Mr V and Mrs K Aravindhan

Granada House

Inspection report

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We undertook an unannounced inspection of Granada House over two days on 02 and 07 July 2015. At the time of our inspection 11 people were living in the home. Granada House is a small care home providing personal care for up to 13 people.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also a registered manager for another location, and left much of the day to day running of Granada House to the deputy manager.

At our last inspection on 01 September 2014 Granada House was non-compliant with two Regulations; care and welfare of people who use services (Regulation 9) and assessing and monitoring the quality of service provision (Regulation 10). Regulation 9 of the Health and Social Care Act 2008 Regulations 2010, corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulations (2014). Regulation 10 of the Health and

Summary of findings

Social Care Act 2008 Regulations 2010, corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulations (2014). We did not see the required improvements had been made.

Systems to assess the quality of the service provided in the home were not effective. The systems had not ensured that people were protected against some key risks, such as inappropriate or unsafe care and support, and had failed to identify where there was poor service delivery which affected the health and welfare of people. We did not see any action plans to address these issues.

People were not protected from the risk of harm. When risks had been identified in people's assessments, plans were not always in place to reduce the risk. Where risk assessments were in place they did not always have suitable measures in place to manage the risk and reduce the likelihood of further incidents and harm occurring.

Care records showed the principles of the Mental Capacity Act 2005 Code of Practice had not been used because there were no capacity assessments for assessing an individual's ability to make a particular decision. Staff were not able to tell us why the Mental Capacity Act 2005, (MCA) Deprivation of Liberty Safeguards (DoLS) or Best Interest decisions were important. The registered manager assured us staff would receive refresher training and will ask that the principles of the MCA and DOLS be explained in layman's terms so everyone will understand what this means in practice.

Care plans did not always contain specific information about the support required to meet people's individual needs. For example, where people exhibited behaviours which challenged others, there was nothing in place to guide staff what may trigger this behaviour and how they should support the person.

People using the service told us they were given their medication by staff at regular times. They said, "Staff leave my tablets, they know and trust me to take them", "Staff bring me my tablets and I insist they stay with me while I take them"; "At night staff keep me company until late when they give me my sleeping tablets." Medicines were stored safely and records were kept appropriately.

A robust recruitment procedure was not in place to ensure people were supported by staff with the appropriate experience and character. Staff told us they were not able to work with people until the appropriate pre-employment checks had been undertaken. However, we looked at staff files to ensure the appropriate checks had been carried out before staff worked with people and found they had not.

All staff said they would be confident to speak to the registered manager if they had any concerns. All staff we spoke with told us they were well supported by the registered manager of the home. Staff received regular supervision and appraisal from their manager. These processes gave staff an opportunity to discuss their performance and identify any further training they required.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering what action to take and will produce a report later.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

The approach to assessing and managing day-to-day risks to people who use services was sometimes focused on clinical risks and did not take a holistic view of people's needs.

Effective systems were not in place to monitor and reduce the risk of infection control.

Recruitment procedures were not followed to ensure people with the right experience and character were employed by the service.

People's medicines were managed well.

People were protected from abuse because staff were trained and knew what to do if they suspected any.

There were enough staff available to meet people's needs.

Is the service effective?

Requires improvement

The service was not effective.

People's rights were not fully protected because the service was not following legislation designed to protect them.

People were supported by staff who felt supported and well trained.

People were supported to have regular access to health care services.

People were provided with choices at mealtimes and were happy with the food provided.

Is the service caring?

Requires improvement

The service was not caring.

People did not always receive care that was respectful.

People told us staff knew them well and we saw staff knew people's likes and dislikes.

Is the service responsive?

Requires improvement

The service was not responsive.

People were unable to express their preference for a care worker of the same gender.

Care plans did not always contain specific information about the support required to meet people's individual needs.

People were able to make choices about their day to day lives.

Summary of findings

Is the service well-led?

Requires improvement

The service was not well led.

The registered manager did not have effective systems in place to audit the quality of the service and identify where there were shortfalls.

Staff told us the registered manager was approachable and they felt supported.

Accidents and incidents were analysed to identify trends and patterns.

People were supported to access appropriate emergency treatment when they needed it.

