Caring Homes Healthcare Group Limited

Garth House

Inspection report

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Date of inspection visit:
11 December 2017

Date of publication:
19 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Garth House is owned and operated by Caring Homes. It provides accommodation and nursing care for up to 42 older people, who may also be living with dementia. We carried out an unannounced inspection on 11 December 2017 and on the day of our inspection 26 people were living in the home.

The home had a registered manager. A registered manager is a person who has registered with the Care 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. There was a new manager in post who assisted us with our inspection. The registered manager assisted us with our inspection.

We last carried out a comprehensive inspection of this service on 2 August 2017 when we rated the service as Requires Improvement overall. We also took some enforcement action against the registered provider as we had found continued breaches of regulations from the previous inspection. Following the inspection in August 2017 the registered provider submitted an action plan to us telling us how they planned to address our concerns. We carried out this inspection to see if the registered provider had taken action in line with their action plan. As such we checked to see if there were sufficient staff, people were being treated with respect and dignity, the requirements of the Mental Capacity Act 2005 were being met, risks to people were being managed and quality assurance processes were in place. We found overall the service people received had improved, however further work was required to ensure sustainability of those improvements.

Staffing levels at Garth House were sufficient; however we spoke with the manager about reviewing deployment of staff during peak times to help ensure people received the support they required promptly. For example, at lunch time. Although we found the environment was generally clean and hygienic, work was required to help ensure the home was of a good standard in terms of maintenance and decoration. The clinical room where medicines were stored was found not to be suitable for purpose.

The registered provider was aware of their statutory requirements to notify us any safeguarding concerns or serious injury. Records for people were not always reflective of the care people needed, however the manager told us this was a piece of ongoing work and we had no concerns that people had not received the care they required.

Risks to people were identified and managed safely. Although people received the medicines they required, we found improvements were needed with regard to medicines records. Some people did not have appropriate guidelines in place to support the administration of occasional medicines, such as pain relief. Staff understanding of the Mental Capacity Act had improved and assessments of people's capacity had been completed.

The management support team had recognised that care had previously been provided in a task based way and had taken effective steps to enable staff to deliver a more personalised approach to care. Care plans

were being updated and reviewed to ensure they accurately reflected the support people required. Group activities were enjoyed by those who participated. However opportunities were missed to deliver meaningful activities to people on a daily basis, particularly those who spent the majority of their time in their room.

Staff were caring and attentive towards people and we observed respectful, dignified interactions between staff and people. People were enabled to be independent when they could and make their own decisions. Before people moved into Garth House their needs were assessed to help ensure staff could provide appropriate care.

The new manager was working closely with other professionals to ensure people's health care needs were being met. People were given a choice of food and those who required a specialist diet were provided with this. People's health, nutrition and mobility were monitored regularly to help ensure they maintain a good quality of life. Complaints and comments received by the manager were responded to in an appropriate manner.

Staff had a good understanding of their roles and responsibilities in safeguarding people from abuse. Appropriate recruitment checks were carried out to ensure suitable new staff were employed. Staff were sufficiently trained and supported to manage people's needs. Staff had regular supervisions with their line manager. The manager told us they were aware that some staff had not received an appraisal and this was an ongoing piece of work.

The provider's senior manager and the home manager were open and transparent about the shortfalls within the service and committed to continuing to take action to improve. Quality assurance processes were more robust and despite the short time the manager had been in post improvements had already taken place. People, relatives and staff felt the service had improved since the new manager had taken up post. Staff felt supported and told us the culture within the team had got better.

Accidents and incidents were recorded and appropriate action taken in response. In the event of an emergency, fire or evacuation; people's care would continue in the least disruptive way.

As a result of our findings we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made a number of recommendations to the registered provider. 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 consistently safe.

Although the home was generally clean and hygienic we found some areas which had not been cleaned as they should. Maintenance and refurbishment were required in order to bring the environment up to a good standard.

Medicines were managed safely.

Staffing levels were sufficient, but deployment of staff needed reviewing at peak times to ensure that people experienced a sociable lunchtime. Appropriate recruitment checks were carried out to ensure suitable new staff were employed.

Risks to people were assessed and managed by staff. Accidents and incidents were recorded and appropriate action taken.

Staff understood their roles and responsibilities in safeguarding people. In the event of an emergency or fire there were suitable processes in place.

Is the service effective?

Good

The service was effective.

