Care Quality Commission

Acegold Limited

Uphill Grange Care Home

Inspection report

Uphill Road South
Weston Super Mare, BS23 4TX
Tel: 01934 635422
Website: www.fshc.co.uk

Date of inspection visit: 11 May, 13 May and 18 May 2015
Date of publication: 18/08/2015

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

This inspection was unannounced and took place on 11 May, 13 May and 18 May 2015.

Uphill Grange is registered to provide personal and nursing care for up to 44 people, at the time of our inspection there were 23 people living in the home. The home specialises in the care of older people.

There is a registered manager in post. 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.

At the last inspection in September 2014 we asked the provider to take action to make improvements. We took enforcement action and served four warning notices around, managing risk, complying with the Mental Capacity Act 2005 (MCA), providing safe care and identifying risk through quality assurance processes. The provider sent us an action plan which said they would be compliant with all areas by the end of January 2015 and this action has been completed.

Throughout the inspection we received varied opinions from people staff and relatives about the way they felt the home was managed and the care provided. Some staff said the manager was not open and approachable and

Summary of findings

did not act on issues identified around some staff in the home. Whilst others said they felt the home was well run and they could approach the manager at any time. People told us they knew the registered manager and could talk to them openly.

Risks had been identified and recorded in people's care plans however; the records to monitor the risks were not always completed. For example one person's care plan said they needed to be checked every 15 minutes. The records did not show this had been carried out. The fluid records for another person who was at risk of dehydration were inconsistently completed. This meant the person was placed at a higher risk of dehydration as staff did not know what fluids they had had.

People and fire personnel were also placed at risk as the records provided for emergency services about people in the home were out of date and had not been reviewed since January 2015. The registered manager reviewed and updated the record on the first day of our inspection.

Some people and staff said they felt there were not enough staff to meet people's needs. However some people said they thought there was plenty of staff on duty. The home is over two floors providing care for people with both nursing and residential needs. Twenty of the twenty three people in the home required two staff to provide personal care. One staff member said, "We used to have a floating care worker to help between floors, but we don't now". Some people commented on the time it took for call bells to be answered and one relative said, "They are so short of staff". When asked about completing records, one staff member said, "We just don't have enough time". We observed through the day that staff were task orientated and did not have time to socialise with people.

People and staff said the home used a lot of agency care staff, which was sometimes difficult as they did not know people or their needs. The registered manager confirmed they had used agency staff to provide the extra cover they needed. They said they had carried out a recruitment programme and had found some new staff which they hoped would become permanent staff following their induction process.

People were not always treated with dignity as we observed at lunchtime some people wore protective covers however they were not asked if they wanted to wear them. During lunch a person who required one to one help with eating was assisted by four different staff members who were busy going between other people. We saw another person who was able to eat their meal independently, albeit slowly. We saw staff assisted this person to eat their meal to speed the mealtime up. This meant this person was disempowered as staff gave assistance when it was not required.

We found people were not routinely involved in the reviews of their care plan. Of the eight care plans we looked at only one person had been involved and consulted. However people told us they could make decisions on a day to day basis and chose how they spent their day. We have recommended the service seek advice and guidance from a reputable source, about supporting people to express their views and involve them in decisions about their care, treatment and support.

Although there was an activities coordinator and programme of activities on the noticeboard we did not observe any meaningful activities throughout our inspection. On the first day people were invited to attend an exercise group in the dining room just before lunch. On all three days people sat in the lounge, the garden or in their own rooms. Some people said they knew there were activities whilst others said they did not do any activities. We have recommended the service seek advice and guidance to ensure all people have the opportunity to take part in activities based on their interests and abilities.

At out last inspection the registered manager had failed to identify shortfalls in the home in their quality auditing processes. We found the manager's quality auditing had improved however they had failed to identify issues such as staff recording best interest meetings in the wrong part of the care plans. Staff failing to complete monitoring forms and staff failing to act on issues when they had been identified and discussed.

At our last inspection In September 2014, we found the registered manager failed to protect people from harm and abuse, had not monitored accidents and incidents and had not completed best interest decisions in line with the Mental Capacity Act 2005.(MCA) The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving

Summary of findings

people who know the person well and other professionals. Where relevant a Deprivation of Liberty Safeguards (DoLs) application is made to the local authority. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

At this inspection we found the manager had met all these shortfalls. We found the registered manager had risk assessments in place regarding the safe use of equipment. They had also taken action to report unwitnessed injuries to the relevant authorities. We found they had carried out best interest meetings with people's relatives and Deprivation of Liberty Safeguards applications had been made. However it was difficult to at first to evidence this had been carried out as staff had recorded the meetings in the wrong section of the person's care plans.