Granada House

Detailed findings

Background to this inspection

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

This inspection took place over two days on 02 and 07 July 2015 and was unannounced on the first day. The inspection team comprised one inspector and one 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.

Before our inspection we reviewed information we held about the home, including notifications about important events which staff had sent to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider therefore provided us with a range of documents, such as copies of internal audits, action plans and quality audits, which gave us key information about the service and any planned improvements.

Some people were unable to tell us their experiences of living at the home. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for five people. During the inspection we spoke with the registered manager, deputy manager, two care staff and the cook. We also spoke with five people using the service, one visitor and one G.P. We looked at records about the management of the service such as staff files, minutes of meetings, complaints and quality audits. After the visit, we spoke with two relatives by telephone.

Requires improvement

Is the service safe?

Our findings

People's records were not maintained accurately and completely. Staff did not have the information they needed to be able to provide the necessary care. For example, we saw national guidance for a healthcare condition in one person's care plan, but there was no further information or guidance such as a personalised risk assessment or care plan for staff how to manage this. This meant staff may not have been aware of the actual risks to the person or how to manage these. Another example was where people exhibited behaviours which challenged others, there was nothing in place to guide staff what may trigger this behaviour and how they should support the person and reduce any risks. However staff said they would respond to people whose behaviour became challenging by keeping them calm, talking to them and distracting them with the offer of a cup of tea, and escorting them away from the situation. Another person used an item of medical equipment for which there was no care plan. Staff we spoke with knew how to use the equipment. This meant although existing staff were aware of how to manage people's needs the records were not complete and did not provide clear guidance, so any new or agency staff may not be able to use the equipment safely.

One care plan recorded the person was not to be taken to hospital for treatment if they suffered stroke symptoms. However the relatives told us this was only accurate for one period of time but not accurate now. This meant this person was at risk of not receiving treatment because there was inaccurate information about them.

One person's risk assessment recorded the continence team had been contacted for advice, but there was no further update. This meant the person may not have received the support they needed because there was no information recorded about the advice received. Another risk assessment identified a person was at risk of self-harming, but there was no information to guide staff how to support this person. This meant new staff may not be able to provide the support this person needed. People were able to move freely about and leave the building as the front door was not locked. There was nothing in place to assess the risks of people accessing the road; we found one person living with a dementia who could have been at risk if they had gone outside.

There was no guidance for staff for one person who used a catheter; however staff we spoke with were able to tell us what they did. This meant whilst staff knew how to care for this person, the lack of information placed them at risk of inappropriate treatment if staff were relying on written information. Another care plan for a person with high levels of anxiety did not give staff any information how to manage this. A document called "This Is Me" did not mention the level of anxiety suffered by the person. "This Is Me" is a document which can be given to other healthcare professionals when people move between services, which gives background information about the person. We spoke with the registered manager about the lack of information in care plans; they agreed more information was needed.

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

Two people we spoke with in their rooms were sitting comfortably in arm chairs. However, their call bells were out of reach on the other side of their rooms. One person was sat in their armchair and the call bell was the other side of the room. They said, "Sometimes it's very busy, I don't ring my bell because it's over the other side of the room. They think I can walk, I don't use my frame any more." This meant people were put at risk because they did not have any means of calling for help when they needed it. We fed this information back to the registered manager, who agreed call bells should be within people's reach.

Risks to people were not always well managed. The carpet in two rooms were potential trip hazards. In one room the carpet was badly fitted and rucked up and had a hole in it; the person using this room used a walking frame. The carpet was frayed outside another room and scuffed carpets were also noted in other areas.

There was a vacuum cleaner stored in a corridor next to a bathroom which reduced the passing space, this was also a potential hazard should the hose become loose. There were hand wash gels and sprays on the handrails which meant people were unable to use the handrails and may trip. Some light bulbs were missing from overhead lights which reduced the light available and meant people could trip more easily; the deputy manager said, "We're waiting for some new shades."

Tea and coffee making facilities were available in the open hall area close to the front door on the first day of our inspection. There was an electric kettle plugged into a

Is the service safe?

multi-plug socket at ground level, exposing the lead. For people with a dementia, there was a risk they would attempt to use the facilities themselves and risk being scalded. There was no risk assessment in place for this; however on the second day of our inspection, we saw the kettle had been removed. Although the deputy manager dealt with the situation, this shows the deputy manager was not proactive in identifying risk.

