix of age and range of experience. Some are more confident with certain tasks and activities. We complement each other because we have strengths and limitations; the team pull together".

People, relatives and staff felt there were sufficient numbers of skilled staff employed at the service. One relative said, "There is plenty of staff about and they are always willing to help". We were told that fourteen staff worked at the service and covered a variety of shifts to avoid the use of agency staff. One staff member said, "There has been a recent advert for a vacancy. This was for a bank staff member to cover for holidays; otherwise we cover for each other and that works well".

Requires improvement

Is the service effective?

Our findings

Consent to care and treatment was not always sought in line with legislation and current guidance. Most people living at the service had capacity to make day to day decisions, although it was unclear how staff were assessing people's mental capacity. Staff told us that several people's ability to make decisions was variable. One staff member explained that where someone did not have capacity to make decisions, relatives would be approached and asked for their 'permission'. One person was being cared for in bed and had bed rails in use. Staff told us that discussions took place with the person when they had capacity to make decisions and this was recorded in their weekly review notes. A risk assessment for bed rails had been completed but had not been dated.

Several people were not able to safely leave the home on their own and would have required assistance and support from staff. These people's mental capacity had declined in the time they had lived at the home. We checked our records and found that we had not received any documents related to decision outcomes made following applications for Deprivation of Liberty safeguards (DoLS), even though some people living at the service would not have been able to independently or safely leave the premises because of their variable capacity. Authorisations for DoLS had not been considered or applied for. This meant that for some people their rights may not have been upheld.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3).

Three people told us that staff sought verbal consent before carrying out care activities. Staff provided examples of how they sought verbal consent from people before administering care. We heard staff ask people questions before assisting them or when administering their medicines. Most records showed that people had provided written consent to their care and treatment at the initial assessment and for some, when reviews were taking place. Where people were unable to provide continued consent discussions took place with family members. No one living at the home required restraint and one staff member said, "If one of our residents chose not to have a bath we do not use restraint". Staff told us they used other strategies or returned later to offer assistance or an alternative

People were supported to maintain their health through regular contact with healthcare professionals. People received health care through appropriate referrals to healthcare professionals including audiologist for hearing aid management, nurses to monitor and manage wounds and through regular contact with their GP. People's records showed they had appointments with a variety of health care teams. One person said, "I get to see the community nurses". Staff were arranging a hearing appointment for one person and was in contact with services to make further referrals. Healthcare professionals told us staff communicated effectively with them about the people they supported.

People received care from staff that were skilled to carry out their roles and responsibilities. Staff were trained to provide care and support to people living at Garden House. They attended a variety of training in medicine management, fire safety, food hygiene, health and safety, moving and handling and safeguarding adults. A training matrix showed when staff received training and when their next training was expected and certificates linked with the training registered on the matrix. Staff confirmed the training they had received from a variety of sources including electronic and group learning and practical skills training.

Newly appointed staff had completed their Skills for Care induction training. They told us they received support from experienced staff and the manager during their induction and had the opportunity to shadow staff until they were confident to carry out their roles. They received regular support and appraisal from their line manager. This was linked to performance and their keyworker responsibilities. One staff member said, "We don't have to wait for appraisal, but we normally speak to the owner, manager of senior care team leaders and they are all usually supportive. However, we were told that one appraisal had been dated and signed before the appraisal had taken place. This meant that not all staff were given the timely opportunity to appropriately discuss their work and performance.

People had sufficient food and drink to meet their needs. They were supported to enjoy their food and experienced a relaxed and balanced meal at lunch time. Staff prepared

Is the service effective?

the meal area with table mats, crockery and drinking glasses and encouraged people to enjoy the meal experience together but those who chose to remain in their rooms had their wishes respected.

Lunch was served and included ham, egg and chips, carrots, peas and courgettes. Food seasoning was freely available for people to help themselves and sauces were offered by staff. Some people enjoyed a glass of wine with their lunch; other people had water or juice. Staff provided choice of food and extra portions. People were offered alternative deserts with a choice of yoghurt, ice cream, custard and stewed apple. Some people had specific requests while others followed specific diets and these were taken into account when meals were offered. People enjoyed a nutritious and balanced choice of food. There was a selection of fresh fruit and salad in the fridge and people had at least three types of vegetables with their main meal. Four people had fruit bowls and fresh fruit was available for others when they requested.

