Underwood Hall Limited

Wentworth Grange

Inspection report

Wentworth Grange Nursing Home
Riding Mill
Northumberland
NE44 6DZ
Tel: 01434 682243
Website: www.wentworthgrange.com

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Ratings

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

Overall summary

Wentworth Grange provides accommodation and support for up to 51 older people with personal or nursing care needs. The accommodation consists of a main house with two floors and a renovated building, referred to as 'Hampton House', within the grounds of the home. At the time of our inspection there were 45 people living at the home and in receipt of care. Some of these people were living with dementia, or some form of cognitive impairment, and they were accommodated in Hampton House.

This inspection took place on 17 and 18 August and was unannounced.

Our last inspection of this service took place in February 2013 where the provider was found to be meeting the legal requirements of each of the regulations that we looked at.

At the time of our inspection a registered manager was in post who had been formally registered with the Care Quality Commission (CQC) since October 2010, in line with this service's conditions of registration. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission (CQC) 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.

Concerns were identified in respect of the safety and suitability of the premises. The garden area of Hampton House was not always secure. Appropriate window restrictors were not in place, where people living with dementia and cognitive impairment were accommodated, and therefore they were at risk of falling from height and injuring themselves. The registered manager told us that they would address this immediately.

Medicines were not managed appropriately. Some topical medicines were out of date and were still being applied to people's skin. The storage of medicines was not secure and access to the medicines room was not restricted to those staff with the responsibility for administering medicines, in line with best practice guidance. In addition, there were some gaps in the recording of the administration of medicines and a lack of individualised instructions about when to give people any of their medicines prescribed on an 'as required' basis.

Staff had been trained in safeguarding and were aware of what constituted abuse or improper treatment. However, the provider had not identified and reported all safeguarding matters to the local authority safeguarding team for investigation in line with their own policies and procedures.

Staffing levels were appropriate to people's needs on the days that we inspected however, both people and staff stated that they felt there was not enough staff. Qualified nursing staff said they were regularly asked to cover shifts at short notice. The registered manager told us that new staff had been recruited and were due to start working at the service very soon which would hopefully ease staffing levels. Recruitment processes were robust.

Risks that people were exposed to had been assessed and most environmental risks. Accidents and incidents were recorded and reviewed although action taken as a result of such analysis was not clearly recorded. Some elements of fire safety had not been addressed and some staff needed training in this area. Fire drills were not being carried out in line with the requirements of fire safety regulations. The registered manager told us that this would be addressed.

People received care that was appropriate to their needs and where they needed input into their care from external healthcare professionals this was arranged. People were supported to meet their nutritional needs and monitoring of their food and fluid intake took place where there were concerns about people's weight.

Staff displayed kind and caring attitudes towards people and people told us that they enjoyed positive relationships with staff. Explanations about care were given to people before care was delivered. People were supported to be as independent as possible and they told us that their privacy was maintained. Nobody living at the home currently needed an independent advocate acting on their behalf.

Staff received appropriate training and supervision. They had a basic understanding of the Mental Capacity Act 2005 (MCA) and people's capacity levels were considered in respect of the delivery of their care. Paperwork related to decisions made in people's best interests was sometimes out of date or not appropriately maintained although we were satisfied that the provider followed the principles of the MCA in practice.

The environment in Hampton House, where people with dementia were accommodated, had not been adapted in line with best practice guidelines.

We recommend the provider researches relevant best practice guidelines about how to make environments used by people with dementia more appropriate to their dementia care needs.

Records related to people's care were individualised and appropriately maintained overall. Some information could have been improved.

People were offered choices and an activities programme was in place. People told us they would appreciate more outings. Feedback about the service was obtained from people and staff via meetings and questionnaires that were issued periodically. A complaints policy and

Summary of findings

procedure was in place. The registered manager told us that there had only been one complaint in the service in the last 12 months and this was not related to a care delivery matter.

