Balcombe Care Homes Limited

Wellcross Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 8 and 9 November 2017. The first visit was unannounced and started at 07:30am. This was to allow us to meet with the night staff and see how staff duties were allocated for the day. The second visit was by appointment.

Wellcross Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People living at Wellcross Grange Care Home were older people, living with physical health conditions and physical frailty. Some people were living with early dementia. However the service is not a specialist service offering support to people to whom dementia is their main need for care. The service accommodates up to 45 people in one adapted building, divided into two separate wings with their own staffing complement and shared spaces.

The home had a registered manager. 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 registered manager was not available on the days of the inspection, so this was carried out with the clinical lead nurse and operations manager for the provider organisation.

The last inspection of Wellcross Grange Care Home took place on 11 June 2015, when the service was rated as good in all areas. On this inspection although we found some good practice, we identified some areas of concern and the service was rated as requires improvement.

Immediately after the inspection the operations manager from the provider organisation gave us an action plan detailing what actions they were taking to address the concerns.

Systems had not always been operated effectively to assess, monitor and improve the quality and safety of the services provided, or mitigate the risks. During the inspection we identified areas of concern about the environment and people's care. For example information was not always sufficient to ensure risks to people from poor hydration could be properly assessed. Recent information of concern had not been acted upon immediately, which could have left people at risk of poor care. We asked the service to make a safeguarding referral about this incident during the inspection.

We identified systems to analyse accidents and incidents were not robust enough to identify learning to prevent a potential re-occurrence. Accident forms had been collated but these did not contain a management review or records of what changes were made as a result of the incident or actions taken. Bruising was not always investigated or included on incident forms.

We found staff were not always using positive or respectful language when supporting or describing people

and their care. We also saw people being supported in ways which did not demonstrate their dignity was respected. The operations director told us they would be reviewing this immediately.

We received positive feedback about the staff and service. People told us the registered manager was approachable and fair. They told us there was a positive atmosphere, and the service worked well with other agencies to support people's needs. Staff were attentive to people's needs, making sure they were well presented and attention had been paid to cleaning spectacles and helping people co-ordinate clothing. The organisation had a set of positive and person centred values, which the operations manager was taking action to ensure were well understood and shared across the staff group. We found the service had an open culture, and saw staff working well as teams, to ensure people's needs were met. The service had a clear organisational structure where people's responsibility and accountability was identified.

A new system for training was being implemented at the service. The service's training matrix showed there were some gaps in staff member's core training skills. However staff we spoke with felt they had received sufficient training to meet people's needs, and we saw staff meeting them confidently. For example, staff understood how to deliver good end of life care and nursing staff had recently been on courses to support people at the end of their life. Registered nurses were completing their re-validation to ensure they were still fit to practice.

People were involved in having a say about the service and people were consulted in a meaningful way about their experiences. People were supported to share their views of the service at regular meetings, and through a series of questionnaires. These were then analysed and action plans drawn up to address any issues raised. Senior staff attended meetings with residents and relatives to ensure any concerns could be immediately understood at a senior level.

There were enough staff on duty to meet people's needs. A full recruitment process was in place which ensured staff were recruited safely. This included the taking up of disclosure and barring service (Police) checks and references. We found some staff were working very long hours. The service was actively recruiting for new staff and the staff we spoke with told us they didn't mind working long hours and made sure they had time off to rest.

People received their medicines as prescribed. Medicines for 'as required' use did not always have clear protocols for their administration recorded. The service agreed to address this with the prescriber. The medicine we saw, which was to manage one person's anxiety had not been needed in the last month. People received good healthcare support. We had feedback from a visiting healthcare professional who told us the service called for assistance early if they had any concerns over someone's well-being. We have made a recommendation with regard to the service requesting treatment escalation plans or 'Do not attempt resuscitation' (DNACPR) forms are updated by the person's GP. This is to ensure they remain an accurate reflection of the person's wishes.

People's rights with regard to the Mental Capacity Act 2005 were respected. Not all staff had received training in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS). However we saw where DoLS had been granted or applied for the service and staff had a clear understanding of the importance and implementation of this. Systems were in place for the management of complaints.

Wellcross Grange comprised a large period house, with extensive grounds and a small lake, which had been extended to the rear to provide a large ground floor extension with en-suite rooms and shared spaces. The building had been adapted to meet the needs of people with physical impairments, with the use of specialised baths and showers. However there was little adaptation to support people with dementia or low

vision. We have made a recommendation about this, as there were people living with both of these conditions at the service.

People were supported to eat a nutritious and varied diet. People told us they ate well, and the chef was happy to make changes to meet people's particular menu choices. Menus were available in a pictorial format and we saw staff working with a relative to understand one person's specific meal choices to help encourage them to eat well.