People told us they had enough to eat and drink and that food was hot. Several people said the meal was 'tasty'. Someone else said, "If I don't like a dish, staff will cook me an omelette or something else." This was confirmed by a staff member who said, "We can also make things like jacket potatoes". One person commented, "I get weighed every couple of weeks to make sure I'm not losing weight." They told us they had a choice of cereals, grapefruit and toast for breakfast and "My water jug is taken early and refilled and also filled if empty" and "Around 10:30am we get tea or coffee or even a vegetable stock drink and at 2:30pm we get offered another warm drink".

Food was being sourced and prepared for a garden party and this included a choice of salmon and roast beef. Two staff members told us that each day people had a choice of two different meals for lunch and menus were used to check what people preferred. One staff member had responsibility for ordering food which included fresh, frozen, tinned and packaged food. There was a range of food available for the preparation of meals and snacks. One staff member said, "People have good food here and they are well nourished". A staff member demonstrated how both the fridge and freezer temperatures were checked and recorded daily and a new meat testing thermometer had recently been purchased.

One relative felt cooking could be improved they said, "Food is not great, it could be more interesting and staff take turns to cook; some are better cooks than others. Sometimes it doesn't look appetizing or appealing and Sunday roast is cooked on Saturday". They also described how the service offered cuppa soups and toast for evening meals. We asked the manager about these points. They informed us that roasts were cooked in the morning when more staff were on shift to ensure there was always sufficient staff to care for people. We were advised that two people specifically requested cuppa soups and freshly made soups or tinned soups were prepared at tea time. We were shown a cupboard where fortified cuppa soups were available for those who needed more calories.

There were enough food supplies available for people at the home. The manager told us people had a hot meal each day and often had sandwiches, cake and fruit for their evening meal and that people could request other options like scrambled egg. We looked at daily meal plans. There was choice of foods offered on two different days and included prawn salad, a vegetarian lasagne dish and omelette and salad. Individual daily food and drink charts for three people showed details about the food and drinks people were consuming was varied and being recorded.

Good

Is the service caring?

Our findings

People were supported by staff that were caring and considerate. One person said, “Staff are caring, they look after me very well, the same ones, and the same staff.” Another person said, Staff treat me well and take care of me”. People living at the home and their relatives told us that visitors were welcomed and there were no strict rules on visiting times. While meal times were not considered the best time for visiting, relatives were welcomed to visit and support their family and assist with their meals. Another person said, “Visitors can visit when they wish but are encouraged not to visit at meal times unless pre- arranged”. Another person said, “Staff are very good, helpful, if I use my bell they respond as soon as they can” and someone else commented, “People can pop in and out, there’s no restrictions on visiting”. One person said, “I can go to bed when I want and I can request when I want a bath”.

People’s dignity was respected. Several people told us how staff protected and respected their safety, dignity and their privacy. One person said, “I’m called by my own name and all staff knock on the door before entering but some will wait to be invited”. Staff gave examples including keeping people’s doors and curtains closed, and restricting their exposure during personal care.

People were treated with understanding and compassion. Staff made time to talk with people and sought to understand their preferences. They showed compassion when working with people and when meeting their needs. Call bells worked effectively and people told us that if they used their call alarms staff responded. We tested one call alarm from someone’s room and a staff member attended immediately. Most people were called by the names they preferred and found recorded in their care records although occasionally staff shortened one person’s name and referred to other people as ‘my darling and ‘love’. However, no one objected to this.

Staff provided care that met people’s needs. For example, staff took care to attend to important aspects of people’s needs including cleaning their glasses, painting their nails, helping people to choose their jewellery once dressed, and ensuring that people had access to the items they required and their drinks. People received personal care and support and looked clean. Their hair had been brushed and dentures had been cleaned. One person required regular care throughout the shift and staff checked on this person frequently to ensure they remained comfortable and free of distress. We observed two staff knock on people’s doors before entering and one staff member waited for a response before entering. Staff gave examples of how they helped make people feel well cared for, respected and valued. One staff member explained that listening was essential. They said, “I listen to people and their problems that is important. One resident often speaks about their past and their family”.