Staff had received training in identifying and reporting abuse. Staff were able to explain to us the signs of abuse and how they would report any concerns they had. They stated they were confident any concerns brought to the manager would be dealt with appropriately. There was a robust recruitment procedure in place which minimised the risks of abuse to people. People told us they felt safe in the home and they all knew who to talk to if they wanted to raise a concern or complaint.

People saw healthcare professionals such as the GP, district nurse, chiropodist and dentist when they needed to. Staff supported people to attend appointments with specialist healthcare professionals in hospitals and clinics. Staff made sure when there were changes to people's physical well- being, such as changes in weight or mobility, effective measures were put in place to address any issues.

A regular survey had been in place asking people and their relatives about the service provided by the home. However the response from people and relatives was very low. The organisation had introduced a system where people and visitors to the home could comment at any time through an iPad in the entrance hall. This iPad could also be taken to people who could be assisted to comment on their care and experiences. Suggestions for change were listened to and actions taken to improve the service provided. All incidents and accidents were monitored, trends identified and learning shared with staff to put into practice.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Records to show how risks to people were being monitored were not always completed, which meant risks may not always have been appropriately managed.

There was insufficient staff to ensure people's needs were safely met in a timely manner.

The service recorded and reported risks of harm from people or equipment appropriately.

Staff had a good understanding of how to recognise abuse and report any concerns.

People's medicines were managed well and staff received training to support them to do this.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not receive effective support to eat at meal times.

Staff received ongoing training and supervision to enable them to provide effective care and support.

People's health needs were met and they could see health and social care professionals when needed.

People's rights were protected because staff understood the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated in a dignified way.

Staff were kind, and respected people's diverse needs recognising their cultural and social differences.

People's privacy was respected and they were able to make choices about how their care was provided.

Visitors were made welcome at the home at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Not all people had the opportunity to take part in activities based on their abilities and interests.

People received care that was responsive to their needs because staff had a knowledge of the people who lived in the home.

The manager worked with professionals to ensure they responded appropriately to people's changing needs.

Arrangements were in place to deal with people's concerns and complaints, However not all staff followed them.

People and their relatives knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team was not always open and approachable.

The quality of the service provided was monitored however some shortfalls in records were not identified.

The management team listened to suggestions for the continued development of the service provided.

Uphill Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 three days on 11 May, 13 May and 18 May 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors on the first day, one on the second day and two on the third day.

Before we carried out this inspection we looked at the provider information return (PIR). This document enables the provider to give key information about the service, what the service does well and improvements they plan to make. However this document had been completed before their last inspection in September 2014. We therefore looked at the action plans the provider had sent in to show us how they planned to meet the requirements of the warning notices we served following the last inspection.

At the time of the inspection there were 23 people living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people, five relatives and eight staff members. We also spoke with the registered manager, the deputy manager and the regional manager.

We also looked at records which related to people's individual care and the running of the home. Records included six current care and support plans, four staff recruitment files, quality assurance records and medication records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said, "I feel safe." Another person said "I feel safe living here and the staff are lovely". However this was not what we found during our inspection. Records relating to risks were not completed consistently which placed people at risk of receiving unsafe care and treatment.

At the last inspection in September 2014 we found that risk had not always been identified and were not always well managed. We received an action plan from the provider that stated they would be compliant by November 2014. We found the specific issues regarding those risks had been addressed. However during this inspection we found other areas of risk that were not always being managed well.

Risks had been identified in care plans, these included risks of falls, manual handling risks and pressure care. Records to monitor risks were not always up to date. For example, a person who was at risk of falls had charts for staff to record checks on this person every 15 minutes. However during a 40 minute observation the person was only checked once. This meant the person could have fallen for a period of time before being checked. This may have resulted in them having come to harm. Staff were able to tell us checks that were needed and the specific needs of people however they also said they did not always have the time to do these checks.