People's care was assessed and care plans developed as a result, and we saw people's care was delivered in accordance with their agreed plans. A wide range of activities were provided, which people told us they enjoyed. People's files did not always contain sufficient information on hobbies or activities they enjoyed, but we saw staff speaking with people to ask them what they wanted to do. Work was being undertaken to address this, and help gather additional information about people's lives and choices.

We identified a number of breaches of Regulations on this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always being kept safe, because the service had not acted immediately on allegations about risks to people's safety.

Risks from the environment or to the person's health were not always being identified or addressed. However people told us they felt safe.

There were enough staff on duty to meet people's needs, who had been recruited safely. Some staff were working very long hours while new staff were being recruited, which showed a commitment to the people they were supporting.

People received their medicines as prescribed. Medicines for 'as required' use did not always have clear protocols for their administration recorded.

We have made a recommendation with regard to the service requesting treatment escalation plans or DNACPR requests are updated.

Is the service effective?

Good

The service was not always effective.

We have made a recommendation about assessing the environment for adaptations to meet the needs of people with impairments, because we found this had not always happened.

We saw some good practice in best interest decisions and the implementation of the Mental Capacity Act 2005.

A new staff training programme had been developed, to improve staff's understanding of the needs of people they were supporting.

People were supported to eat a nutritious and varied diet, and told us the food was very good.

The service had good links with local agencies and services and worked well with them to support people's wellbeing.

People received good healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw staff using language and providing support at times that did not demonstrate people were treated with dignity or respect. We also saw people being treated with kindness and caring approaches by staff.

We received positive feedback about the staff and service. Staff were attentive to people's needs, and people's privacy was respected.

People would benefit from assessments of whether additional equipment was available to assist their independence.

People were supported to share their views of the service at regular meetings.

Is the service responsive?

Good

The service was responsive.

People's care was assessed and care plans developed as a result. People's care was delivered in accordance with their agreed plans.

We have made a recommendation in relation to improving accessible information for people needing additional support, for example in larger print.

Staff understood how to deliver good end of life care and nursing staff had recently been on courses to support people at the end of their life.

Activities were provided, but people's files did not always contain much information on hobbies or activities they enjoyed. Plans were in place to address this.

Systems were in place for the management of complaints, which were investigated and addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems had not always been operated effectively to assess, monitor and improve the quality and safety of the services provided, or mitigate the risks.

The service had a clear organisational structure where people's responsibility and accountability was identified. People in the management structure had a 'visible presence' in the service, and ensured significant concerns were escalated to them.

People told us the registered manager was approachable and fair. They told us there was a positive atmosphere, and the service worked well with other agencies to support people's needs.

Wellcross 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 was 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 8 and 9 November 2017 and was unannounced for the first visit. The second visit was by appointment. The first visit started at 07:30am. This was to allow us to meet with the night staff and see how staff duties were allocated for the day.

The inspection team comprised one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had experience of working with and supporting older people and people living with dementia.

Prior to the inspection we reviewed information we held about the service, and notifications we had received. A notification is information about important events, which the service is required by law to send us. The registered manager had completed a PIR or provider information return in July 2017. This form asked the registered manager to give some key information about the service, what the service did well and improvements they planned to make.

During the inspection we spoke with or spent time with nine people who lived at the service, three relatives, and eleven members of nursing, care and support staff, cleaning and catering staff. We also spoke with the clinical lead nurse, operations manager for the provider and a visiting healthcare practitioner. We spent time observing how people spent their time as well as how people were being supported by the staff team. We spent several short periods of time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who

could not communicate verbally with us in any detail about their care.

We looked at the care records for seven people with a range of needs, and sampled other records. These records included support plans, risk assessments, health records and daily notes. We sat in on a morning handover meeting to see how information was shared and how duties were delegated for the day. We looked at records relating to the service and the running of the service. These records included policies and procedures as well as records relating to the management of medicines, falls, moving and positioning, nutrition and fluid support, food and health and safety checks on the building. We looked at three staff files, which included information about their recruitment and other training records. We also viewed a number of audits undertaken by the service to identify concerns to people's health and well-being.

Requires Improvement

Is the service safe?

Our findings

On our last inspection we rated this key question as Good. On this inspection we found this had not been sustained and we rated the key question as Requires improvement.

People told us they felt safe at the service. One person told us "I often get frightened, but staff are always there if I ring my bell", and another said "I feel comfortable knowing that there are staff here."

People were not always being kept safe, because the service had not acted immediately on information of concern about risks to people's safety. On the inspection we identified a concern over a person's welfare. This related to the actions of a staff member in supporting a person to eat in ways that did not support their wellbeing, and could have presented significant risk. We spoke with senior staff about this. They told us the incident had been reported to them two days previously. The senior staff member told us they had spoken with the staff member concerned and the person who had raised the concern, but had not yet carried out a full investigation of the incident or informed other agencies as required by law. We asked the service to make a safeguarding referral in relation to this incident to ensure it received adequate external oversight and review.