Mental Capacity Act assessments and best interests decisions had been made for people in line with the legal requirements.

Staff were sufficiently trained and supported by the provider and senior staff so as to ensure they followed best practice.

People had choice over their meals and were being provided with a specialist diet if they needed it.

People were supported to access the other healthcare services they required.

Assessments were carried out prior to people moving in to Garth House to help ensure their needs could be met.

Is the service caring?

Good

The service was caring.

People had good relationships with the staff who supported them.

Staff treated people with dignity and respect and we received positive feedback from people and relatives about staff.

People were involved in making decisions about their care.

People were enabled to maintain relationships with people close to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities for people lacked individualisation and meaningfulness. Particularly for people who spent the majority of time in their room.

Staff followed guidance in people's care plans to help ensure they received appropriate and responsive care with positive outcomes.

End of life care was discussed with people to ensure their wishes were known.

Complaints and feedback was listened to by the manager and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Internal auditing and monitoring had started to identify shortfalls and the new manager was taking action to improve the service that people received.

Records in relation to people contained conflicting information in some instances. However the manager had told us they were aware of this and a complete review of the records was underway.

People, relatives and staff were involved in the running of the service.

The manager was aware of the need to notify CQC of any incidents or safeguarding concerns within the service. In addition

there was a duty of candour process in place which demonstrated the registered provider was open and transparent.	

Garth House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was a re-inspection of this service to check 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 an updated rating for the service under the Care Act 2014.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not request a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because the inspection was carried out to follow up on concerns identified at our last inspection.

This inspection took place on 11 December 2017. The inspection was carried out by two inspectors, a specialist nurse and an expert by experience. An expert by experience is a person who has experience of caring for a person living in this type of environment.

During our inspection we spoke individually with three people, five relatives, six staff, the new manager and a member of the provider's senior management team. We observed interactions between people and staff throughout the day and joined people across the service at lunchtime to gain a view of the dining experience. We also reviewed a variety of documents which included the care records for five people, three staff files, medicines records and other documentation relevant to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Although people lived in an environment that was generally clean and hygienic we noticed the environment in which people lived was in need of refurbishment. Some areas of the laminate flooring were lumpy and raised, woodwork was chipped and stained and the décor was not conducive to those who may be living with dementia. For example, people's rooms were not easily identifiable. One relative told us, "I object to the poor decoration."

We also noticed that the clinical room in which medicines were stored was not suitable for purpose. The fronts of the cabinets were stained and were in a poor state of repair. The floor covering was torn in one place and we found a sheathed needle and rubbish under it. As such we found medicines, syringes and various other clinical items under the cupboards, together with dust and dirt. In addition, the sharps bin (a container used to safely dispose of used needles and other sharp medical instruments) lid was not on securely. We spoke with the manager about the state of the clinical room and action had been taken by the end of our inspection. However, the lack of cleanliness in the clinical room had not been identified by staff despite daily checks being undertaken.

We also found that the kitchen had received a three star rating from the local authority. This was due to cracked tiles, food storage shelves having holes and the extractor hood not covering both fryers in the kitchen. We saw that no improvements had been made to the kitchen as a result of this rating and the chef was unsure whether or not the kitchen formed part of any planned refurbishment.

Following our inspection the manager sent us planned works for the home. We noted these included refurbishments of people's rooms, communal areas and staff areas. They told us they anticipated this improvement programme would commence in the new year. 'Although we noted that this did not include any improvements to the kitchen, we were informed by the registered manager that work would be carried out to the kitchen in response to the short falls identified by the local authority'.

The failure to ensure premises were clean, tidy and fit for purpose was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received the medicines they required. We saw each person had a Medicine Administration Record and we found no gaps in the recording of medicines. We found protocols for occasional medicines (PRN) such as painkillers were not always completed fully for each person. However we spoke with staff about this who were able to demonstrate they could identify when people were in pain. We were satisfied therefore that this was a records rather than safety issue.

Medicines were stored and administered safely. There were lockable rooms for the storage of medicines. Medicines trollies were locked when left unattended. Medicines that required refrigeration were stored in fridges, which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored daily to ensure the safety of medicines. Where nursing staff administered medicines they told us they had undergone practical competency checks. When staff were carrying out the

medicines rounds they wore a 'do not disturb' tabard to prompt others from distracting them. One nurse told us, "The medicine round can take up to two hours sometimes, but I always make sure that I respect the intervals between doses for people who are on time specific medicines."