Where people had been identified at risk of weight loss and malnutrition, appropriate professionals had been involved and care plans had been put in place to address these issues. They clearly showed when staff should record food and monitor fluid intake However the records for one person who had been identified at risk of choking lacked information. For example, the food and fluid chart noted the person required thickened fluids but did not give any information about the consistency of food or fluids. This meant this person may have received food or fluid at the incorrect consistency. This person was also at risk of dehydration. Their fluid intake was inconsistently recorded, for example one record stated "drank 10mls", and another record stated "50%". Other records did not have any amounts shown. The fluid balance records showed this person had a coffee on 7 May but no other drinks were recorded. On 9 May the records showed "6am water drank" but no amounts were shown and no other entries were made for that day. On 10 May at 6.50 records stated, "Had a sip of water", and then nothing had been recorded until 20.45 when records stated "Drank 200ml water". On the first day of our visit the records showed, "6.45 am had a few sips of water". When we asked a member of staff about the fluid balance records the staff member said, "If it isn't written down it didn't happen or they didn't have anything. If a relative gives someone 200 ml juice we need them to tell us so we can document it." When we bought this to the attention of staff, one staff member who was not a member of the nursing or care team gave the person water that had not been thickened. This placed them at risk of choking, or developing pneumonia through breathing in the liquid.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection people were not protected against the use of equipment that may cause them harm. We also found they had failed to take action when un-witnessed injuries were identified; and when a person was at risk of abuse from a family member.

At this inspection the registered person had risk assessments in place regarding the safe use of equipment. For example one person had been assessed as at risk if bedrails were used. The person had been given a high/low bed. This is a bed that can be lowered so people do not have far to fall if they roll out of bed. They also had a crash mat in place so if they did fall the risk of injury was minimised. We discussed, with the regional manager, the need to review the thickness of the crash mat if the person became more mobile as it could become a trip hazard with. They agreed to re-examine the person's mobility in relation to the thickness of the mat.

The registered manager had taken action to address the reporting of un-witnessed injuries. They notified North Somerset safeguarding team and sent a notification the Care Quality Commission. The registered manager explained how they had identified one blood thinning medicine increased people's risk of large haematomas; these are large bruises that swell. Staff had been given guidance on applying compress dressings to reduce the swelling. In one daily record staff had followed the guidance when a person had knocked their shin. This meant the risk of developing a haematoma had been reduced.

At the last inspection the registered person had incorrect information in the behaviour care plan for one person.

Requires Improvement

Is the service safe?

During this inspection the registered manager confirmed they did not have anybody living in the home whose behaviour posed a risk to themselves or other people who lived at Uphill Grange.

People were able to maintain freedom of choice whilst their risk to harm was minimised. For example people were able to sit outside in the sun if they wished. One person said, "Staff said they were worried about me being out in the sun but I chose to stay out. I have a portable bell which rings inside, so I can call staff." We observed people also had pendant alarms so they could summon assistance whilst moving around the home.

Risks to people in emergency situations were reduced because a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared for each person. These detailed which room the person lived in and the support the person required in the event of a fire. However these PEEP's had not been reviewed and updated. The information for firemen and staff in an emergency was kept in a "grab bag" in the hall. The documentation contained a room register which included the occupants name and manual handling needs of each person. The document stated, "This should be checked monthly;" however the last date for review was "December 2014." We asked the registered manager if the information would be current if an emergency situation occurred. They said, "No not if it hasn't been checked, and it should have been." The registered manager took the folder to the homes administrator who updated the information before the end of the day of our inspection.

People were not supported by sufficient staff to meet their needs promptly and in a person centred way. Comments on whether there were enough staff in the home to meet people's needs varied. Some people said there were generally enough staff available to meet their needs. Comments included, "There are quite a number of them. Some agency and some new staff" and "Yes there seems to be enough of them". Whilst others said, "Sometimes they're a bit short, but on the whole it's alright" and "We have a lot of agency staff, especially at weekends." One relative said, "It's awful; they're short staffed."

Comments received from staff on staffing levels in the home also varied, some staff felt they had enough staff with the support of agency. One staff member said, "We've needed an extra member of staff to manage one to one's but otherwise its ok" and "We're not rushing or struggling." However other staff told us there were not enough of them available to meet people's needs. Comments from these staff included: "Staffing levels are too low," "We need more staff as we just don't stop, especially as more residents need two to one care. People are safe but we do need more staff." "It's very busy and sometimes I feel I would like to do more for the residents". One staff member said, "We used to have a floating carer who could help out where they were needed but not anymore, that's all we need really."

Uphill Grange has two floors with a mixture of nursing and residential people on each floor. There were ten people on the ground floor and twelve people on the first floor. Each floor had two care staff and there was one qualified nurse to cover both floors. Only three people out of twenty three required one care worker to support them with personal care. We observed people were supported with personal care by two care workers while the trained nurse was engaged in administering medication. The manager did not have a clear system in place to identify the number of staff needed to look after and meet people's needs at Uphill Grange. At lunchtime we saw staff were unable to dedicate their time to an individual to assist them with eating and were constantly leaving them to assist others. During the inspection we noted the call bell could ring for quite a while before it was answered. One relative said, "They don't always come straight away, but I understand they have others; when they do come, it's probably a few minutes."