Records related to the operation of the service were disorganised and could not always be located when we asked for them. Office space was limited and the medication room was also being used as an office. Quality assurance systems were limited and it was not always clear how matters were identified and then subsequently addressed to drive through improvements within the service.

Staff told us that the registered manager was not always available for staff to approach about day to day matters in the running of the home and they would appreciate more direction and guidance at times. The registered manager told us that he was aiming to develop an 'open door' culture within the service where staff could come to him at any time.

The provider had not notified us of all incidents that they should have in line with the requirements of the CQC (Registration) Regulations 2009. We discussed this with the registered manager who told us that he would familiarise himself with the requirements of the aforementioned regulation. This matter is being dealt with outside of the inspection process.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were related to 'Safe care and treatment', 'Safeguarding service users from abuse and improper treatment' and 'Good governance'. You can see the action we told the provider to take at the end of the full version of this 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?
The service was not always safe.

Medicines were not always managed safely and not all safeguarding incidents were reported to the local authority safeguarding team and other relevant parties.

The premises were not always safe and secure and people were at risk because of this. Fire safety drills were not undertaken and some environmental risk assessments had not been reviewed.

Staffing levels indicated that people's needs were met. However, people told us that there were not enough staff. In addition, staff told us that they often had to cover shifts at short notice.

Recruitment procedures and processes were robust.

Requires improvement

Is the service effective?
The service was not always effective.

People living with dementia were accommodated in an environment that had not been adapted to meet their needs.

The Mental Capacity Act 2005 was applied correctly but records of best interest decisions were not well maintained. Decisions made in the event that a person should stop breathing had not been reviewed when they should have been and were out of date for several people.

People told us they were happy with the care they received and that it met their needs. The care staff delivered was effective. Healthcare professionals were involved in people's care where required to ensure they remained healthy.

Requires improvement

Is the service caring?
The service was caring.

Staff displayed kind and caring attitudes towards people and people told us that they enjoyed positive relationships with staff. Explanations about care were given to people before care was delivered.

People were supported to be as independent as possible and they told us that their privacy was maintained.

Nobody living at the home currently needed an independent to act on their behalf.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

The provider responded to people's care needs and sought medical intervention from the relevant healthcare professionals when needed.

Care was person-centred and staff were knowledgeable about people's care needs.

People's care records overall were maintained but at times, there was a lack of consistency in the recording of care that was delivered.

People were given choices and there were activities for them to partake in if they so wished. Some people told us they would appreciate more outings.

Is the service well-led?

Requires improvement

The service was not always well-led

Records were disorganised and could not always be located when we asked for them. Office space was limited and the medication room was also being used as an office. Some care records required review to ensure that all appropriate and relevant information was retained.

Some measures were in place to monitor the quality of the service, such as assessing the competency of staff when administrating medicines, and the monitoring of staff training needs. However, we found that quality assurance systems were limited and it was not clear how matters were identified and then subsequently addressed to drive through improvements within the service.

The provider had failed to notify us of all incidents that they should have in line with the requirements of the CQC (Registration) Regulations 2009.

Wentworth Grange

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 18 August 2015 and was unannounced.

The inspection team comprised of an inspector, a specialist advisor in the field of nursing 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.

Prior to our inspection we reviewed the provider information return (PIR) that the provider sent us in advance. This is a form which asks the provider to give some key information about the service, highlighting what the service does well and identifying where and how improvements are to be made. In addition, we gathered and reviewed information that we held about the service. This included reviewing any statutory notifications and any other information that the provider had sent us over the 12 months. We contacted the commissioners of the service, the local authority safeguarding team and Healthwatch (Northumberland) in order to obtain their views about the service. We used the information that they provided us with to inform the planning of our inspection.