At our inspection in August 2017 we identified that the provider had failed to maintain suitable staffing levels. At this inspection we observed and were told that things had improved.

People were cared for by a sufficient number of staff. The manager told us that five care staff and two registered nurses were on duty each day and three care staff and one registered nurse during the night. Staffing levels were based upon people's dependencies and as such were adjusted as necessary. The manager told us when they had first commenced work at the home there was a large amount of agency staff use but they had successfully recruited to vacancies which had resulted in the agency usage reducing. A staff member told us that there was previously a lot of agency staff used, but they felt this did not happen now.

We saw staffing levels were in line with what we had been told during the day. We did not see people needing to wait for attention from staff whilst they were in the lounge and we were not aware of people's call bells ringing for any length of time which indicated to us that staff were responding in a timely manner. Although staff were busy they did not appear to be rushing around and the atmosphere was calm and relaxed throughout the day.

However we spoke with the manager about our observations during the lunch period. We saw that some people had to wait for their lunch. This was because deployment of staff was not organised in a way that help ensured people who required support to eat received that at the same time as others were eating their lunch. For example, one person sitting at their table was given their dinner but required prompting to eat it. Staff missed the opportunity to do this as they were busy helping others. Eventually a staff member spoke with them and they started to eat their dinner, but it took a five minutes before staff had noticed this person was not eating. The registered manager told us they were aware that meal times needed to be reviewed to help ensure they were a social experience for people and that they would review deployment of staff during these periods. A couple of relative's told us that they felt there were periods when there could be more staff available. For example, in the lounge and dining room.

We recommend the registered provider ensures deployment of staff is organised in such a way that it responds appropriately to peak times within the service.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services. There were also copies of other relevant documentation, including employment history and professional and character references in staff files to show that staff were suitable to work in the service. We noted that nursing staff had provided evidence of their registration with their professional body.

People and their relatives told us that they felt safe with staff. One person told us, "I think I am safe here. I can't walk very well anymore but they (staff) help me and it's nice to know someone is always there." One relative said, "I don't worry about her." Another told us, "I think mum is safe here." A third said, "Mum is definitely safe. I trust staff."

At our inspection in August 2017 we found risks to people had not always been identified and where they had, staff were not necessarily working in a way to mitigate any risks. We found at this inspection things had improved.

Risks to people's health were identified and managed. Care records documented the risks that had been assessed in respect of areas such as skin care and people's risk of falls. Where a risk had been identified there was a plan in place to manage it. One person's health condition meant their legs should be elevated when they were seated and we saw this happen. Another person was at risk of falling out of bed. Their care records recorded they required their bed put at the lowest level and protective mats in place. We observed that both were as they should be in their room. Where people required two staff to transfer them we observed staff used appropriate moving and handling techniques. One person had a risk assessment in place for taking their medicines as they had an increased risk of choking when swallowing. Guidance was clear to staff in that they should ensure medicines were given to the person with plenty of fluids. Where people could not use the call bell staff carried out hourly checks on them and when people's needs changed staff were made aware about the individual risks to people. Where people were at risk of a breakdown of their skin pressure relieving equipment was in place to help reduce this risk. We saw that some people slept on pressure mattresses and others had pressure cushions to sit on when in chairs. Daily mattress checks were undertaken. One person who had developed sores on their ankles had these dressed and staff were monitoring the sores regularly in case of further breakdown.

Accidents and incidents were recorded and appropriate action and learning in relation to them to help prevent reoccurrence. One person had a fall from their bed and as a result a call bell pendant was purchased for them so they could call for assistance at all times. Another person had an assisted fall by a staff member. As a result the manager felt the staff member would benefit from some additional moving and handling training which was provided. The new manager demonstrated their knowledge of people living at the home and as a result had good oversight of all accidents and incidents.

Staff understood their roles and responsibilities in safeguarding people. Staff were clear about the need to report any safeguarding concerns and told us they would report abuse to outside agencies if necessary and knew where to find the contact details for these. One staff member told us if they saw something like bruising on someone they would report it to the nurses and if they were not available, the manager. The management team referred safeguarding matters to the local authority and us in a timely way. There was evidence that the manager had worked closely with recent safeguarding investigations with the local authority and assisted them in carrying out investigations in relation to any safeguarding alerts.