We asked staff about the use of agency staff, they said, "We've had some agency who have never been here before, they are just dropped in the deep end," and "We sometimes have more agency than regular staff; this is happening more and more recently." One person said, "We're not too keen on agency staff, they don't know us and you have to tell them everything." One relative said, "Agency staff don't know the residents."

The registered manager confirmed they used a high number of agency staff to ensure people's needs were met. They had carried out a recruitment programme and had employed new staff both trained nurses and care workers. The registered manager also confirmed they used the organisations dependency tool to determine the numbers of staff on duty per shift. However the registered manager did not take into account the numbers of people

Requires Improvement

Is the service safe?

requiring two care workers to support them when developing the staffing rota. This meant staff were focused on managing tasks to ensure all care needs were met and did not have the time to socialise with people.

This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were protected from harm because staff understood how to recognise signs of potential abuse and how to report their concerns. Staff members gave examples of the possible signs of abuse and correctly explained the procedure to follow if they had concerns. Staff told us and training records confirmed they completed safeguarding e-learning and said, "It's quite good" and "It's easy to understand, you can record it if you want to." All staff told us they would report any suspected abuse to the manager; however most staff didn't know what to do if the manager was not available. One member of staff we spoke with was aware of national guidance regarding the protection of vulnerable people from abuse.

All staff understood their responsibilities to whistle blow. Staff said they would have No hesitation whatsoever" about whistle blowing if they had concerns. All staff were aware of the organisations policies and procedures for safeguarding people and whistleblowing.

Risks of possible abuse to people were minimised because relevant checks had been completed before staff started to work at the home. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were of good character. The DBS checks people's criminal history and their suitability to work with vulnerable people.

Medicines were stored safely for each person in a locked room and kept in a lockable trolley. The current Medicine Administration Record (MAR) chart was kept with the person's medicine in the trolley and filled in each time medicine was administrated.

The service had a controlled drugs (CD) cupboard which was appropriately secured to the wall. There was only one key and this was held by the nurse in charge. The CD register was fully completed and legible. Daily stock checks were undertaken of the medication register and this was countersigned by an appropriately trained second member of staff. One person said, "I have my tablets given to me every morning." Another person was able to tell us what medicines they had and what most of them were for. The service had provisions in place for people to maintain control over and administer their own medicines if they wanted to.

Environmental risks to people, visitors and staff were reduced because there were regular maintenance checks on equipment used in the home. These included checks of the fire alarm system, fire fighting equipment, fire doors, and hot and cold water temperatures. The hoisting equipment, specialist baths, passenger lift and call bell system had also been serviced and were maintained in good working order. The registered manager checked these had been completed as part of their regular audit of the environment.

Requires Improvement

Is the service effective?

Our findings

People said they felt staff knew how to support them and meet their needs. However we observed lunchtime experience in the dining room. Some people waited twenty minutes before having food served to them. Where people required assistance to eat their meals, staff were constantly leaving them to attend to others. One person who required help to eat had four different care workers assist them. Staff regularly disempowered another person when they assisted them because they were able to feed themselves; this did not promote independence and choice.

We observed drinks available throughout the home, and staff offered people drinks and snacks regularly through the day. One person said, "There's plenty to drink, we can have a choice of tea or coffee and juices or water." Water and juice was available in the lounge, however, the people sitting there were unable to get up and help themselves.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to comment said the food in the home was really good. One person said, "The food is marvellous, but sometimes there's too much." Another person said, "It's good food, cooked well and plenty of it." However one person said, "I'm not all that keen. I had pasta and didn't enjoy it." Everyone who was able to comment said they were able to choose their meals from a menu. People said, "We have a menu and they ask what I want" and "We don't help plan the menus; they come round with them and ask what we want for the next day." Everyone confirmed they chose their meals the day before, but that choices were available on the day if they changed their minds. One person said, "They always say if you don't like the choices you can have an alternative, things like omelettes and jacket potatoes are available." People were able to eat their meals in their rooms if they preferred. One person said, "Staff ask me 'Why don't you come down for meals' but I prefer my meals in my room so they bring them to me."

Although the environment was well maintained and appropriate for most of the people in the home, it did not meet the needs of people living with dementia. For example, there was no signage to direct people and sloping floors did not have a handrail on the wall at the same angle; this could create a trip hazard for some people. Not all areas in the corridor had handrails to aid people with mobility issues. We discussed this with the registered manager and the regional manager. They confirmed and we saw evidence that a survey had been arranged for the following week with the organisation's advisor on creating an environment suitable for people living with dementia.