During our visit we spoke with 14 people who lived at Wentworth Grange, five visitors/relatives, nine members of the care staff team, the chef, the administrator, the nurse manager, the auditing/training manager, the registered manager and a community healthcare professional visiting their patient at the home. We walked around each floor of the main building and Hampton House, a separate building in the grounds where people with dementia care needs were accommodated. We viewed all communal areas such as lounges and dining rooms, the kitchen and with permission we looked in people's bedrooms. We observed the care and support people received within the communal areas. We analysed a range of records related to people's individual care and records related to the management of the service. We viewed eight people's care records, six staff recruitment records, and records related to; training and induction; medicines administration; quality assurance; health and safety matters; and the servicing of equipment.

Following the inspection we spoke with another healthcare professional linked with the home and obtained their feedback about the service. We have incorporated their feedback into this report.

Requires improvement

Is the service safe?

Our findings

We identified some concerns during our inspection in respect of the safety and suitability of the premises and the management of medicines.

Whilst the main building had appropriate window restrictors in place, in Hampton House, where people were living with dementia care needs and cognitive impairment, the majority of windows had no restrictors in place. Access to these windows was not restricted and they opened fully onto a sizeable drop outside. People were at risk of falling from height and injuring themselves. Some of the windows in Hampton House did have a thin chain restricting them from opening, however, these chains were not robust enough to prevent them from being tampered with. They did not reflect Health and Safety Executive guidance entitled 'Health and safety in care homes' which informs providers about the precautions they must take to control the risks of people of falling from height. Following our inspection we received correspondence from the administrator for the service, informing us that appropriate window restrictors have been fitted to Hampton House.

There was a garden area linked to Hampton House which people could access freely. Staff told us the gate enclosing this area was checked regularly and it was safe and secure. However, we noted this gate was waist height and the lock could easily be reached. At one point during our inspection the gate to this garden area was left open, meaning that people with limited capacity, and who may be confused or disorientated, could leave this area undetected. Staff told us that people did not go out into this area alone and there was always a staff member present. However, relatives told us that some people had attempted to leave this area and another had fallen, when a staff member was not in the vicinity.

The management of medicines was not robust and placed people at risk of unsafe care and treatment. We found topical medicines were out of date in people's rooms but these were still being used on people's skin. Topical medicines are medicines usually in the form of ointments, foams, creams and lotions. In one person's room there were three tubs of the same cream in use, all were passed their expiry date, some of which had expired in 2013. Nursing staff and care workers told us that the administration of topical medicines had been delegated to members of the care staff team and they signed topical administration records retained in people's rooms to evidence when creams had been applied. However, we found that this was not the case and the application of topical medicines in recent weeks, had not always been recorded. There was no instruction for care staff on how or where to apply topical medicines and no body maps were in place to guide staff. The provider did not have an effective system in place to ensure the application of topical medicines was appropriate, timely and safe.

We reviewed a sample of medicines administration records (MARs) and found that the recording of the administration of medicines was not consistent and there were gaps where staff had not signed these records. This meant it was not always possible to establish whether people had received their medicines as they should have. Individualised written guidance about the administration of medicines prescribed for people to take "when required" (such as pain relief medicines), was not in place to guide and inform staff. Staff told us they "just know" when people should be offered such medicines, as they were familiar with the symptoms they displayed. This practice relied on staff drawing their own conclusions, for example where people were unable to confirm if they were in pain, and it was not in line with best practice guidelines.

Medicines were not stored securely. The medicines room was also used as an office for the nurse manager. Whilst there was key coded access to this room, access was not restricted to staff with the seniority and skills to administer medicines. We saw many staff from a variety of roles entered this room freely. This was not in line with NICE best practice guidelines about the management of medicines in care homes which states that medicines should be securely stored with access restricted to only authorise care home staff.