Environmental risks had been considered. A daily walk-around was carried out by the maintenance person to look at environmental and fire safety, along with the security of the building. In the event of a fire each person had a personal evacuation plan which recorded any individualised support the person needed to vacate the building. For example, in the case of one person who would be transferred to a manual wheelchair to help ensure a swift exit. Should the home have to close, the registered provider had made arrangements with another local provider to help ensure people's care continued in the least disruptive way possible.

Good

Is the service effective?

Our findings

At our inspection in August 2017 we found a lack of compliance with the legal requirements in relation to consent. We found at this inspection documentation regarding people's capacity had improved, however further work was required.

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 when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the majority of assessments had been carried out to determine a person's capacity in relation to using bed rails for example. We also found that people who were on covert medicines (medicines disguised in food) had mental capacity assessments with involvement from the GP, pharmacist, relative and staff. Clear indication as to the method of covert medicine was available for staff. Staff knew the key principles of the MCA and told us that they put these into practice.

Staff had the skills and experience to support people effectively. Staff received an induction when they first commenced working at Garth House. This was in line with the Care Certificate (a set of nationally recognised standards for people working in care). The manager told us that new staff who had no experience of previously working in care were undergoing a more robust induction to help ensure that they were satisfied that staff were working in the way they expected them to. A staff member confirmed they had completed a two week induction before they worked alone. They had also been allocated a buddy who they could speak to initially. Another said they had also undergone the induction and found it to be helpful and allowed them to see what they should be doing and how to do it.

Staff training included areas such as first aid, food hygiene, infection control, moving and handling and fire safety. We noted that as of November 2017, compliance with training was 86%. Where staff were yet to do their training or were behind with refresher training the manager sent them a letter giving them a deadline to complete it. We saw evidence of these letters having been sent to staff. Staff showed good knowledge and skills in the management of fluid, prevention of pressure ulcers, management of incontinence, the risk to people of malnutrition, choking and falls. One person said, "Yes, I think they are trained. They are always helpful. If I need anything they sort it out." A relative told us, "Staff seem to be being trained now and it shows in the way they interact with the residents." Another commented, "I think the staff they have now are well trained."

Staff told us that they had regular supervision sessions. The manager told us at the start of our inspection they were aware that some staff appraisals were overdue and that this was a piece of ongoing work. However staff felt supported by the new manager and that they could speak to them whenever they needed.

People had choice over their meals and were effectively supported to maintain a healthy and balanced diet. One person told us, "I like the food." A relative said, "The food seems to be quite good." Another said, "She likes her food and they are really good with her and talk to her as they go along."

People who needed assistance to eat and drink received appropriate support. For example, we saw staff sitting at eye level with people and talking to them as they offered each mouthful slowly. One staff member showed a lot of patience each time they placed food in a person's mouth, ensuring that they had finished and checking with them before giving them another spoonful. We observed that people who required specialist diets such as pureed or fork mashable food did receive this. Portion sizes were appropriate and people were offered a choice of drinks with their meal. Throughout the day, drinks were located next to people.

The chef maintained a list of people's dietary requirements from allergies to likes and dislikes and food consistency. They were able to tell us about one person who had a nut allergy and that they prepared their food separately. The chef told us they had fortified foods for people losing weight. For example, by adding cream to potatoes. People were weighed routinely each month and where staff had concerns about people's health this was increased to weekly. Where there were concerns about the food or fluid intake for a person, we saw that this was being recorded and monitored. One staff member told us, "This person [name] needs to take fluid because she can get constipated and her skin can break easily. Se we make sure that we encourage her to take fluid every hour when she is awake."

Where people required specialist input staff organised this. For example, we noted one person was recorded as having, 'trouble swallowing the fork mashable food'. We saw that staff had made a referral to the Speech and Language Therapy (SaLT) team for an up to date review of their swallowing ability. Furthermore, staff had been in contact with the GP who had agreed that the person should be provided with pureed food in the meantime to help reduce the risk of them choking.

People were supported to maintain good health and had access to external healthcare support as necessary. We saw evidence in people's care plans that they had seen health professionals such as a doctor, dentist, optician, podiatrist, physiotherapist and occupational therapist. A relative told us, "If she is unwell the manager will phone us and let us know if they are calling the doctor." Another said, "They (staff) ring me straightaway if one of them (parents) is poorly." A third told us staff were extremely responsive if their family member was unwell.

Before people moved into Garth House an assessment was carried out to help ensure that the service could meet their needs. We noted people's assessments held information about their medical needs, mobility, nutrition and personal care. Information was detailed and covered all aspects of a person's care needs.