The staff team consisted of a mix of long standing and new staff. Staff were able to tell us how they would care for each person. Staff said they usually worked as a team however they said there were occasions when the trained staff did not support care workers when they were struggling to meet people's personal needs.

An induction for new staff was in place. The induction programme followed the Skills for Care induction standards. These are nationally recognised standards for people to achieve during induction. New staff were supported to attend two days of classroom based training and to meet the residents. They also shadowed more experienced staff which allowed them to observe practices and learn how to care for individuals before they worked unsupervised. One care worker confirmed they had completed induction before they stared to work in the home, They said, "I did some training especially manual handling and fire procedures and I met the residents. It was a good start."

Staff confirmed they received regular supervision; however how regular this happened varied. During supervision they were able to discuss people's needs, their training and any issues that concerned them. Staff said, "We have supervision once a year," and "We do our own then the manager goes through it with us." A new member of staff said, "I've not had one yet, but I think it's every three months." The manager said they carried out staff supervision at one to one meetings, through staff meetings and working alongside staff. However they agreed they were behind with the supervision one to one meetings. They had arranged for this to be delegated to other senior staff so all staff would benefit from a meeting with a senior person.

We spoke with staff and reviewed training records. Care workers said there were opportunities for on-going training and for obtaining a recognised national qualification. Staff training included annual updates of the organisation's statutory subjects such as, manual handling including use of hoists, safeguarding vulnerable people, infection control, health and safety, health and hygiene, and nutrition.

Requires Improvement

Is the service effective?

Records showed most of the staff had attended all the statutory training. Staff comments on the training they received varied, one staff member said, "I think the staff training is lacking, it's all eLearning without hands on training." Another member of staff said, "We are encouraged to do our studying but we aren't rewarded for getting them." However other staff said, "We get the training we need it is good," and, "I can go on the computer and the training is really clear and easy to understand." People said, "They're good at what they do." And, "They're all nice; they've got the skills they need."

At the last inspection we found the registered person failed to ensure where a person was unable to makes decisions that the Mental Capacity Act 2005(MCA) had been followed. They also failed to make a best interest decision for a person who received a modified diet, and another person on the use of bed rails and a lap belt under the MCA. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

At this inspection we found the registered manager and senior staff had carried out best interest meetings with people's relatives and best interest decisions had been made following the MCA. The registered manager had asked all relatives with Lasting Power of Attorney (LPA) to send a copy to the home as proof they were entitled to make decisions on behalf of their relative. The registered manager confirmed they had received some LPA's but said they would be repeating the request in writing. An LPA gives a person the legal right to make decisions on another person's behalf.

We looked at the records for people who had been identified as lacking capacity to make decisions. We saw the organisation's booklets for recording best interest meetings and decisions were blank. However staff had recorded the meetings and decisions in the communications part of the persons care plans. This was not in line with the organisations policy of recording best interest decisions in the appropriately named booklet. The registered manager was able to provide evidence of the processes they had followed for seven people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. At the last inspection we found the registered manager failed to make a Deprivation of Liberty Safeguarding application for a person.

At this inspection we found the registered manager had made an urgent DoLS application for one person, and an application was in the process of being sent for another person on the first day of our inspection. The registered manager was familiar with this legislation and had carried out appropriate assessments to ensure people were not deprived of their liberty and had their legal rights protected.

We recommend that the service seeks advice and guidance from a reputable source about environmental adaptations that would support the specialist needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with felt staff treated them with dignity and respect. However when observing lunch time, people were not always asked if they wanted to wear protective clothing. Staff did not take time to sit on a one to one basis with people who required assistance to eat. This did not demonstrate an awareness of respecting people's dignity. We observed staff knocking on people's doors before they entered their rooms and people confirmed that staff did this routinely.

Only one of the seven care plans we read showed people had been consulted about the care and support they required. This person was able to comment on their care and the records showed they had been involved in regular reviews. One person was able to confirm they had been involved in a review of their care and support needs with their relative. The remaining six records contained no evidence that people had been involved. One person said, "I never bother, I didn't know I'd got a care plan." Another person said, "I don't know anything about a care plan." The registered manager said people were involved in discussing their care when possible. However they confirmed people did not always understand that they had care plans which recorded their needs.

Everybody spoken with confirmed they did not get involved with writing care plans. However people said they were able to make choices about their day to day care. They told us they could choose when they got up or went to bed and whether they took part in an activity or not. We spoke with one person who chose to stay in their room and was able to confirm that staff always respected their choice. This person told us, "I prefer my own company and so stay in my room and I'm quite happy here". Another person explained how they liked to leave their bedroom door open, and said, "I leave the door open and staff wave as they go by". One visitor said, "They let (my relative) stay in bed or get up as they want" and "They can choose what to do."