People were involved in making decisions about their care. Staff were knowledgeable about people’s life experiences and their level of ability. They were aware of, and sensitive to, people’s wishes and concerns. Several people wished to remain as independent as possible and staff provided examples of how they understood what this meant to people and how they met these needs. One person had expressed a wish to manage part of their care themselves and another person requested a limited number of staff to provide support for one aspect of their care. A keyworker approach was used to help address these requests. A staff member said, “The keyworker system we now use is much better”.

Staff told us that the service was a small friendly and family run business. One staff said, “There’s a family feel about Garden House, it’s not institutional and everyone is friendly; we care for each other, staff and residents”. Two comments included, “We look after people really well; one resident was quite down and I was singing to them and then they joined in, and “It’s like home from home here for residents”.

A relative said, “Fantastic care. Our overall impression is that we couldn’t have hoped for anything better; we are very pleased with the care. It’s a small friendly home approach here”. Another relative said, “Staff are informal, there’s no uniforms here, this is more like a caring home. I feel comfortable here; we can go to the kitchen and make a cup of tea”. Another relative said, “Most staff are caring and supportive”. Another relative said, “Staff treat everyone as if they were their mum”, and “They are endlessly flexible and accommodating; all staff are nice and it’s really relaxed here because staff have time for people”. They told us that people were called by their preferred names and that staff understood people’s needs very well, and commented “It’s a fairly happy ship; quite a happy team”.

Healthcare professionals all confirmed that care staff and the team were caring towards people and demonstrated a

Good

Is the service caring?

kind and empathic approach. One healthcare professional said, “Care tends to be carer-led rather than management-led” and “our visiting staff are always welcomed and well supported during visits at Garden House” and “Staff are very kind”. Another healthcare professional said, “Staff shows understanding and insight”. We were also told that staff were supportive and gave very good end of life care, where this was possible, for those who wished to remain at the home with the support from other services. Two relatives shared with us similar views.

A comment from one healthcare professionals included staff awareness of residents’ needs and respect for their confidentiality. However, one person had written a letter of complaint directly into the complaints book and this meant it would have been possible for them to have read all previous complaints and the outcomes. This could have breached the confidentiality of others. There was also an information board in the utility area, out of the main public visiting area, where information was updated about specific events like appointments and medicines. However, if relatives were visiting the kitchen area, which some did to make a drink, it would still have been possible for the information to be viewed by people’s relatives.

Most people at Garden House had friends or relatives who visited to support them. We asked whether advocacy services were used to help people make decisions or to speak up on behalf of people. Staff felt that advocacy services were not required or necessary for anyone living at the home.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. People told us they felt they could talk to staff and the manager if they had concerns or wanted to discuss a complaint. We checked the complaints book where complaints and concerns were logged. There were two complaints from the beginning of the year. Both people had received responses from the service and a letter of apology.

One person said, "I'm very happy here, I've no complaints, I fell on my feet when I came here." Another person said, "things are done, staff clean our rooms and bathrooms and if I didn't like something it would be changed." A healthcare professional said, "I've never heard any of the residents complain or make a derogatory remark and staff seem very caring".

Action was taken to respond to people's individual needs. Complaints were managed and used as learning and to help improve the experiences of people and their families. Relatives told us they could approach staff at the service to discuss their concerns and had confidence that complaints and concerns would be addressed. One relative told us that they raised a concern about accidents and being contacted and as a result procedures on managing falls and accidents had changed. We saw this from records we viewed. Another relative commented, "I feel comfortable and confident in raising a concern; in the first instance I would take my concern to the manager or senior staff or with the staff on a day to day basis. I'd expect a positive response."

People were encouraged to share their views about the home. There was a suggestion box kept in the lounge for people to contribute their ideas and provide feedback about the service. One person confirmed its use. A staff member said, "The suggestion box can be used by residents, their families and staff, and it's checked regularly". Relatives felt they could ask to speak with staff including senior staff and they were confident their concerns would be taken seriously. One relative said, "Staff never mind my approach, I've had to raise a few issues like general cleanliness". They told us that matters discussed, were usually addressed.