The above findings constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in safeguarding. A policy and procedure was in place which stated that any instances of abuse should be brought to the attention of the registered manager, who would then report the matter to the relevant local authority safeguarding team and notify CQC. Whilst staff could tell us about what constituted abuse, we could not establish if all matters of a safeguarding nature were reported to the local authority as they should have been. We were aware of one safeguarding case which had been

Requires improvement

Is the service safe?

reported to the local authority safeguarding team by a third party, but not by the registered manager/provider. Records held within the service showed that nursing staff had made an initial attempt to report this case to the local authority, but this was not followed through when contact could not be made in the first instance. Since our inspection another safeguarding matter has not been reported to the local authority safeguarding team or CQC. Therefore, we cannot be satisfied that robust safeguarding procedures and processes are in place to ensure that people are protected from abuse and improper treatment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. One person said, "Of course I feel safe here; it's my home." Another person told us, "The staff are always nice to you. There are nurses here if you need them." One person said that part of the reason they had come to live in a residential home was the need to feel safe and Wentworth Grange had fulfilled this need. Relatives told us they had no concerns about how their family members were treated but they had concerns about the safety of some of the steps in the garden area of Hampton House.

Risks people faced whilst carrying out activities of daily living, such as moving around the home and eating and drinking, had been assessed and were regularly reviewed. For example, risks had been considered for people who were prone to falling and sensor mats were used to alert staff if they moved from their chair or bed. Some records needed further detail to ensure that staff had clear information to refer to. In practice, staff were aware of the risks people faced and they took the necessary precautions to minimise these risks and manage them safely.

Accidents and incidents were recorded and analysed to see if any changes were needed to people's care plans or risk assessments. A monthly audit of accidents and incidents took place but there was not always a record of any actions taken.

Most environmental risks related to safety issues within the buildings had been assessed. However, these risk assessments had not been reviewed in recent years and the risks related to window safety had not been identified by either the registered manager or the provider. The electrical installation within the building had been checked to ensure it was safe and control measures were in place to prevent legionella bacteria from developing within the water supplies. A business continuity plan was in place which detailed actions staff should take, for example, if there was a loss of heating, staff or other unforeseen incidents.

Equipment used in care delivery was serviced regularly to ensure it remained safe for use. Hoists and specialist bathing equipment had been serviced within the six months prior to our inspection and fire safety checks and testing of fire-fighting equipment were carried out at regular intervals in line with manufacturer's guidelines. However, fire drills were not carried out and not all staff had received training in fire safety from a competent person. Basic and very limited information was available about the equipment people would need to support them to evacuate the home in an emergency, such as a fire. Individual personal emergency evacuation plans for each person living at the home were not in place. We have shared out concerns about fire safety and emergency evacuation with Northumberland Fire and Rescue Service.

We reviewed staffing levels and found that overall people's needs were met. People told us that staff came quickly when they rang their call bells and we found that although staff were busy, there was a calm environment within the home. Some staff expressed concern about the skill levels of some of the nursing staff team, a high turnover in staff in recent months and having to cover shifts at short notice. The registered manager and nurse manager told us that two new nurses were due to start work imminently and in the meantime gaps in the staff team were covered with agency staff. People told us there was a high turnover of junior staff and that at times, there were not enough staff. Staff met people's basic needs such as assisting them with toileting or eating, but they had little time to interact with people. During lunch, people had to wait for short periods before staff were able to assist them. People commented that at times they had nobody to talk to, as staff did not have the time to sit with them and engage in meaningful conversation. Since our inspection some concerns, which we will follow up, have been shared with us about further changes in staffing levels at Wentworth Grange.

Recruitment procedures were thorough and protected the safety of the people who lived at the home. Staff had been interviewed, their employment history reviewed, their identification checked, references obtained and their

Requires improvement

Is the service safe?

health explored. The provider had made appropriate checks with the Disclosure and Barring Service (DBS) to ensure that potential new staff were not barred from working with vulnerable adults.

Requires improvement

Is the service effective?