During the inspection we looked around the service with the operations manager, looking at areas of risk within the environment. We had seen records showing environmental risk assessments had been completed covering areas such as water temperature regulation, window restriction, and the security and safety of furnishings, including some trailing cables. We also saw regular audits had been completed. On the inspection however we identified water temperatures in some bedrooms or communal bathrooms that were too hot to measure on a thermometer, and presented a risk of scalding. A number of rooms had furnishings which were unstable; Some rooms had dangling wires from wall mounted televisions. Some windows on the first floor did not have restricted openings. This meant people could have fallen from the window. Apart from the communal bathroom these rooms were not occupied, however could have been accessed by people, as doors were open. The provider started taking immediate action to address the areas identified before the inspection was completed, including the securing of furnishings, and unoccupied rooms where risks were identified were locked.

Some people were prone to falls, which were recorded. However, for one person records did not demonstrate that sufficient action had been taken when the person was injured as the result of a fall. We saw one person had fallen in June 2017, and had been found by staff with a bump on their head. The record indicated the person was 'observed' and an ice pack applied. We looked at their records with a senior staff member to identify the actions that had been taken to assess the risk of harm to this person. There was no record of any checks on their well-being, such as checking the person's blood pressure or level of consciousness in their records and no record of them having seen a GP or medical advice having been sought following the injury to their head. The records did not confirm if any other actions had been considered to see if risks to the person of falling again could be reduced. This could have been through assessing their environment, referring them for specialist advice or requesting a review of their medicines.

We were told the service regularly made alterations to people's environment as a result of risks, but we did not see evidence of this process being recorded. We could not see that learning was always taking place as a result of accidents or incidents.

We saw in people's files and in discussions with staff that where a person had developed bruising this was not always being analysed or investigated. For example one person's file notes had recorded they "sometimes get bruising due to the hoist" and had "tissue paper skin". Bruising had recently been assessed by the GP. However we were told by senior staff an investigation, (and the completion of an accident form or recording on a body map) would only take place if the person's 'skin was broken'. This meant the service might not be using information gathered to improve people's health outcomes or improve people's safety. Action had not been taken to identify why the hoist was causing the bruising or to prevent this happening.

The registered persons had not ensured all risks to people's health, safety or welfare were being identified, mitigated or managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

We looked at the records for people who had been assessed as being at risk of dehydration. Charts had been completed to identify the person's intake on a daily basis, and a total figure had been recorded for each day. However there was no individualised amount recorded for each person to identify the appropriate fluid intake to maintain their well-being, based on their body mass. This meant it was not easy for staff to determine the level of risk to the person from their individual intake over several days. We did not identify anyone had been harmed by this, and the operations manager took immediate measures to address this.

One person's records showed they had been identified following a hospital stay as being colonised with a specific bacteria in their urine. There was no indication on the person's catheter care plan to support staff understand how to manage this risk or prevent cross infection to other people. We spoke with two staff members who told us they were not aware of anyone at the service having any infection risks. The clinical lead nurse told us at one time the person had been subject to additional measures to reduce risks, but did not know why they had been discontinued, and there was no record on the catheter care plan to show the person had been cleared from colonisation. The clinical lead nurse told us they would look into this. We identified other areas of infection control practice were good, for example the systems to manage potentially infected laundry and linens was well understood. Staff wore gloves and aprons when supporting people with personal care, and carried disinfecting hand gels. Faculties were available for handwashing throughout the building, and paper towels and hand soap dispensers were in people's rooms.

Not all staff had received training in safeguarding practices or were clear about how to raise concerns outside of the home's management structure. However staff told us they would ensure any issues they saw were raised with senior staff within the home. One told us they would "note everything that happened and report to the senior above me" if they had any concerns. A senior staff member told us they would report any concerns to CQC. The service had co-operated with the local safeguarding authority when previous issues had been reported to help resolve them.

Other risks were being well managed. People's weights were recorded each month, and were recorded on a graph which helped identify longer term trends that might be associated with poor health. Clear information was available to reduce the risks of poor moving and handling, with moving and handling plans and risk assessments for each person. Risks to people's skin from pressure were well monitored and the service only had one person needing attention to a pressure ulcer, which had been acquired in hospital. A visiting healthcare professional told us the service called for assistance at any early stage if there was the slightest concerns over people's skin.

Some people's files contained copies of clinical tools in relation to decisions they had made regarding any resuscitation they may wish in case of a sudden deterioration in their health. Some of these tools had been completed while the person was in a hospital setting, or at a time of more critical care. These had not been reviewed, so may no longer reflect the person's views or wishes. Some of these were over two years old. Although these tools did not originate with the service, they would be expected to act in accordance with the expressed wishes. This left people at risk of their most recent views not being known or acted upon.