Good

Is the service caring?

Our findings

At our inspection in August 2017 we found people were being shown a lack of dignity and respect by staff. We had no such concerns during this inspection.

People were treated with respect and dignity. One person told us, "They (staff) look after me very well. I'm fed and warm." A relative told us they had no concerns in this area and said, "Staff are very polite and helpful." A second family member told us, "Previously we had concerns around her dignity. That seems to be better now. They (staff) seem to be working more as a team, to be thinking a bit more about her as a person." A third said, "There is more consideration of residents (by staff)." Another said, "I think I can say that the staff now are caring."

We heard that some people had expressed a wish to have female staff only when receiving personal care, however relative's told us this was not always respected by staff. We spoke with the manager about this at the end of the inspection. They told us, "We will always try to comply but in instances where it is an emergency a male member of staff may be the only person available to assist someone. Staff will always ask people first if it is okay however." They told us that they will review people's requests and speak to individuals in relation to this. Following our inspection the manager sent us evidence to demonstrate they had consulted with people and updated the records.

People's individual characteristics were recognised by staff who demonstrated good skills at communicating with people. One staff member told us, "I have learnt that with this person likes you to knock and wait for her to reply before going in (to their room). So I never go in unless she tells me that it is okay to come in. This is common sense but very important." Another staff member said, "[Name] is deaf and you have to get close to her and shout." We observed that when staff communicated with people they listened actively and gave people opportunities to respond. A staff member told us how they described to a person how long their personal care would last. This helped to ensure the person understood what was happening. We observed one staff member supporting a person who was hard of hearing during lunch. The staff member demonstrated a respectful attitude towards the person by positioning themselves in such a way that they could communicate with the person at all times.

People were cared for by staff who were attentive and caring in the way they supported people. We noticed that staff crouched down when they spoke with people to enable eye contact. Staff were tactile in the support they provided. For example, we saw one staff member bringing someone in their wheelchair through a doorway into the lounge area. Another staff member put their hand up to ensure the person's elbow did not hit the architrave of the door. One person was tired in the afternoon and when staff spoke with them they stroked their arm saying, "You've had a busy day today." Another person was having hand cream massaged into their hands by a staff member. The conversation they had with the staff member and the smile on their face showed they were enjoying the experience. One person said, "Oh yes, they are lovely girls, always smiling and laughing." A relative told us, "They (staff) seem to be tremendously patient and very kind." Another said, "I think the staff are very caring. " A third told us, "I think the care mum gets now is good."

People had good relationships with staff. It was clear people were comfortable in staff presence and we heard staff encouraging people to interact with them. One person said, "They have a joke with me sometimes and they are always very helpful." A relative told us, "I come when I can and the home never makes me feel in the way." Another said, "We come at different times, never routine. I've never seen anyone being anything other than kind to her."

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences. One relative told us, "They don't come out of their room at all anymore. They just sit and watch TV. The room is mum's security – it's how they want things and the staff don't press them to do things differently. I think the help they (staff) give them is how they want things."

People were enabled to be independent and have privacy when they wished it. We saw that people who were mobile returned to their rooms or went to other parts of the home at any time during the day. One person liked to sit in the lobby area and staff respected this and as such ensured they served the person with their drinks whilst they were sitting there. Other people preferred to spend time in their room, rather than sitting in communal areas and staff respected their wishes. We heard staff knock on people's doors and close doors when they were carrying out personal care to people. A relative told us, "They have help getting washed but they choose what they want to wear and eat." A second relative said, "They are always very gentle and considerate of mum. I've seen staff knocking on people's doors and asking if it's okay to come in." We saw staff knocked on people's doors before entering and closed the door behind them when supporting people with their personal hygiene.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained sufficient information so a person's care needs could be easily understood by staff. People on the whole received responsive care and treatment and we observed a general improvement in this area from our last inspection. A relative told us that their family member's care plan had not been properly maintained under the previous management but it had been reviewed now. Another relative said, "I think her care is tailored to her needs." A third relative said, "I asked (the new manager) to keep an eye on mum's eating because she seemed to not be eating much and she was straight on it. Overall I think it is an amazing home."