Records contained information to show some relatives had been involved in reviews when the person lacked capacity. Staff told us how they explained to people what they were doing and how they obtained consent.

The care plans did not contain life histories. This meant staff would not understand people fully to help with some conversations. We discussed this with the registered manager who confirmed the activities organiser had been completing life histories for people, which were kept with the activities records. This meant staff could be aware of people's hobbies likes and dislikes.

The interaction we observed between staff and people varied, we observed some interactions were neutral. Staff briefly called to people in passing but didn't spend any time with them. One member of staff popped their head round the door to the lounge and called out "Everybody all right in here?" but didn't go in to check. On other occasions we observed staff responding to people positively. For example people enjoyed some time in the garden with staff chatting cheerfully.

People said staff respected their privacy. All rooms at the home were used for single occupancy. People told us they could spend time in the privacy of their own room if they wanted to. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home.

One visitor told us about a time when their relative was receiving personal care and had been hoisted. They said, "They used two members of staff to hoist. They closed doors and were helping [their relative] to do things for themselves. They respected their privacy and dignity and were very good." Staff explained how they preserved someone's privacy and dignity whilst giving them personal care. They told us they would cover people with towels, shut doors and windows and try to get them to do as much as possible for themselves.

People said they felt staff were very caring. Comments included, "Staff are marvellous" and "All the staff are so helpful and kind". Other comments included, "I'm well looked after", "I get on very well with staff" and "Staff are lovely. They're very, very nice, all of them".

People were happy to talk about the relationships they had built up with regular staff. One person said, "There are some staff I like better than others, it's their personality". Another person said, "Staff make me laugh" and "I have fun with them". However one person said, "When they use agency it is difficult as the usual staff know you." Staff members said, "I love it, absolutely love it here" and "Caring is about listening to them, to ask if we can help and to be there for them". Another staff member said, "I think we give excellent care".

Requires Improvement

Is the service caring?

People who were able to comment told us they could see their friends and relatives whenever they wanted. Visitors came and went throughout the day, one visitor told us they visited often and always felt welcomed. Another visitor told us they were made welcome when they visited and said, "They'll always offer us a cup of tea and biscuits." People told us they could maintain contact with friends and family in the community and go out if they wanted to. Throughout the inspection we observed people going out with family or friends.

Requires Improvement

Is the service responsive?

Our findings

The service employed an activities co-ordinator, who said they had a programme of activities and the activities for the week were advertised on the noticeboard. They also said they provided one to one sessions for people who chose to stay in their own room, or who were unable to join in due to health issues. On the first day of the inspection people were asked if they wanted to join in with an exercise activity in the dining room. This activity was just before lunch and did not last long. Other than the exercise session on the first day of our inspection we observed no set activity programme in the home on the other days. There was little in the way of mental or physical stimulation for some people. We observed no activities to engage people in the home in line with their personal preferences. Most people spent the day sat in chairs in one of the two lounges or in their rooms. Some people did go into the garden to enjoy the sunshine. Staff told us not all people were encouraged to participate in activities, they said "They hardly get any" and "They start at 11.20 then at 12.15 it's time for lunch".

One person told us, "There's plenty (of activities) going on, but I don't go down. One of the staff is always trying to persuade me to go down, but I'm not a mixer." Other people said, "I have my newspaper brought in every day for me" and "I don't have any activities." We observed four people sitting in the lounge for 35 minutes in silence. Staff walked in and out but did not engage with the people in any way. A member of staff then asked people if they would like some music on and gave people a choice of music. One person said, "I have enjoyed that music. We decided what type of music we wanted in each lounge, there's classical in this room and more modern in the other lounge. This was my choice."

Before a person moved into the home their needs were assessed to ensure the home could meet them. The registered manager confirmed the assessment involved the person as far as was possible, healthcare professionals and relatives of the person. Relatives told us, "They spoke with us about some of [my relatives] care needs" and "Things have changed, they're no longer independent." One person told us they were supported to be as independent as possible.

Following the initial assessment each person had a personalised care plan which reflected their individual needs. The care records were up to date and included regular reviews and changes made when people's needs changed. The records to monitor risk were clear on how staff should minimise risks to people, however staff had not completed the forms to show they had carried out the checks put in place. This meant the records were not up to date and did not reflect the systems put in place to reduce the risk. The care plans contained plenty of information and guidance for staff. One care plan for a person with specific dietary needs contained in-depth guidance for staff on how to manage their nutrition. Staff told us they found the care plans useful and gave them the information they needed to be able to provide appropriate care for people. One staff member said, "It says whether they need two staff for personal care or transfers, about their hobbies, dislikes, allergies and general lifestyle. It gives me what I need." Staff were able to demonstrate an awareness of people's needs and how they would be met.