Tea, coffee and sugar were stored in lidded jars, but a small bowl of sugar and jug of milk were uncovered. A member of staff commented that people had been known to dip their fingers into the sugar then lick them. This meant infections could be spread easily. Staff made all residents hot drinks in this area and relatives were free to help themselves. We discussed this with the registered manager. We observed one person escorted to a toilet close to the front door by a staff member who was wearing gloves but no apron. The same staff member was later seen preparing residents' tea. This was potentially an infection control risk because they had not protected their clothes while carrying out personal care duties.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations (2014).

Some risk assessments were undertaken to assess any risks to people and to the staff supporting them. Risk assessments covered risks about health and support needs of the person, such as mobility and environmental issues. For example, one person's risk assessment for falls identified they were unable to weight bear and identified the aids used by the person. Staff knew the people who required assistance and which mobility aids they used.

Although there was a recruitment procedure in place Granada House did not always follow this to ensure people were supported by staff with the appropriate experience and character. Staff told us they were not able to work with people until the appropriate pre-employment checks had been undertaken. The recruitment policy included completing Disclosure and Barring Service (DBS) checks and two references. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people. However, we looked at staff files to ensure the appropriate checks had been carried out before staff worked with people and found they had not. We saw four staff files; two of these had unexplained gaps in employment and two files only contained one reference. This meant the provider was not following their recruitment policy. We discussed this with the registered manager and showed them the files; they assured us they would follow these up.

People told us they felt safe using the service. One person told us, "I feel quite safe, people do wander into my room but it does not bother me." Other people said, "I am safe because there is always someone walking about, I am able to keep my door open and see people. I keep my room tidy and all my possessions are kept safe. Everyone is good to me and I have nothing to complain about. I choose to stay in my room all day and have my meals here", "I am perfectly safe here, I am my own boss and please myself what I do but I have the benefit of having staff here if I need them", "I am safe, there is always somebody here if I need them" and "I am comfortable and safe, all my private things are locked away, I have someone to tell my worries to".

Staff said, "We know residents are safe because we've had training in all aspects of care, and we've had safeguarding training." When asked about their safeguarding knowledge, some staff were hesitant when describing types of abuse, although staff assured us they would inform the manager if they had any suspicions. A safeguarding policy was available and staff were required to read it as part of their induction. Training records showed 63% of staff had received training in safeguarding vulnerable adults.

People using the service told us they were given their medication by staff at regular times. They said, "Staff leave my tablets, they know and trust me to take them", "Staff bring me my tablets and I insist they stay with me while I take them"; "At night staff keep me company until late when they give me my sleeping tablets." "Staff give me my tablets, I do not know what they are, but I know what they are for, staff make sure I take them." One person was able to self-medicate. A lockable drawer was provided in their room to ensure their medicines were safely stored. Medicines were stored safely and records were kept for medicines received and disposed of. Controlled drugs were stored in a separate locked cupboard which complied with the relevant legislation.

The registered manager said, "Staff normally have an annual medicines refresher and review during their appraisal." We viewed training records; however these had not been updated to reflect recent training done by staff. The training records showed six of the ten staff who had completed medication training had done so in 2010;

Requires improvement

Is the service safe?

another seven staff needed to complete this training. The registered manager told us they would review the training records. We did not see any adverse impact to people at the time of the inspection.

Staff told us training was provided by the chemist who supplied medicines. Staff said they completed a workbook and had four or five supervisions with their manager to ensure they were competent to administer medicines. There were no risk assessments or mental capacity assessments for medicines where people lacked capacity to consent to taking medicines. One person was taking a medicine which meant they needed to avoid a certain fruit juice. Staff had not been made aware of this and it was not included in this person's care plan. At the time of the inspection the registered manager arranged for these details to be available in the person's care plan and made the staff aware.

Most people felt there were usually enough staff on duty to care for them, although they thought staffing was stretched at holiday times. On the day of our visit, we observed there to be enough staff to meet people's needs. Staff were able to respond to call bells in good time. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased if required.

Requires improvement

Is the service effective?