We recommend the service requests the responsible medical practitioner reviews these records with people regularly to ensure they remain an accurate reflection of the person's wishes.

There were sufficient numbers of suitably qualified and experienced staff to meet people's needs. A registered nurse was always on duty and during the day a registered nurse was allocated to each wing of the home. In addition the clinical nurse lead and registered manager could provide additional nursing advice and support where needed. Care and support staff had a range of skills and experience, but senior care support staff were always on duty. The service used a recognised staffing tool, based on people's dependency levels, but modified to take account of the building layout. We were told there was also some flexibility in hours if needed, for example if someone was ill.

Some staff were working long hours whilst the service was recruiting to fill vacant positions. In the week of the inspection for example, one staff member had worked over 75 hours. The operations manager told us there had been recent concerns around recruitment, but they were trying to fill vacancies through an active recruitment programme. They also told us they monitored the health of staff working excessive hours. We spoke with a staff member who was also working long hours. They told us they did not mind this and ensured they had at least one day off a week. Staff told us that sometimes staffing levels on the care side were depleted because staff time was needed to cover the kitchen duties between 3.30-6pm. On the second day of the inspection a care staff member was taken off the floor to provide cover in the laundry. We did not see this led to unsafe levels of care staffing but may have delayed some activities.

We looked at three staff files, and saw safe recruitment procedures were in place. Staff files showed evidence that pre-employment checks had been made including written references and satisfactory disclosure and barring checks (police checks). Evidence of staff identity had also been obtained. The registered manager told us that there were no staff requiring 'reasonable adjustments' to be made to their working conditions as a result of disability or other protected characteristics under the Equality Act 2010. This is legislation that protects staff from discrimination in the workplace and in wider society.

People received their medicines safely and as prescribed. We identified there was a lack of clarity over the administration of some 'as required' medicines. We looked at the medicines practice with a registered nurse who was carrying out the morning medicines round. We found one person had been prescribed medicine to manage distress or anxiety. There was no guidance or protocol to indicate when the person would benefit from this medicine. We asked the registered nurse when they would give this. They told us "when the person is not like themselves." This gave us concerns staff may have differing understanding of when this should be given. We saw the medicine had not been given in the month preceding the inspection, so was not in regular use, but the registered nurse agreed to ensure this was put in place.

Medicines were stored safely in lockable cupboards or trolleys. There was a medicines fridge for those medicines that needed to be kept cool, and records were kept of the temperatures to ensure medicines were being stored safely. Records were completed which showed medicines had been given to people in accordance with the prescribing instructions (MAR). Additional records were completed where for example there were variable prescriptions or where medicines required additional precautions due to their strength

or effects. These were up to date and an accurate reflection of the stock balance held. Policies and procedures were in place with regard to the administration of medicines and audits were carried out monthly.

We saw people being given their medicines, which was done with enough time to enable the person to take them at their own pace. No-one at the service managed their own medicines. We saw and heard staff discussing trying to get one person's medicines available in liquid form as they were beginning to have difficulties swallowing them. Records contained information about how people liked or needed to take their medicines, for example one person needed their medicines put in their mouth via a teaspoon. No-one at the service was receiving the medicines 'covertly'.

Information was available within the service and some staff had an awareness of abuse. For example, one staff member was able to identify possible signs of abuse to us and another said they "would note everything that happened and report to the senior above."

In the service's statement of purpose they had a statement on "Residents rights". This said "we place the rights of residents at the forefront of our philosophy of care. We seek to advance these rights in all aspects of the environment and the services we provide and to encourage our residents to exercise their rights to the full". Staff had access to a policy on equality, diversity and inclusion, provided in 2016. The policy covered areas such as anti-discriminatory practice and the use of oppressive language, and stated "all staff are trained to follow the home's policies on equality and diversity". We were told this had not yet happened but training had been bought forward to December 2017 for all staff.

We saw a copy of the last fire report for the service from 2016. The operations manager told us all the works identified had been completed. This had involved the changing of some fire doors and fitting of new emergency lighting. Regular testing of appliances for electrical safety were carried out. People had individual evacuation plans to ensure their needs regarding evacuation would be understood in the case of a fire.

Good

Is the service effective?

Our findings

The service was effective.

We found the service had not always assessed people's individual needs to see if their personal environment could be adapted to better meet their needs or increase their independence. For example we looked at the care records for one person with impaired vision. Their care plan stated staff "will go and provide sighted guidance" to assist the person move around. We observed a staff member enter the person's room. The staff member did not introduce themselves to the person when they went in, to help the person know who they were. There was no specific assessment of lighting or contrast and colours that might assist them to be more independent in their bedroom, although there was an overall risk assessment of the environment. The person's bedroom risk assessment stated their call bell should be nearby. We spoke with this person and they had their call bell with them, but told us they sometimes lost their call bell at night in the bed. We discussed this with the operations manager who told us they would explore if the person could have a wristband type alarm compatible with the service's call bell system.