Everybody spoken with confirmed they did not get involved with writing care plans. However people said they were able to make choices about their day to day care. They told us they could choose when they got up or went to bed and whether they took part in an activity or not. We spoke with one person who chose to stay in their room and was able to confirm that staff always respected their choice. This person told us, "I prefer my own company and so stay in my room and I'm quite happy here". Another person explained how they liked to leave their bedroom door open, and said, "I leave the door open and staff wave as they go by". One visitor said, "They let (my relative) stay in bed or get up as they want" and "They can choose what to do."

Staff had alternative ways to communicate with people to assist them to respond to their needs. For example, one person was unable to communicate verbally. This person had a set of communication cards and were able to give a thumbs up sign to indicate they were happy. The cards covered personal care, eating and drinking and whether the person would like some sweets or other comfort needs. A card was also available to ask if the person was in pain.

People knew how to make a complaint and told us they felt confident that staff would deal with their concerns. One person explained "If I have a problem or complaint, I ask the carers and if they cannot answer me, they get the manager or deputy in". Another person said, "If anyone complains they're nuts; I've got everything; I don't want for anything." Information on how to make a complaint and

Requires Improvement

Is the service responsive?

who to contact was on the noticeboard in the hall. However one person said, "I can't remember being made aware of the complaints procedure, but I would be willing to tell someone if necessary."

We asked people if they had ever mentioned a concern to staff, and whether staff had listened and tried to put things right. One person said "As far as I know they would". Another person said "I've mentioned a concern over food to the manager and she said she will look into it". Records showed the manager had discussed menus with people and had made some changes following these discussions.

We asked three staff members how they would respond if they received a complaint. One staff member said, "Depends what it was about; if it was serious I would go to the manager" whilst another said, "If it was to do with my work I would try to sort it out myself." There was an electronic record to show a complaint or concern had been received and how it had been managed. The registered manager explained the activities coordinator spoke with people and if they raised a concern it was reported to her. She confirmed she would follow up with the person and record it in the organisations electronic system. Complaints had been dealt with promptly and included outcomes for the person as well as a record of what could be learnt. This showed the service listened to, acted on and learnt from the concerns raised.

The registered manager confirmed they held resident and relative meetings three or four times a year. Records of the meetings showed people had been able to discuss the menus and the homes fund raising event. One relative gave an example where an issue raised at a resident's meeting last year had been responded to. People who used the service had been provided with pendants which they were able to use to alert staff if they required assistance. One person told us, "I couldn't get in when I was outside." The relative said, "They've taken it on board." One person told us they did not have residents meetings very often.

The organisation carried out an annual customer satisfaction questionnaire. The registered manager explained that for the last survey they had sent out 26 questionnaires and only four had been returned. From the response the organisation produced a report which was mainly graphs and percentages rather than action taken. However this report was misleading as it did not reflect the low number of responses. For example where it identified a specific question it said 100% satisfaction. The regional manager explained the organisation would not be carrying out paper questionnaires on an annual basis in future. They had trialled an electronic system at other care homes and were introducing it at Uphill Grange. On the second day of our inspection we were shown the new system which was an iPad near the main entrance for visitors', staff and other health professionals to use at any time.

We recommend that the service seek advice and guidance to ensure all people have the opportunity to take part in activities based on their abilities and preferences.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the manager failed to undertake audits that identified changes in people's needs. As a result, they failed to ensure a person was not at risk of unsafe care and treatment. At this inspection we found the manager carried out audits of care plans and needs were assessed regularly by nursing staff. However this did not always involve the person.

The audits used identified where improvements were needed. Shortfalls were recorded and discussed with staff at team meetings and during some supervision meetings. Although there were improvements because of these audits they were not fully effective. For example, we found the registered manager had failed to identify the shortfalls in recording best interest decisions in care plans in the appropriate place, according to the organisation's policy. However staff had recorded the information in the communications section of the care plans.

We also found the registered manager had failed to identify the shortfalls we found regarding the monitoring of risks, such as fifteen minute checks and fluid records. The registered manager told us part of their audit system was to assist on the floor they said they had assisted at lunchtime and would record this as part of their audit system. However they had failed to note one person being assisted to eat by several members of staff, or staff disempowering one person to speed up the mealtime.

The registered manager failed to recognise the impact on people due to shortage of staff. This meant staff felt they spent most of their time meeting tasks rather than spending social time with people and building on relationships.