People and their families were involved in regular opportunities to provide feedback and the results were used to drive improvements. We were told by one staff member that a resident's survey had recently been carried out and a relative said, "Residents and relative's fill in surveys and most issues are addressed. One person told us, people had a choice of whether they wrote their name on the surveys. They told us they had requested an alternative to the prepared desserts and had been regularly offered fruit since.

Staff listened to people's views and experiences. A recent survey result showed that the survey questions had been designed around the topics of caring, effective and responsive. We were told by the manager that changes had been made to ensure the survey was more 'user-friendly', following direct feedback from people at the home. People were also encouraged to complete a detailed food survey on their likes and dislikes. Records showed detailed descriptions of people's preferences.

Group meetings meant that people's views were regularly sought through discussion on how the service was working. One person said, "Resident meetings are every couple of months". Another person said, "We are invited to resident meetings to talk about the home and changes we'd like to see". However, another comment included, "There are residents' meetings periodically but some people don't always speak up".

People were encouraged to be independent where this was possible. A staff member said, "I encourage people to do things for themselves". Examples included enabling people to wash and dress and administer their own creams as part of personal care delivery. One person was managing one aspect of their care but needed staff to support and assist them. Someone else needed help only with getting into bed but could manage other aspects of their routine themselves.

Staff were aware of people's individual abilities and adjustments were made where people's needs changed. These included where people used walking frames to assist their movement around the home and became tired, wheelchairs were made available. A stair lift meant that those on a different level had the opportunity of joining others in the communal areas. Some people chose to remain in the privacy of their own room for their meals. A bath chair meant that people could enjoy bathing while others had access to showers in their en-suite rooms with shower stools and secure hand grab rails for safety.

Some people required hearing aids to support their sensory needs and referrals for these had been made to the

Good

Is the service responsive?

relevant healthcare professionals for assessment, treatment and adjustment. One person required regular eye care; we checked the care plan and found guidelines to staff about this. Staff told us the GP had seen the person and their eye required regular bathing with warm water swabs, however, we visited this person three times during one of the day's we inspected and found the eye was very sticky at each time we visited. We spoke to staff about this because the daily record had not identified that the care had been given and staff agreed to check on this.

Staff told us that there were a variety of activities for people to get involved with. We saw a range of activities had been recorded for people to get involved in, including trips out to local places, preparations for the annual garden party with teapot decorating, raffles and flower arranging. This was confirmed by people living at the home who invited friends and family. Topics of interest were regularly discussed with people, drawn from national and local news updates and television. Staff involved in activities gave numerous examples. These included clay modelling, egg decorating, cake baking, pizza top preparations, gardening, tapestry and live entertainment.

People were encouraged to partake in activities and events designed to promote community involvement. For example, local musicians and a military service choir visited to provide entertainment and social contact with people. At Christmas, carol singers were invited to sing and an advert in local shops advertising a coffee morning at Easter raised funds and local awareness about the service. Several people enjoyed lunch out with friends and relatives. Staff told us about a local entertainer who provided dance, comedy and song which people enjoyed. Religious communion was offered at the service weekly and trips and visits were discussed and arranged monthly with people. These included visits to local pubs, manor houses and a day out at the beach. The activity flier confirmed that varied activities were offered each month.

We were told that new risk assessments identified potential risks to people when visiting places and taking trips. These included hydration levels, sun care and people's mobility needs. People's risk assessments confirmed this.

Some people chose to spend time in their room and while people were encouraged to join in social opportunities, people's wishes were respected. We asked how people who chose to remain in their room had their social needs met. One staff member said, "I visit and sit with them, show them what activities we have arranged. I also take a memory box and offered the teapot decorating activity with one person."

Staff were keyworkers to individual people and changes in care were discussed directly with people by their assigned keyworker. Keyworkers were expected to update daily, weekly and monthly care records and included people and their relatives in these changes. Relatives told us that they had been involved in contributing to people's assessments and reviews. Staff discussed relevant changes with people as they supported them and responded to relative's enquiries. Care staff involved in the new keyworker approach gave examples of how this worked to improve the care people received. Records showed that one person's pressure relieving needs had changed and someone else at risk of falls had recently had their care reviewed.