Our findings

Some people who lived in Granada House were not able to make important decisions about their care due to living with a dementia. The registered manager was knowledgeable about the Mental Capacity Act 2005; however none of the other staff members we spoke with were able to tell us about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards or Best Interest decisions. These are laws which protect people who are unable to make decisions for themselves. Training records showed all staff needed MCA and DOLS training because although some staff had been given this training, according to the registered manager's records it was out of date. Training records showed MCA and DOLS training should be repeated annually; however most staff last received this training in January 2014. Where families had a lasting power of attorney to support people who lacked capacity in relation to important decisions this was recorded in their care plan. Records showed where there may have been doubts about people's ability to make a particular decision, their capacity to do so had not been assessed. For example, one person's glasses had been taken away from them but there was no capacity assessment or best interest decision for this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 Regulations 2014)

Care plans lacked information and did not give staff guidance on how to meet people's needs. Most information included was health and risk-based, and gave staff very little information about people's preferences or personal history. Staff said they had got to know people by chatting with them, especially when supporting them with their personal care. In one person's care plan a GP had requested a further urine sample on 13 May 2015 following a urine test where blood had been detected, however, at the time of our inspection in July, this had not been collected. This meant the person may not have received necessary treatment.

Most people told us they felt staff were well trained and knew how to care for them in the way they wished. People said, "I am sure staff have not had training, some staff are good at certain things but not so good at others", "I think staff are well trained and have the skills needed to look after me" and "Staff are very capable, they will do anything I want, I only have to ask, they know I get anxious about things and they always ask me before they do anything." Staff training records confirmed staff received a range of training, including food hygiene and manual handling. Most staff were up to date with training.

One visitor told us, "From what I've seen staff are competent and have the skills to look after [name]. They are free to make choices and decide what they wish to do."

One person said, "I think staff are well trained and have the skills needed to look after me." In addition to the training Granada House considered essential, two staff were completing further training in health and social care to increase their skills and knowledge in how to support people with their care needs. Staff told us they had training in all aspects of care and that some courses were done in-house by district nurses; they felt this made training more relevant and they learned more.

Staff received regular supervision and appraisal from their manager. Staff told us these processes gave them an opportunity to discuss their performance and identify any further training they required.

During our inspection people were provided with enough to eat and drink. A variety of fresh fruit was available in the dining room; people were able to help themselves at any time. Drinks of squash and water were freely available in all communal areas and people's rooms.

The dining room was situated in the middle of the ground floor and there was a constant flow of staff through it. The dining room led to a corridor which gave access to the kitchen, the area where medicines were stored, a bathroom and people's bedrooms. As the dining room was used by staff for writing notes and making telephone calls when not in use for meals, it was difficult to ensure complete confidentiality for people. Some people's files were also kept in the dining room. We overheard the deputy manager speaking on the telephone while we were in the dining room, compromising the confidentiality of the person they were discussing. We raised this with the deputy manager and they recognised the importance of not discussing private information in a public area.

We observed lunchtime in the dining room. People were happy with the food provided and commented, "I make sure I have a good breakfast, they know I like prunes and make sure I get them, other meals are alright, when there is something I do not like they will cook me something different, usually fish in a bag", "Meals are okay, the cook

Requires improvement

Is the service effective?

knows I cannot cut my food and does this for me in the kitchen before I get it, they know what I like and will have a go at anything, staff think they are being kind but they give me too much to eat; there is always plenty to drink", "Food is not what I would like but it is wholesome and served hot", "Food is very good, it is home cooking, we get a choice and if we do not like it the cook will make something else. We get plenty to eat and drink", "Food is very good and plenty of it, it suits me, it is more or less what I am used to."

People were able to choose where they ate their meals. People were encouraged to eat in the dining room, however, some people preferred to eat in their rooms. A member of staff placed a cushion behind one person to make them more comfortable. One person wore a clothes protector; we did not hear staff asking this person if they would like this. Meals were hot and were served ready plated from the kitchen. One person was supported to be more independent because they were given adaptive cutlery and another person had a plate guard to enable them to eat without staff support.