Our findings

People told us that they were happy with the care and support they received and they confirmed that staff met their needs. Some people commented that it would be nice to have more time to talk to staff although they appreciated that staff were busy. One person commented, "I really have got a lot of confidence in the staff and if I was to ask for anything or need it I think I would get it. I have been very comfortable here. Staff always offer to help but I don't need much help." A second person told us, "Staff are nice. I can't think of anything I have had to complain about and the food's pretty good; it's better since the new chef arrived." Other comments included, "Staff are willing to help; If I call the call bell they come to see what I want very quickly" and "Staff do their best to make you comfortable". A relative commented, "The carers are really kind and the food is nice."

Staff practices demonstrated that care and support was managed positively and appropriately. People were assisted to move around the home and to eat their meals if they needed this level of support. Staff displayed patience when assisting people and encouraged them to support themselves as much as possible. Where people had specific health conditions and care needs, such as diabetes, their condition was regularly monitored and details recorded within their care records. Some people had input into their care from specialist healthcare professionals such as respiratory nurses or speech and language therapists, and there was evidence that referrals were made where necessary. People's general health and welfare was maintained, as they were supported to access routine medical input from professionals such as general practitioners, dentists and opticians.

People's nutritional needs were met. They were weighed regularly depending on their needs and where people had been prescribed fortified drinks to assist with weight gain, staff ensured they received these. People who required their fluids to be thickened because they had swallowing difficulties or were at risk of choking, received their drinks at the correct consistency. Food and fluid intake was monitored if necessary.

A list of people's dietary requirements was in the kitchen for the chef to refer to and he told us that care and nursing staff kept him informed of any changes. Staff told us people were asked for their choice of meals about an hour before food was served, but they were able to change their mind at the time the meal arrived. We noted that some food choices were basic, such as the same soup for both meals in a day and tinned fruit salad. People commented on the food served at lunch and said it was uninspired, but well cooked. Some people described how they had asked for particular foods since coming to live at the home and they received these regularly. The registered manager told us that the quality of food was being reviewed, following the recent appointment of a new chef, who was working with people to improve menus and food choices.

There was evidence that people were asked for their consent to care and treatment and this was recorded in paper copy files. We observed staff informing people about their care and treatment and obtaining their consent and agreement before delivering any care. For example, people were asked to agree to take their medication and to consent to seeing healthcare professionals visiting the home.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures that lawful restrictions are not placed on people in care homes and hospitals. Staff were aware of people's capacity levels and these were taken into account when planning care delivery and assessing risks. Decisions had been made in people's 'best interests' in line with the MCA and the provider had adhered to their legal obligations under this act. However, records to evidence these decisions were not maintained within people's care records. We shared our findings with the registered manager and nurse manager who told us that records related to people's capacity levels and decisions made in their best interests would be improved.

Applications had been submitted to the local authority for Deprivation of Liberty Safeguards (DoLS) authorisations, for those people who needed them. DoLS are part of the MCA. They are a legal process which is followed to ensure that no person is unlawfully deprived of their liberty.

Care decisions had been made in the event that people should stop breathing. However, we saw that 'Do Not Attempt Cardiovascular Pulmonary Resuscitation' (DNACPR) records in Hampton House were no longer valid

Requires improvement

Is the service effective?

as they had passed the date by which these decisions needed to be reviewed by a general practitioner. In addition, some of this documentation had been superseded, but the decisions had not been reassessed in line with this. The manager of the Hampton House building told us that they would address this matter immediately. Where people's families had a health and welfare based lasting power of attorney in place to make decisions on their relation's behalf, copies of these had been obtained by the provider and placed in people's care records for reference purposes.

Staff had a basic understanding of the MCA, people's capacity levels and their right to make their own decisions wherever possible. The auditing/training manager told us that plans were in place to deliver a training session on this topic to staff as soon as practicable.