Staff updated each other about how people were cared for through daily shift handovers and at team meetings.

We spoke with healthcare professionals who told us that people's independence was respected and encouraged, one healthcare professional said, "I received a telephone call directly from one of the residents who had been encouraged to make contact. The staff member also checked with the resident before speaking with me, showing they had insight and respect for people's privacy and confidentiality."

Requires improvement

Is the service well-led?

Our findings

The service was not well-led. The service is required to have a registered manager in post to manage and lead the home and this had not been met. We checked our records and found that no application had been made to register a manager with the Care Quality Commission. There had been no registered manager at Garden House for 22 months. This is a condition of registration The manager told us they were still pursuing their application to be the registered manager with the help of the owner's daughter. We asked what role the owner's daughter had in relation to the service and were told, "an informal support role".

The manager told us that with support from the owner's daughter changes had been made since the previous inspection and this was on-going. The manager showed us examples of how policies had been amended and explained the staff performance process.

Responsibility for the leadership of the home was unclear as management support was being provided by a relative of the owner. The lack of a registered manager impacted on the support, leadership and guidance to staff. There was no assurance that improvements made since the previous inspection were likely to be sustained and continued without the support of the owner's daughter.

There was a lack of effective governance at the home. It was unclear how leadership of the organisation was being addressed and managed. We received comments from staff about leadership and the management of the home. Staff felt there was a lack of leadership from the manager and they were unsure on how management decisions were made and who to go to about some management decisions. Staff also told us that the manager was usually approachable but not always available and they were unsure of when to expect the manager or when they would be working at the home.

Staff told us that there was a lack of staff support. They told us that feedback was not provided by the manager in a constructive, supportive or motivating way. Comments included a need for greater diplomacy, discretion and privacy to avoid staff being criticised in public spaces and communal areas, away from earshot of residents and relatives. Staff explained that advice and guidance should be given in privacy and shouldn't be repeated.

Staff comments about management included a lack of effective management and decision making skills. An example included that actions by the manager would be agreed but not followed through. This included an issue relating to when someone needed a specific mattress for support this was only arranged following a visit from the GP even though it had been previously raised with the manager. They told us the manager had acknowledged that a mattress had been ordered, but this did not materialise and was only addressed when the GP visited and suggested a more appropriate mattress be arranged.

Most staff felt that the progress made since the last inspection had been through the support of the owner's daughter.

Staff told us that more checks were completed in the home and that results were followed up and linked to performance outcomes. This was confirmed by the manager. Staff explained that the owner's daughter was good at management but that staff needed a manager that could provide direction. We were told that some staff wanted to leave but stayed because of the residents.

A relative commented, "Leadership is good, but it gives the appearance of a bit chaotic at times. In comparison to larger homes it is good". Another relative commented, "Leadership and management has got better, there's been improvement in the last six months, but no one seems to take overall responsibility. The manager gets support from others but is very approachable and willing. The owner is approachable but leaves the general running of the service to the manager and his daughter, who helps out a lot with administration".

One relative told us that the service had good ideas but they are not always followed through and that two deputy managers had recently been appointed which the relative said was, "a good move" and "This is a new level of responsibility, relatives are invited to contribute ideas and it's more informative".

We received mixed feedback from healthcare professionals, some spoke positively about the service. One said, "A very adequate service, staff are friendly and receptive; they are on the ball and the owner is often on site which is good to see". Another said, "I don't know who the owner or manager is, I don't think I've ever met or seen them". We were told that equipment like specialised beds and pressure relieving mattresses were not always purchased

Is the service well-led?

quickly enough but this had not impacted directly on care as resources were initially provided for a month by health care staff. They said, "There seems to be reluctance to purchase pressure relieving equipment. The relatives seem to be approached to pay and at times this is delayed. There seems to be an unwillingness to purchase or order equipment; they won't always buy the necessary equipment".