We recommend the provider seek guidance on environmental adaptation and aids for people with specific impairments to increase people's independence.

In September 2017 the organisation developed a new staff training and development plan as they wanted to improve the training provided. One staff member told us their previous training had not always been successful in improving outcomes for people. The new programme looked at ensuring the appropriate competencies were in place, and had put training schedules in place to support positive learning for all staff, and was just commencing. A visiting healthcare professional told us "staff are on the ball" and "have initiative".

Although many staff working at the service had not yet undertaken elements of the new training programme, for example training in dementia care, we found some evidence of good practice and understanding in supporting people with this condition. A staff member could tell us about how one person's dementia affected them day to day, for example by them asking repeated questions. They understood the person's deafness also impacted on them sometimes appearing more confused than they actually were. Another told us they had not had dementia care training but said "all they need is patience. If they are not kind to me I don't worry as they are sick, they can't help it." This told us although not all staff had received training they had an understanding of how to support people.

Rotas confirmed registered nurses were on duty 24 hours a day to meet people's needs. Registered nurses were checked by the service to ensure they were completing their revalidation and still had current registration to practice. Some staff showed dis-satisfaction with the way their previous training had been provided. Staff received support and regular supervision from more senior staff. They also had an annual appraisal, including a self-assessment review. Some training had included quizzes to ensure staff understood and had learned from the training. Work practice supervision was also in place, so staff were observed carrying out tasks to ensure these were at the correct standard.

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.

Not all staff had undertaken training in the MCA, and those we spoke with were not always able to explain what the implications of the MCA were for their work. However we saw good practice in place. We found best interest decisions were being undertaken where needed for more significant decisions. For example we saw in one person's file they had been recommended to have a small surgical procedure. The person had been assessed as being able to make simple decisions but not to have the capacity to consent to the procedure. The service, medical support team and relatives had met and made the decision in the best interests of the person.

The operations manager took immediate action to schedule a group supervision session in December 2017 to improve staff understanding of the principles and practice of the MCA in practice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had made applications where appropriate for authorisations to deprive people of their liberty. Conditions on the authorisations granted were being respected. Other authorisations had been applied for but had not yet been granted due to delays with the local authority systems.

Wellcross Grange had been developed from an attractive detached period property. The service was divided into two 'wings' each with their own daily staffing compliment, and shared spaces. There was also a dining room and wood panelled entrance hall. The adaptation provided for a larger number of ground floor rooms. Some rooms, particularly in the older part of the building were much larger with views over the gardens and lake, and could be reached by a passenger lift. Many rooms had en-suite facilities but there were also shared bathrooms with specialist bathing facilities. The accommodation was clean, bright and odour free. The operations manager told us there were plans in place to refurbish the bathrooms.

People told us the meals were good and they ate well. One person told us they had always enjoyed cooking and baking. They told us "All the cake we get here is good – decently made and tasty". The service had a pictorial menu showing people the meals on offer, which was also on display in the hallway. People were asked to pick their meal choices the previous day. This left some people confused over meals available to them. For example one person told us "We don't have a choice at lunchtime –I don't think. Supper time we have a choice of different things". They were not able to tell us if they were able to ask for something else, although the chef told us they were happy to accommodate changes. Choices were available at all meals; on the day of the inspection meals were honey roast gammon or a Cornish pasty, with a selection of potatoes and 3 vegetables. Dessert was a cinnamon apple turnover and cream or rhubarb fool. Supper was fresh carrot soup, a choice of sandwiches, a coronation chicken vol au vent or ham and potato tortilla.

People were protected from risks associated with their eating. Risk assessments were completed for people at risk of poor nutrition, and we also saw one person had been supported to lose weight which had helped with a long term health condition. Staff were also speaking with a relative on the inspection about how to

encourage one person to eat, including food choices they enjoyed and how they liked their food prepared and presented. They told us they would be asking the chef to prepare this person's meals as they liked it, as they were concerned over their poor food intake. The person had a very limited range of meal preferences, and very 'plain tastes' in food. The staff member told us there would be no problems accommodating this as the chef was 'very good'. Fresh vegetables and fruit were delivered regularly. One person told us they had never had much of an appetite in the morning but "really enjoyed" their meals at lunchtime. Another said they really enjoyed their breakfast – "A good breakfast, a proper breakfast. Best meal of the day."