Training was monitored via a training matrix which identified the training staff had undertaken, on what date and when it needed to be refreshed if applicable. Staff training was a combination of face to face and online training accessed through Northumbria Healthcare Learning and Development Unit. Training records showed that staff had completed training in key areas such as moving and handling and medication. In addition, some more specialised training around catheter care and end of life care had been delivered. A large number of staff in the home were in the process of completing vocational diplomas in health and social care and key staff were preparing to undertake relevant management level diplomas. People told us that staff did everything they asked them to and they were confident that staff had received the necessary training. Staff completed an induction when they started in their role, however, this was basic and essentially involved staff reading through the home's policies and procedures. There was no evidence that during induction staff competencies and understanding was assessed to ensure they were suitable to work alone. The auditing/training manager told us that the new Care Certificate was being embedded into the induction package at the home.

Care staff told us that they received one to one supervision and they felt supported by the nurse manager and other nursing staff. Nursing staff told us that they received supervision from the provider, but that more support in their roles from the registered manager would be appreciated.

The environment of the main building was fit for purpose and had been adapted to suit people's needs. There was a lift to move between floors and handrails in communal areas to assist people when moving around the home. People's bedrooms were personalised and communal areas were well maintained. However, the environment in Hampton House did not have handrails on the walls and it had not been adapted to aid people with orientation and provide stimulation, where they had dementia care needs. For example, there was no signage and people did not have a way of identifying their own bedrooms, or of finding their way around the building both purposefully and independently.

We recommend the provider researches relevant best practice guidelines about how to make environments used by people with dementia more appropriate to their dementia care needs.

Good

Is the service caring?

Our findings

People told us they found staff to be kind and caring. Our observations confirmed this. One person told us, “Staff are very nice; in fact the girls (staff) are wonderful.” Another person commented, “They (the staff) are not just doing a job; they really care.” People described how they liked the staff, and they believed the staff liked them. Some talked about enjoying relationships with staff which they considered to be friendships. Relatives’ comments supported what people had told us, and our observations. One relative told us, “The carers are really kind with X (family member).” Healthcare professionals told us that staff displayed caring attitudes towards people and that people seemed comfortable and happy with staffs’ approach.

We reviewed a compliment card that had been received in the service in recent months. It had been sent to the home by a relative expressing their thoughts about the care delivered by staff. It read, “I must send you and your staff my sincerest thanks for all your kindness and patience towards my father. It is a warm, friendly place where the ‘patient’ can feel at home in as far as possible. The care is superb, the surroundings lovely. Thank you for the great care compassion and affection you showed my dad during his time with you.”

We observed one person who had taken ill during our visit being comforted by a care worker who displayed a caring nature. They placed their hand gently on the person’s back whilst they were being unwell and gave reassuring words of comfort which included, “It’s alright; don’t worry you will be fine”.

People were involved in their care and explanations were given to them as care was delivered. Several people told us that the nursing staff always discussed treatment options with them and asked for consent before they delivered care. One person commented, “The nurses always tell you what they are doing and why.” Relatives told us they were kept informed of their family member’s health and communication between themselves and the home was generally good. One relative commented, “They keep us informed, for example if X (family member) was ill or she fell or something.”

People were supported to be independent and we saw staff encouraging people with mobility to progress themselves as much as possible. Equipment was available which enabled people to remain independent when eating. This included, but was not limited to, plate guards which prevent spillage and drinking cups with specialised handles.

People’s privacy was promoted. People explained how staff politely ‘popped’ their heads around their bedroom doors if they were open, to see how they were, and if closed, staff would always knock and wait to be invited in before entering the room. People were able to utilise the communal areas at their leisure, or have private time and space in their bedrooms either alone or when entertaining visitors or guests. People were well presented and their personal cleanliness maintained. We observed one staff member encouraged someone to return to their room so they could help them reposition their clothing, which had been put on incorrectly. This showed that staff were mindful of people’s personal presentation and they sought to maintain their dignity.