People were not involved in menu planning although the cook was aware of people's food preferences. The cook had spoken to people earlier in the day and had asked them if they would like the meal of the day, which was beef stew with dumplings served with mashed potato carrots and peas, followed by rhubarb crumble and custard. People were able to request an alternative meal at this time. The meal looked appetising and the portion size was appropriate; people appeared to enjoy their meal. One person required some support from staff who placed their meal in front of them, placed a spoon in their hand and guided it into the food, the person then carried on eating independently. However, we did not hear staff telling the person what the meal consisted of. The cook told us the deputy manager planned the meals weekly. People told us, "There's no choice" and "Food is not like I would have at home but it's wholesome and hot" and "they make sure we have a good breakfast. The food's not great, if you don't like what's on offer the chef goes round and tells everyone what the meal for the day is. If you don't like it you can have something else, it's usually fish in a bag."

People told us they received the support they required to see their doctor. One person told us when they were very unwell staff called a doctor, who then admitted them to hospital. Other people said, "When I have told staff I ought to have the doctor because I am feeling bad they have told me to wait a while and it usually passes", "They are very keen on getting a doctor to see you, but I prefer not to." Care records showed people had received support from a range of specialist services such as chiropodists and occupational therapy teams. People who had hospital appointments were usually accompanied by a member of staff but visits to opticians and dentists were organised by family members. Staff monitored people's changing health needs and recorded their observations in daily care notes.

Requires improvement

Is the service caring?

Our findings

Whilst most people received a caring service, some aspects needed improvement. We observed one member of staff speaking to one person in a communal area in front of other people and saying "[name], will you come with me I want to empty your catheter bag." This was repeated as the person did not understand the first time it was said. This meant the person's privacy and dignity was not respected Other people said, "One keeps pestering me to have a bath, I accept it with a grimace and let them carry on", "Staff are not too bad, they are kind, no one ever sits and chats to me, I suppose they know me" and "Staff are always pleasant but do not know or understand what I need, they are kind and have a joke, they try to jolly me along, it is not what I need. When I am having a bad time, they just say it is my medical problem."

Some people told us staff were sensitive and discreet when supporting them with their personal care. One person commented how well a named member of staff treated them and how they were not embarrassed with even the most intimate care. They told us staff ensured doors were closed and curtains drawn. Other people said, "Staff are pleasant, kind and very caring, they treat me with dignity and respect, staff will chat if I want, and do their utmost to help me, but allow me my independence." Staff confirmed they aimed to preserve people's independence by encouraging them to do as much for themselves as they could. A visitor confirmed, "Independence is encouraged."

Staff interacted with people in a friendly, caring and compassionate manner. However, some people told us some care was provided when it suited staff because staff responded to them when they had time to, not when people requested it. One person said, "Staff say they will do something when I ask but they do not always do it."

Staff knew people's likes and preferred choices well. People responded well and appeared to be comfortable and relaxed when approached by staff. A visitor told us they thought the person they visited was comfortable with staff and they had seen very positive interactions between them. Other comments included, "Staff are kind, some are like family", "Everybody has been good to me, they are very reassuring", "Staff are very good and thoughtful", "Staff are lovely, they say if you are worried come and find me, they listen" and "Staff speak to me kindly" "Staff are very good they know I like to be independent, they respect this."

Most people said they were treated with respect and dignity. People told us, "They knock before coming into my room", "Staff always knock before coming into my room and ask me what I would like and respect my decisions", "Staff are friendly and treat me well, they are in and out of my room and are helpful, you only have to say and they will do it. They always ask permission before they do anything and respect my choice and decisions" and "Staff knock on the door before coming in, they work hard and are very thoughtful, I do not lack any attention, they treat me alright." However, during our inspection we observed staff entered people's rooms without knocking and seeking consent. Staff said they usually knocked before entering people's rooms but if the door was open they walk in and call out.

Relatives and visitors were welcome; there were no restrictions and they able to visit at any time.

Requires improvement

Is the service responsive?

Our findings

When we inspected the service in September 2014 we found they were in breach of Regulation 9 of the Health and Social Care Act 2008 Regulations 2010, which corresponds to Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 Regulations (2014). During that inspection, we found care plans lacked information to provide guidance for staff. For example, care plans asked staff to provide personal care, but did not outline how this was to be done. This meant there was a risk people could be provided with inappropriate care. We asked the provider to send us an action plan and tell us how they would make improvements. No completed action plan was received. We found on this inspection improvements had been made, but further work was needed.