People were involved in having a say about their food and the way it was presented. People were asked for their preferences on admission, and lists of these were kept in the kitchen. Some people needed their food or drinks to be presented in a specific texture, such as syrup thickness. We spoke with a member of staff who was preparing a thickened drink for one person. They were clear about the texture required to help the person swallow safely and how much thickening agent was needed to achieve this. One person told us "I like to eat on my own, but I know there is always someone around…I can't live alone. I hate being on my own." This was also included on the sheet completed by staff when asking people for their preferences. This helped ensure people were not given inappropriate food.

Staff at the service worked well with other agencies to ensure people's welfare was maintained. We spoke with a visiting healthcare professional who told us they visited the home regularly and the service also contacted them early if a person was deteriorating to ensure they could be reviewed. GPs also did regular 'rounds' at the service. We saw evidence of people receiving ongoing healthcare support, for example optical and dental care. One friend of a person living at the service told us "my friend has lost her false teeth, but she won't have any new ones, she is happy with the few she has. The dentist comes in regularly." If people went into hospital we saw contact was maintained with the service to ensure information about the person's needs was shared.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring.

People told us "the staff are excellent" and a visiting relative said "I visit (person's name) every day. I know all the staff names and residents. I can talk to staff at any time and I can visit anytime." Another said they were very involved with their relation's care. They said they were always made to feel welcome at any time and were kept up to date with any changes.

During the inspection we saw evidence of both good and poor practice in relation to caring relationships and values. Some interactions we heard did not demonstrate respect for the person or their dignity. For example we saw staff placing stick on paper clothes protectors, which they called 'bibs' on people at lunchtime, often with no explanation or discussion. We heard or saw a number of instances where poor or de-personalising language was written or spoken during the inspection. We heard people being referred to by staff as "feeders" or "one of the walkers". This use of depersonalising language did not demonstrate people were treated with dignity or respect.

We saw staff carrying out poor practice when supporting people, for example we saw one person being supported to eat. The staff member assisting them did not speak to them whilst putting food in the person's mouth, but talked with people and staff across the room instead. This did not demonstrate respect for the person being supported.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and Respect.

We spoke with staff about their understanding of the people they were caring for. Experienced staff knew people well. They could tell us information about the person and their life history, people who were important to them and the support they needed and liked, without reducing their independence. For example a staff member discussing one person told us "they are a trousers lady, not bothered by jewellery" but said the person liked having their hair done regularly.

We saw staff were attentive to people's needs. We heard staff supporting people to get up and dressed, asking them about what they wanted to wear, and laughing with the person about their day. We saw a person being supported to walk to the lounge, and saw staff ensured they were comfortably settled, with a glass of water and their call bell before leaving them. Staff understood people's likes and dislikes, and were aware of their emotional needs. We saw for example one staff member reassuring a person who was feeling very low in mood. We also saw evidence of positive relationships and fun, with positive chatter and gentle 'banter' amongst people. This was respectful, and cheerful. We heard a staff member speaking with a person living at the service. They asked the person if there was anything interesting in the paper. The person said "No, nothing saucy today" and they both laughed.

Visitors were welcomed to the home at any time. We told the service would support relatives who wished to

stay at the service overnight with a relation who was approaching the end of their life. Three relatives we spoke with told us they felt involved with the service, and we saw another relative being re-assured they could visit their relation whenever they wished.

Some people were cared for mainly in bed. Staff spent time with people assisting them to be clean, tidy and well presented, even if they were not in shared areas. People's glasses were cleaned, and nails filed. Any clothing changes were done quickly and without any fuss or undue disturbance to the person. People were asked if they wanted cardigans or warmer clothing, if they wanted the television or music on and if they wanted a drink throughout the day. One person complained about the music at lunchtime. A member of staff turned it down rather than switching it off, as one of the other people had said they loved it.

People were invited to be involved in "Resident's meetings" to share their views about changes they would like at the service. These were attended by the operations director to ensure any issues would be 'heard' by higher management. We saw the minutes of the last meeting held in October 2017. Seventeen people had attended and areas covered included comments on the food; nursing care and support; information about staff recruitment and any new staff; comments on housekeeping and maintenance; activities and any other issues. Positive feedback was passed onto the staff concerned, and any concerns taken up. Meetings were also held with relatives, the last being held in October 2017. These covered questions and answers about areas such as fees, staffing, housekeeping and food. Responses also contained information about future plans for development, such as an assessment to see if additional car parking could be provided. Comments from relatives from this meeting included "The level of care is excellent, my father was losing weight and this has been looked at and he is now improving." And "(staff member's name) does a brilliant job of keeping the room clean, (staff member's name) talks to my mum and makes her laugh, she is very caring and funny."

People's privacy was respected. Care was delivered in private and people's confidential records were kept securely.

Good

Is the service responsive?

Our findings

People or their relatives told us they were very much involved in making decisions about their or their relation's care.