Staff had received training in equality and diversity and there was a policy in place for them to follow. The provider promoted people’s diversity, for example by arranging for a local vicar and choir singers to visit on a regular basis to fulfil people’s spiritual needs. Staff told us how they respected the wishes of one person who liked to dress in a particular way.

The manager of the Hampton House building told us that nobody currently had an independent advocate acting on their behalf. Staff explained how they advocated on people’s behalf, where relevant and only if appropriate, where they did not have family members to do this for them. Advocates represent the views of people who are unable to express their own wishes, should this be required.

Good

Is the service responsive?

Our findings

People told us staff were responsive and proactive in getting to know their needs and how to satisfy them. Comments included, "They (staff) know what you like and need and they get it for you" and "We (people) are really made to feel that our opinion matters".

Care was person-centred and people told us they received the care they needed. Staff were knowledgeable about people's individual care needs. Records showed care was assessed, planned and regular reviews took place. They reflected that the service responded as and when people's needs changed and that input into their care from external healthcare professionals such as general practitioners was obtained when necessary.

Records related to people's care needs were held electronically and were individualised. They gave staff information about how to deliver people's care, without exposing them to unnecessary risks, depending on their individual circumstances. For example, there was an eating and drinking care plan in place for one person which stated that they were at risk of dehydration. There was accompanying information for staff to refer to about how to mitigate the risk of them becoming dehydrated and the actions to take if their fluid consumption fell below a specified level. Whilst staff were aware of the risks people faced in their daily lives in relation to their physical and mental health, some people's care records needed to be reviewed to ensure that all assessed risks were fully documented.

A handover book was in place to pass messages between shifts and also a range of records were used to monitor people's health and the care they received. Some of these records, including those used to monitor people's food and fluid intake, the application of topical medicines and positional changes, needed to be completed more consistently.

People were offered choices during our visit, for example, about where they ate their meals, what they wore and where they spent their time around the home. This showed that staff recognised people's individual right to make their own decisions.

People told us that activities were available to them such as 'exercise classes' twice a month and regular visits from a hairdresser and masseur. On the first day that we visited a local choir singing group were providing entertainment to those people who wished to be involved. People in the Hampton House building enjoyed movies and singing with staff on the second day of our visit and there was a vibrant, happy atmosphere during this activity. Some people said they were supported by their families to access the local community or garden areas of the home, but other people said they could only go into the garden if there were staff available to take them. People told us that staff were very welcoming to any friends and family who visited the home. One person told us the provider had embraced modern technology and WiFi was available in people's rooms. They said that several people had access to tablet computers. People commented that there had been a reduction in outings arranged by the provider this past year, where they could access the community. They said they would appreciate an increase in outings again.

A complaints policy and procedure was in place for staff to refer to and they told us that if anyone raised a complaint with them they would refer this matter to the registered manager. The administrator told us and the registered manager confirmed that there had only been one complaint within the 12 months prior to our inspection and this was related to the format of some correspondence as opposed to a care related matter. The records related to this complaint could not be located whilst we were present in the home but the registered manager told us that the matter was resolved to the complainant's satisfaction. The registered manager confirmed that records of low level concerns as opposed to complaints were not kept and that generally the matters people raised were dealt with immediately, so they rarely, if ever, escalated to formal complaints.

Staff told us they had the opportunity to feedback their views at any time to senior staff, the nurse manager or the registered manager. In addition, staff meetings and separate residents' meetings were held to discuss the operation of the service, delivery of care and any other matters such as menus and activities. These meetings also provided a channel through which people who lived at the service, and staff, could feedback their views.

Questionnaires had recently been issued to people in order to gather their views about the service and these were in the process of being returned. This showed the provider had systems in place to gather people's views and feedback about the service that was delivered.

Requires improvement

Is the service well-led?

Our findings

We identified shortfalls in respect of governance and the management of records.