Staff were aware of people's needs. We observed one person who remained in bed. Each hour staff would check them to ensure they were safe, comfortable and free from pain. Staff did this by asking them specifically whether they wanted a drink, wanted to use the toilet and checking whether they needed pain killers. Staff confirmed their intervention by recording this on an hourly 'checking' chart. Where people had behaviours that may cause themselves or others harm staff followed this guidance which had resulted in positive impacts to people. One person could, 'hit out at staff' when they carried out personal care. Information to staff recorded, 'leave [name] alone and try again later'. This meant the person was much calmer with staff. Another person had been transferred to the home because the previous provider was unable to deal with their challenging behaviour. We read that Garth House staff had involved the psychiatrist and the community mental health team in the management of the person. The records showed that this intervention had enabled this person to be supported more effectively.

We read people had end of life care plans in place. These recorded their wishes and desires during this time. One person was noted as stating their wish to have, 'family with her'. Where appropriate, end of life care was discussed with a family member to help ensure staff supported the person at this time in their preferred way.

At our inspection in August 2017 we made a recommendation to the registered provider in relation to activities and stimulation for people. We found at this inspection there had been little improvement although the new manager told us they had recently recruited two new activities coordinators who were to commence in the New Year. They said this would mean they would be able to offer activities to people seven days a week. We will check at our next inspection whether or not this has happened and things have improved for people.

People did not always have access to activities and engagement that were individualised and meaningful to them. This was because they were not enough staff who were skilled in running activities. The structured group activities were stimulating and we did see some people joining in. However, the majority of people spent their day just sitting in the lounge with little stimulation. When we arrived at our inspection we saw seven people were in the lounge area. Of those seven, five people were asleep. Some people spent the majority of their day in this way. Other people who spent most of their time in their room received little one to one interaction from staff, other than for their hourly checks. For example, one person's contact with staff was restricted to their hourly check, personal care and meal times. In between we observed that they slept. When we spoke with them after their meal they were full of smiles and engaged in reminiscing. Staff

demonstrated to us they had the skills to interact with the person, but these were mostly restricted to their clinical care as there was no time identified to engage in activities.

We recommend the registered provider ensures people spend their time in a stimulating and meaningful way in order to avoid social isolation.

However, we found that one person received appropriate intervention from staff to help reduce their risk of isolation and behaviour linked to their dementia/frustration. A staff member told us, "It is important that when she is out of her room we keep her busy and this puts her in a good mood. We get her to do activities that we know she enjoys." This was important as this person became frustrated if they were not kept occupied. We also saw a game taking place in the afternoon. Each person was involved and staff made sure they went round one by one so people got the opportunity to play. One person was completing a puzzle, but stopped to join in. They told us, "It's a bit of fun." One relative told us, "They used to have singing groups and animals coming in for petting but there doesn't seem to be much going on at the moment." However, another told us, "There is more interaction with people now."

Complaints and comments were listened to by the manager and responded to in a way that demonstrated to people they were taken seriously. We read feedback from one relative who was unhappy with some aspects of their family member's care. We read that the manager had met with the relative to discuss this and they had worked together to agree a plan of care for the person. Complaints information was displayed in the hallway of the home for people to read, it was also provided to them in the information booklet given to them when they moved in. Relative's told us they had made complaints in the past, but this was before the current manager took over and the consensus of opinion was that things were improving. One relative told us, "I can't recall being given any information about how to raise a complaint but I would speak to the manager straight away."

Requires Improvement

Is the service well-led?

Our findings

Relatives were impressed with the new manager. One told us, "She's improved things." Another said, "There have been big improvements since the current manager came." Another commented, "There have been vast improvements in the standard of care since the new manager came." A third told us, "The new manager is good for the home and she always makes a point of talking to us when we come and keeps us up to date with how mum is."

People's care records did not always provide consistent information about a person's needs and some monitoring information was not analysed by staff to check whether or not people's care needed adjusting. For example, where people were on food and fluid charts. One person's fluid target for the day was 1023ml, however we noted on four occasions they had fallen well below this target. The information had not been reviewed over the period of a month to look at their average intake to see if further action or professional intervention was required. We spoke with the manager about this who was able to explain the action being taken, however this was not clear from the records.

Some medicines protocols did not record how a person may indicate pain, the dosage of medicine they should be given and the maximum dosage they could receive over the course of a day. These guidelines are important for people living with dementia as they may be unable to communicate that they require pain relief. We spoke with the manager about this at the end of our inspection. Following the inspection the manager sent us evidence to demonstrate this shortfall had been rectified.