People or their relatives told us they were asked about their care needs and wishes. For example one relative told us their spouse was not able to participate in this process so they were involved and had signed their plan to show their agreement. A senior staff member told us they "sit with people and write the care plan." Care plans were reviewed after a 4 week period from admission and then every three months after. However, care plan files contained large amounts of old information which had not been summarised and archived, to ensure current information on the person's needs was easily available.

People's care plans did not always include information on how people's communication needs could be supported. Information kept by the home had not been provided to people in differing formats, but we were told every effort would be made to do this if people wanted. For example the operations manager told us the complaints procedure could be read to people, or could be provided in larger font. Some people may benefit from different coloured paper backgrounds to help address some visual problems, although this had not been assessed. People with a visual impairment at the service had developed this later in life, so were not familiar with supported communication systems such as braille. We were told people could have access to their plan of care in an adapted format if they wished.

We recommend the service consider how information could be made available to people to support assisted communication where they may benefit from this.

We saw people were given support in accordance with their care plan. For example we observed staff supporting a person to move and position themselves in accordance with their plan. Staff told us people were able to get up and go to bed when they wished. When we had arrived at 07:30am there were very few people awake across the building, and we saw people being assisted to get up throughout the morning. One person told us they spent much of their day in bed. However they said "Staff come when I need them." Another person told us about their day. They said they had a cup of tea in bed and got up when they wanted. We saw staff speaking with people and relatives to clarify elements of people's care and help them to understand he person better.

Care staff told us they followed people's care plans but had not always been involved in helping to write them and sometimes felt they had things to contribute to the detail. Staff completed daily tick lists to record the activity they had carried out for the person, such as washing and dressing. One staff member told us about a person they had supported that morning. They understood how the person liked their room, what things they enjoyed doing and how they needed to be supported to move. They told us the person was "very smart" and they enjoyed word puzzles and games.

The service had an activities organiser who provided group and one to one activities, however care files did not all contain information about people's pre-existing hobbies or lifestyle choices they had made to

support this. This information is useful as it helps staff understand the person in the context of the life they have lived, and what they liked to do in sufficient detail if they were no longer able to communicate this freely. For example one person's file indicated they liked listening to the radio, but there was no information on whether they liked music or information channels to listen to. Work was underway to address this with information being gathered about people's lives, hobbies and interests.

People told us they enjoyed the activities they joined in. One person said "They do quizzes, games and musicals." A member of staff joked "I try to give the answer to them but often they can't hear you." The service had a hairdressing 'salon' and we saw people receiving 'pampering sessions' during the afternoon with nail care and hand massages. The provider's website told us activities included "themed lunches, arts and crafts sessions, games and quizzes, making Christmas and other decorations, movement to music, picnics, Pets as Therapy visits, ball games, flower arranging, card making, baking, charity events, hand massage, cooking and tasting sessions. We welcome guest entertainers too who provide singing and musical recitals, magic shows and various productions. We can arrange shopping trips to Horsham or the local garden centre, and outings to local places of interest. And we take full advantage of the gardens and enjoy blackberry picking, feeding the ducks and bulb planting."

People were supported because efforts were made to reduce risks of social isolation. We saw in one person's care plan "I am suffering from short term memory loss. Ensure to place me next to other residents while I am in the conservatory." Other people were visited in their room and staff were aware of the need to spend time with people. A staff member told us how they liked to spend time with one person who was very frail, and was aware of the importance of talking with them while helping them to eat and have personal care.

Nursing staff had recently attended a course on counselling for bereavement and end of life care, which included both support to the person at the end of their life, and for relatives or other supporters. Staff were experienced in end of life care, and people's files contained information about their wishes for end of their life where they had wished to share this. For some people this only included funeral arrangements but for others there was more detail recorded. Files recorded any religious, social or cultural needs for the end of the person's life. The service told us in their PIR they aimed to put in place full End of Life Care plans for people to ensure people's views were fully understood and any post death wishes were carried out wherever possible. The service asked families or relatives if they wanted to be contacted if the person deteriorated in the middle of the night to ensure any wishes were understood.

The service had a complaints procedure that was on display in the service's hallway. We looked at the records of complaints and concerns that had been raised with the service since the last inspection. We saw there were records on how these had been managed including the involvement of other agencies where this had been needed. People we spoke with told us they would speak to the staff or a relation if they had any concerns. The minutes of a recent relatives meeting had included views of people on what they would do if they had any concerns. The person had said "If I have any problems I see (name of manager), who is very helpful and I feel comfortable talking to her"

Requires Improvement

Is the service well-led?

Our findings

We found the service was not always well led.