We found that records related to the operation of the service were not appropriately stored and could not be easily located when required. In addition, some records related to elements of people's care had not been made, or they needed to be reviewed to ensure they contained the most relevant and up to date information and risk assessments. On several occasions staff and the registered manager were unable to locate records that we asked to see. Some of these records were eventually located during our inspection and some were not. For example, the minutes related to recent meetings held within the service and the complaints file with associated documentation could not be found. We were not always able to find the outcome of certain matters, as the records we needed to see, were not available to us.

The medication room was being used as an office for the nurse manager and some records were stored within this room. Many of these records were not currently in use and staff seemed to have difficulty finding records they may need access to regularly, such as a recently completed handover book. The registered manager told us that a review of office space within the home was currently underway and hopefully this would allow for records to be stored in a more structured manner.

Some measures were in place to monitor the quality of the service delivered, such as assessing the competency of staff when administrating medicines, and the monitoring of staff training needs via a colour coded matrix system. Internal audits were done, but only on an annual basis. These were limited, as essentially they were 'tick-box' checklists which looked at the environment, medication, maintenance, food and activities. Where audits or meetings did take place, it was not clear whether any matters arising had been addressed, in order to drive through improvements within the service. For example, action plans had not been drafted to evidence that the registered manager or provider had identified matters which needed to be addressed, and put measures in place to address them. Senior staff or the registered manager had not checked records such as food and fluid charts or topical medicines administration records to ensure they were appropriately completed by the relevant staff.

The provider could not demonstrate that they had effective and suitable quality monitoring systems in place, which they used to improve the standards of the service they delivered. The registered manager told us that he was in the process of reviewing all elements of the service including quality monitoring and auditing, with a view to bringing about changes.

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

We found evidence that a number of incidents had not been reported to us as they should have been, in line with the requirements of the Care Quality Commission (Registration) Regulations 2009. We discussed this matter with the registered manager to ensure they were clear on their responsibility to notify us of deaths and other incidents, such as serious injuries, incidents reported to the police and any instances of abuse or allegation of abuse. We also spent time with the nurse manager discussing this matter as they managed some areas of care delivery. The registered manager gave us his assurances that he would familiarise himself with the requirements of these regulations immediately, ensuring that all future notifiable incidents are forwarded to us without delay. This matter is being dealt with outside of the inspection process.

A registered manager was in post who had been formally registered with the CQC since October 2010. He was present for a proportion of the first day that we visited and all of the second day. Wentworth Grange is a family run business and the registered manager is related to the provider.

We spoke with people and staff about the leadership of the home. People were aware of who the registered manager was and they had heard him speak about his concept of the culture of the home. People were very familiar with senior members of the care staff team and the nurse manager whom they commented knew them very well. Staff told us that the registered manager was approachable, but that he was not always present around the home and did not get involved in 'day to day' matters. Staff said that at times this left them feeling isolated and they thought there was a lack of discussion about how key challenges, concerns and risks could be met to improve the service. We discussed this with the registered manager who shared with us his visions for the future and the

Requires improvement

Is the service well-led?

improvements that he planned to make to the service. He told us that he hoped to create an 'open door' culture where all staff could come and see him at any time in his office.

The registered manager told us that the home was undergoing refurbishment in stages and some bathrooms and bedrooms had been recently renovated. He informed us that he was in the process of reassessing all aspects of the service saying "We need to become the best we possibly can be". He was passionate about his vision for the future, which was to provide people with a positive outcome, a homely environment to live in and "Good old fashioned care".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected against the risks associated with unsafe care or treatment because the provider had failed to identify environmental risks and manage medicines appropriately. Regulation 12(1) (2)(a)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People were not protected from abuse or improper treatment because the provider did not follow their own safeguarding policies and appropriately identify and report matters of a safeguarding nature to the relevant parties. Regulation 13 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected against risks of receiving inappropriate or unsafe care and treatment, and the risks associated with health and safety, as appropriate systems and processes were not in place to monitor the service. Regulation 17 (1)(2)(a)(b)(c)(d)(f).