Records about the employment of staff and people's care records were stored in a lockable filing cabinet. However, this cabinet was not routinely kept locked and the manager told us that all staff had access to their own employment and training files (which were stored in individual document hanging files but in the same drawer together). The manager told us that staff were advised that it was their responsibility to make sure their training certificates were stored in these files. This meant that staff employment details and other personal details were not confidentially stored. The cabinet was left unlocked during shifts.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3).

We checked our records and found there was no current Statement of Purpose for Garden House Rest Home Limited. Services registered with the Care Quality Commission are expected to submit a Statement of Purpose setting out their key functions and responsibilities.

There was no clear or consistent vision or set of values for staff to be guided by. The manager told us that there was no specific vision or set of values driving improvements at the service but that informal meetings took place between the owner and the manager, although nothing had been recorded. We spoke with the provider who told us that what mattered most was, "keeping people well cared for and the residents' happiness". There were inconsistencies in what staff and relatives understood about the service values. A staff member told us they thought the values included friendship, family and a relaxed home environment. Another staff member said, "our values are meeting resident's needs and providing good care". One relative told us that they were not aware of the service vision and values and said, "They are not well defined", while another relative felt that the values included "Keeping residents comfortable and happy".

There was an open culture at Garden House. People told us they felt the home was a family friendly atmosphere. One person said, "The owner and the manager are very approachable. The owner comes in at lunch time; he's very generous and will do any little jobs that need attention, if you ask". However, one person told us they didn't see the owner very often. One person's visiting relative said, "It's a good culture here; they have an open door policy". One staff member said, "People and staff are made to feel welcomed, there is an open atmosphere here, the manager is very supportive of ideas". Another staff member said, "it's the residents' home, we make suggestions like staff uniforms and identity badges but residents don't want this and told us so". Comments from other staff included, "the owner is a fantastic boss, he values staff and gives us all a bunch of flowers each year" and, "it is family orientated here, we are like one big family" The owner is the best boss I've ever had".

The quality of the service was monitored to improve the care people received. Staff had been given new responsibilities and these had improved the overall quality of the service. They told us they achieved better understanding of the service because of their new roles and responsibilities. Staff were aware they were accountable to senior staff but were unsure of who led the service as the changes they had described had been made as a result of the owner's daughter becoming more involved in the home.

Medicine, cleaning and record management checks had been carried out and actions had been taken to address standards in these and other areas of care. Improvements had been made at the home which included the purchase of new medicine measure pots and syringes were used to accurately measure some liquid medicines.

A new record management system was in place to assist staff in supporting people's changing needs. Staff were each responsible for recording daily, weekly and monthly reports on the progress and changes affecting the people they supported. These were detailed and specific. Staff were monitored on their performance of this and checks were made to ensure that records were kept up to date. The manager was aware of one staff member who needed to update their care records and we were told this would be addressed in their next meeting with the staff member.

Staff were kept informed of changes and developments through team meetings. Minutes from team

Requires improvement

Is the service well-led?

meetings between January and July 2015 suggested that there had been changes to staff appraisal, new medicine storage key-holding responsibilities and staff were reminded of the importance of completing accident reports and maintaining confidentiality. One staff commented, “Handovers have improved with more information now and there has been good developments since the last inspection, but we don’t see much of the manager”.

Policies and procedures had been updated and staff were asked to sign new policies on a monthly check sheet. This was confirmed by staff and signed policy records. The manager told us that as policies were updated, staff was given the opportunity to read and sign they understood these changes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2)(a) Paragraph (1) The registered person did not have effective recruitment and selection procedures in place that comply with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11(1) (2) Paragraph (1) is subject to paragraphs (3) and (4). The registered person did not seek consent from the relevant person when carrying out care and treatment and where people did not have the capacity to consent. The Registered person did not act in accordance with legal requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) Care and treatment was not provided in a safe way. The registered person did not assess certain risks or take reasonable action to mitigate these risks.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirements relating to: Good governance Regulation 17 (1) (2) (d) (i) (ii)

The registered person did not securely maintain records in relation to persons employed in the carrying on of the regulated activity and did not send Provider Information Return as requested by the Care Quality Commission.

This section is primarily information for the provider

Enforcement actions

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