Balcombe Care Homes Limited is a family run company operating three care homes in the South East of England. Wellcross Grange has a registered manager in charge of day to day operational matters. Their practice was overseen by the operations manager for the organisation. The provider organisation has a clear structure with members of the provider family as directors for individual areas such as finances or estates. On their PIR the registered manager for Wellcross Grange told us "We have developed a positive culture that is person centred, open and empowering."

We identified a number of concerns on this inspection that had not been identified in the service's own quality assurance systems.

People could not always be assured of safe or high quality care because audits in place to assess the quality and safety of services had not always identified issues. For example, an analysis was undertaken of incidents, including falls, on a monthly basis to help the service learn from the occurrence and attempt to reduce risks. The analysis numbered the number of falls and incidents in each month, and collated accident reports. However they did not demonstrate any management review of these incidents and there was not always evidence of actions taken to prevent a re-occurrence. Changes had not always been considered to adapt the premises or information to meet the needs of people with disabilities or impairments. The infection control audit, identified in the service's infection control policy could not be located. Some staff communication and training needed to be improved to ensure people were treated with dignity and respect. We found concerns over the safety of the environment.

Although we did not identify people had come to harm as a result and swift action was taken to address the concerns, the failure of the services own quality assurance systems to identify the issues did not give us confidence they were operating effectively or were robust.

The failure to establish and operate effective systems to assess monitor and improve safety; assess, monitor and mitigate risks and maintain accurate records was a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to give their views about how well the service was working and what could be improved. Families, supporters and others such as visiting professionals were able to give their views about the operation of the service, through a series of questionnaires. We saw actions were taken as a result. Regular staff, residents and relatives meetings were held to help ensure effective communication and identify any issues. These were attended by the operations manager when possible and the registered manager on each occasion to ensure they also had a good understanding of any issues or concerns. The registered manager told us in their PIR they welcomed feedback.

The service's infection control policy stated the registered manager completed an annual infection control

report. This could not be located on the inspection.

The organisation had a series of quality assurance processes and audits in place to assess and improve the quality of people's experience. The service had a quality assurance consultation matrix, which collated the results of regular questionnaires sent to people living at the service, staff and other stakeholders. From the matrix it was possible to see where people felt any changes could be made that would improve the home. Questionnaires focussed on specific issues, for example one issue would focus on food, another on dignity. A recent survey focussing on dignity at night had identified issues from people regarding the way they were supported. The report showed for example 36 % of people said night staff always talked between themselves when supporting the person. Clear action plans were in place to address this, including direct monitoring of staff practice at night. An unannounced night inspection had also been made to monitor staff working and people's welfare.

The service had a quality audit matrix, for audits carried out weekly, fortnightly and monthly. This included making sure evacuation plans were up to date, checks of moving and positioning equipment and first aid boxes.

We found the service had a busy and positive atmosphere. Feedback from visiting health professionals was positive about the way people were cared for and how the service was run. This included effective partnership working between the service and local GP practices. People told us they were happy with the service and had good relationships with the staff and management. A director had recently attended a relatives meeting to offer people the opportunity to ask any questions and discuss any issues. This helped to ensure board level management had a visible presence at the service and could have first-hand knowledge of people's experience. Lines of accountability were clear within the management structure, and action plans we saw for the development of the service indicated the person's responsible for taking actions and when they should be completed by. This also included when they would be reviewed to ensure they were being effective.

People and staff told us the registered manager was approachable and fair. Staff told us the registered manager understood the issues they faced when caring for people and the registered manager told us in their PIR they regularly worked alongside the nursing staff so they understood about people's care needs and priorities. A staff member told us "It's very nice here….they are very kind". We saw staff working well as teams, supporting each other to deliver care. However not all staff were positive. One staff member told us they did not always feel respected and that "some things are not always done properly here." The operations director felt there was a need following the inspection findings to work on developing the staff understanding of the 'visions' of the organisation and develop a more positive culture. By the second day of the inspection they had organised workshops to commence from mid-November to start to address this. This showed us there was a strong commitment to review and take advice to improve the service.

Senior staff regularly updated their skills and knowledge. The registered manager told us in their PIR they attended local forums and took advantage of networking opportunities to enhance their knowledge. The clinical lead nurse worked alongside them, supporting the nursing staff with their skills, and additional feedback and oversight came from the operations manager who visited the service regularly, setting targets for improvement and undertaking quality surveys and audits.

The service had a statement of purpose in place. This reflected the regulated activities the service was registered for. It was reviewed during the inspection and it was agreed the service was registered for an activity it currently did not provide. The operations director agreed they would make an application to have this regulated activity removed from their registration.

Other than the most recent safeguarding issue the service had notified the CQC of events they were required to do by law. Policies and procedures were kept up to date and regularly reviewed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to reduce risks to people. The registered persons had not ensured the safety of the premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been operated effectively to assess, monitor and improve the safety of the services provided, or mitigate the risks.