Furthermore one person was noted as requiring half hourly checks, but staff told us that they were checking the person hourly. Another person's records recorded they needed a 'medium' sling for transfers in one part of their care plan but a 'small' sling in another part. A third person was recorded in their care plan that they liked to be up and dressed by 09:00, however in the records in their room it stated 10:00.

The manager had told us at the beginning of our inspection that a full review of people's care plans was ongoing and they knew they were not, "Where we need to be" in relation to documentation. The manager had made steady improvements to the service since they commenced in post in September 2017 and as such we had no major concerns that people were unsafe living at Garth House because they were not receiving appropriate care. The manager sent us evidence following our inspection to demonstrate they had responded immediately to some of these shortfalls. To this end we have made a recommendation to the registered provider in this area.

We recommend the registered provider ensures that documentation in relation to people's care needs is up to date and accurate.

The registered provider was aware of their statutory duties in relation to their registration with CQC. As part of registration providers should notify us of all safeguarding incidents or serious injuries to people. We found that relevant notifications had been submitted to us. In addition, the new manager had worked closely with external stakeholders to look at incidents within the home and to learn from these and improve the service.

Incidents were monitored and discussed at senior management level and any learning cascaded to staff.

At our inspection in August 2017, we found there was a lack of effective systems in place to monitor and improve the service. At this inspection we found the new manager had already started to improve the service and between them and senior management quality assurance was having a positive impact for people.

Internal auditing by the management team took place to help ensure a good quality of care was provided. We read that the provider visits covered areas such as pressure equipment, care assessments, safeguarding concerns, bed rail assessments, accidents and incidents and infection control. Where actions had been identified these had been addressed or were ongoing work for the manager. For example, it was noted there was gaps in the recording of water temperatures in some bathrooms and that people should always be weighed when their MUST (malnutrition assessment) was being undertaken. We noted these were now both happening. An ongoing action plan recording progress was held by the manager. This recorded when actions had been completed and what pieces of work were ongoing.

Medicines audits took place both internally and externally. The most recent external audit identified that expiry dates of medicines were checked but not recorded. This was now happening. An internal audit noted an error with some controlled medicines. As a result this was raised as a safeguarding concern and a full investigation was carried out. In addition, the clinical lead carried out medicine rounds observations routinely to check staff were continuing to follow good practice.

Despite the short time the manager had been in post they had demonstrated a commitment to turning around the service and as such had addressed the shortfalls one by one and in a methodical manner. We read that training, wound documentation, supervisions and staff practices had been addressed. They had focussed on turning around the culture within the staff team to reduce the 'task' orientated institutionalised practices and had worked with staff to take ownership for ensuring they provided person-centred care. In addition we found good multidisciplinary work within the home to understand the type of care individual people needed.

We found the culture within the staff team was more positive and saw staff working together as a team. In turn the provider recognised the commitment and dedication of staff. They had recently introduced a 'Caring Stars' award scheme in which care staff could be nominated for the way they cared for people. A relative told us, "There's no atmosphere anymore. Previously everyone seemed to be on edge and the communication is better. They listen more now and the new manager seems keen to get things right." Another told us, "Staff now act more as a team. Before they didn't seem to have any direction." A staff member said, "Teamwork has really come along. We are now all on the same page." Another told us, "We work with each other now, not against each other." Staff told us things were, "One hundred percent better than a year ago", and that the manager was, "Fussy about who was employed meaning care standards were higher."

People were involved in the running of the home. Residents and relatives meetings took place. We read topics discussed at the most recent meeting included the Christmas party, menus, care plan reviews, the CQC inspection, activities and staffing levels. Where the manager received comments from relatives or people they addressed these straight away. A relative told us, "We do attend the relatives' meetings and we feel that we are being listened to now." Another said, "We've had surveys through and we attend the residents meetings too. It (the home) seems to be on the up at the moment." A third told us they had recently attended one meeting where the manager had spoken about the plans for the service and had tried to assure people that changes would be made to make things better."

Staff meetings were also held at all levels. A recent care staff meeting attended by six staff looked at records and in particular room folders. It was suggested these were all arranged in the same order for simplicity for staff. We saw the ones that we reviewed had been organised in this way. Staff told us they had regular meetings, individual and group supervisions and felt supported by the manager. One staff member described them as, "Exceptional."

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider had demonstrated the principles of this regulation by sharing openly acknowledging and addressing the shortfalls of the service.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to provide appropriate premises which were clean, tidy and fit for purpose.