Some aspects of the service were not responsive to people's needs. Information obtained from consultations with family were not accurately recorded, which meant staff did not have the correct information for providing care. For example, we looked at a care file for one person who lacked capacity and whose family was authorised to make decisions on their behalf. The care plan had not accurately recorded the person's need for glasses which resulted in them not having the glasses they needed.

One person told us, "At one time the manager would bring new staff around and introduce them; this does not happen anymore. When I commented on this I was told that I was living in the past, but it made all the difference."

We observed one person with their feet up on a foot stool which did not provide the correct support because it was too low; the person's weight was therefore taken on their heels. This could lead to pressure on the heels and make the person susceptible to pressure ulcers. When staff noticed blood in one person's urine, nothing had been done about this. We asked the registered manager about these observations and they told us, "There should be systems in place to follow up from this, but it's obviously not been done" and "This should be in the communications book." The registered manager said they would attend to these matters.

We observed three people sitting in the lounge. Two people spent most of the day sitting in the lounge, only moving to the dining room for lunch. Apart from a short time during the afternoon when a member of staff did an activity which lasted about ten minutes and when being offered a drink, people were left alone. There were no call buttons within people's reach which meant people would not be able to call for assistance when they needed it.

People were not given the opportunity to express their preference for a care worker of the same gender. Some people had reservations about this. They said, "[Name] is alright for some jobs but not for jobs of a personal nature" and "Some staff need to be reminded I need help, for example a care worker of a different gender said to me 'be patient woman, I will be there in a minute' to which I replied 'yes I am a woman and I have a name'. I have never been asked if I mind having a care worker of a different sex, I think it is alright for some jobs, but not for things that are personal." Another person said they would prefer a care worker of the same sex but had been too embarrassed to say so. However, they told us they were used to it now and added this care worker would sit and chat with them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulations 2010.

Call bells were ringing constantly throughout our visit; they sounded loudly in a continuous tone and could be heard in every room. Several people commented how, even though they had got used to it, it could still make them jump. One person said it could be a nuisance at night or if they were speaking on the telephone. Another said, "The call button drives me nuts." We observed call bells, when used, were responded to in a timely way; people confirmed this was usually the case and a visitor said, "Staff respond quickly to call bells and are very vigilant."

People said they were able to please themselves what time they got up and went to bed and were able to choose where they spend their day, and where to eat their meals. One person said, "I get up at 6am every morning as I have done all my life, I can please myself what I do all day." One staff member said they had done personal shopping and bought underwear for one person who has no one else to do this for them, as they know how important it was for them to feel good.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs. We observed a member of staff accompanying one person out into a designated smoking area in the garden so they could have a cigarette.

Requires improvement

Is the service responsive?

Some people told us they were able to go out with their families. People were able to be accompanied by staff to local shops, which were within easy walking distance. There were no planned activities displayed. An activity book was seen which had the date and names of people attending the activity. During the afternoon of our visit, we heard an activity which lasted around ten minutes. People who chose to stay in their rooms said they read or watched television; one person told us night staff often sat in their room and watched a programme with them.

Some people said they were aware of how to make a complaint. People told us, "If I had a complaint I would not say anything, I would keep it to myself", "Staff have got enough on their plate without me adding to them", "I would tell the manager", "I would tell a member of my family who would not stand for any nonsense" and "I have never had cause to complain about anything serious, I would tell my family if I had, I can stand up for myself." Staff knew how to respond to complaints and understood the complaints procedure. The complaints procedure was located in the Granada House handbook which was situated in the front lobby. This meant it was not easily available. We raised this with the registered manager who said they will address this. They later informed us information about complaints was displayed on the wall. We saw the complaints file, there had not been any made since 2013. The complaints policy gave guidance for staff how to respond and deal with complaints.

Requires improvement

Is the service well-led?

Our findings

When we inspected the service in September 2014, we found they were in breach of Regulation 10 of the Health and Social Care Act 2008 Regulations 2010, which corresponds to Regulation 17 (2) (a) of the Health and Social Care Act 2008 Regulations (2014). The provider did not have audits or quality assurance systems in place to monitor the quality of the service. This meant the provider did not ensure that people were safe against the risks of inappropriate or unsafe care and treatment. We asked the provider to send us an action plan and tell us how they would make improvements. No completed action plan was received.