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

The provider had a system in place for auditing the quality of care provided. The regional manager carried out a monthly visit. They used a theme each month which followed the CQC fundamental standards. They reviewed care plans and talked with people about their experience of living in the home, however there was no record to show they asked people about their care plans. The regional manager had also failed to identify the shortfalls we had found so these had not been bought to the registered managers attention by the provider. They also carried out a health and safety audit and were supported by health and safety advisors and an estates surveyor.

At our last inspection we found the manager had failed to audit incidents and accidents recorded in care plans. At this inspection we found the registered manager audited all incidents and accidents and recorded them appropriately in their electronic system which also enabled them to be audited by the organisation as a whole. The time and place of any accident was recorded to establish patterns and monitor if changes to practice needed to be made. Where concerns with an individual were raised additional support was provided. For example one person received one to one support and another person had a low bed and crash mats in place.

There were audits and checks in place to monitor safety and quality of care. Where shortfalls in the service had been identified, some actions had been taken to improve practice. For example the registered manger identified shortfalls in nursing staff signing medication records. This had been identified three months in a row. We asked the registered manager what they had done to reduce the incidents. They explained that when it had first been identified they discussed it with staff at a meeting and introduced a monthly audit of signatures. When it occurred again they made nursing staff responsible for a weekly signature checks. On the third occasion they had introduced a daily checking system so when a nurse handed over to the next nurse in charge all records were checked. This showed the registered manager had taken action to ensure people were not at risk of receiving inappropriate medication.

At our last inspection we found the provider had failed to carry out an environmental audit to identify areas of concern and address appropriately. At this inspection we found a full audit and environmental survey had been carried out and areas for improvement had been identified; a plan for refurbishment was in place.

Staff gave mixed feedback about how well the home was managed and the approach by the registered manager. One agency member of staff said the home was "Better managed than the other homes I have been to". Another member of staff told us the deputy manager was supportive and so were some of the nurses in charge. However half the staff we spoke with raised concerns that

Requires Improvement

Is the service well-led?

the registered manager was not approachable to all staff, did not listen to all staff and they did not feel confident that action would be taken in response to concerns. One staff member said it would help if we were listened to and staff meetings were not used to, "Just tell them off." However another staff member said, "I love it, absolutely love it here". The regional manager confirmed night staff had approached them for a meeting as they felt they could not talk to the registered manager.

People told us they felt they could talk to the manager and deputy and commented on seeing them around the home. One visitor said they could approach the manager if they wanted to discuss anything. One person said, "I think she is lovely, she pops in and talks to me and anything I say is taken on board."

We found the registered manager did not have the confidence in trained staff to carry out reviews and complete people's records appropriately. This meant the registered manager did not delegate many jobs to the trained staff and attempted to do everything herself with the support of the deputy manager. Poor practice by some trained staff had not been managed through staff supervision or the organisations disciplinary process. One staff member said the issues bought to the registered manager's attention regarding a member of staff had not been dealt with.

Minutes of meetings with residents and relatives showed they had been asked for their input into decisions about menus, trips, activities and anything needed to improve their lives. However people did not always have input into their care plans. We asked the regional manager how people would be asked for their opinions following the introduction of the new system of using an iPad. They explained the system included pictures of smiling and sad faces so people could indicate their level of satisfaction. Some people met with the activities coordinator to discuss the type of music they would like in each lounge for the week. The regional manager said it was at these times when people were talking with the activities co-ordinator that people could be encouraged to comment using the iPad. There were also minutes of meetings with all levels of staff. During these meetings the manager would discuss best practice issues and raise concerns over shortfalls found in audits.

Uphill Grange is part of Acegold Limited (Four Seasons group), who are a large organisation with many locations. There are senior managers in place to support the registered manager. There were also specialist teams such as human resources available to support specific functions of the service. Staff members had job descriptions which identified their role and who they were responsible to. Staff rotas showed there was a senior member of staff on each shift for staff to go to for guidance. The registered manager confirmed they were also considering a senior care worker role for additional support for care staff.

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 were not protected from the risk of unsafe care and treatment because the monitoring records required to show people had been checked regularly and received adequate fluids were not being completed appropriately. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person failed to ensure fluids were placed in reach of people who were unable to mobilise to get it themselves. Regulation 14 (4)(a) The registered person failed to ensure people were supported in a relaxed way and at a suitable pace for them to eat and drink independently. 14 (4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person failed to ensure there was sufficient qualified, competent skilled and experienced staff to meet people's needs. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered manager did not operate an effective system to identify and monitor shortfalls in recording information in care plans, staffing levels and the way staff managed mealtimes. Regulation 17 (2)(a)