At this visit, we found there had been no improvement. Audits had continued to fail to identify where there was poor service delivery which affected the health and welfare of people. There were no audits of care plans which meant they had not identified the issues we raised previously in the report. For example, some care plans did not contain risk assessments for some healthcare needs and safety situations such as accessing the road. There was no guidance for staff for managing people who may exhibit behaviours which challenge others. There was no system in place for the manager or deputy manager to review the care records to ensure they were accurate, complete and up to date.

Similarly, staff files had not been audited to ensure they contained all the information required by the home's recruitment policy. We found unexplained gaps in employment in two staff files and two files which did not contain the necessary two references. There was no reliable system in place to check everything necessary had been completed before staff started work.

We saw audits had been completed of the communal areas, the kitchen and the bedrooms. The bedroom audit identified areas that needed attention, such as where the carpets were frayed. However there was no action plans to address these issues, and the audits were not dated so it was not possible to see how long ago the issues were identified.

The provider visited monthly and completed various audits; however these did not include looking at care records. The provider visited in February and April 2015 and looked at finances, staffing and the environment. This meant the provider had not identified the shortfalls we found in care records.

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

Everyone we spoke with said they respected the registered manager and said how approachable they were. People said they had confidence in them and could talk to them easily. A visitor told us they thought the home was well run and well managed. They said, "The manager is pleasant and overall it is a happy place." Staff thought the home was well run and people were happy. All staff told us the registered manager was very supportive and they felt they could go to them at any time with problems. Staff said they got on well and helped each other, and morale was good. All staff said that they would be confident to speak to the registered manager if they had any concerns about another staff member. They told us that they had no concerns about the practice or behaviour of any other staff members.

None of the people spoken with could recall if they had ever completed a questionnaire or had been involved in any residents' meetings. However, the manager provided us with the results of the 2015 statistical review where the results of staff and resident questionnaires had been analysed. People were asked questions about the staff caring for them, the environment, meals and activities. The questionnaires had not been completed anonymously as people's names were written on them. The questionnaires had been completed by staff, who asked people questions and wrote down scores between one (excellent) and five (poor). This meant people may not have answered the questions honestly because some people may have found it very difficult to say anything negative directly to staff. Overall satisfaction rates in all sections were either one or two, indicating high levels of satisfaction. Results of the staff survey similarly scored one overall, indicating staff felt the home was an excellent place to work.

The registered manager was able to identify trends and patterns from the information gathered from accident and incident records, which showed most accidents were falls. When people were identified as high risk of falls, the falls team were contacted. District nurses, ambulances and rapid response teams were contacted as necessary.

Requires improvement

Is the service well-led?

A range of policies were provided for staff, who were expected to read and sign to say they had done so. Granada House implemented a policy of the month, which meant staff were regularly reminded of the major policies. We saw two policies covering 'Psychotic behaviour' and 'Dealing with aggressive behaviour' which did not give staff appropriate guidance because it was not specific to the people living at the home. We discussed this with the registered manager who assured us the policies would be reviewed and appropriate changes made.

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

Staff understood their role in relation to emergency situations. We saw there were plans in place for example for example such as for an outbreak of fire.

The registered manager used the Residential Home Support Team. This team is based in North Somerset and provides advice, guidance and support. This meant the manager used external support to aid them in the management of the service to ensure they provided appropriate care.

People we spoke with felt the culture of the home was friendly. They described the home as being very comfortable and friendly and said, "On the whole this is a nice place and I am better off here than many other places, I have no worries and staff do everything", "This home is good to moderate, it is friendly" and "I am happy here, I would not be here otherwise, life is too short to put up with things, we are all mates".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks of unsafe care and treatment because risks to the health and safety of service users of receiving care or treatment were not always assessed. Regulation 12 (2) (a). Granada House did not do all that was reasonably practicable to mitigate any such risks. Regulation 12 (2) (b) People were not protected against the risk of infections because Granada House did not assess the risk of, and prevent and control the spread of infections. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not act in accordance with the 2005 Act. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9 (1) (b) (c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to monitor and improve the quality and safety of the service. Regulation 17 (2) (a) The service did not maintain accurate, complete and contemporaneous records for each service user. Regulation 17 (2) (c)