Greensleeves Homes Trust

St Cross Grange

Inspection report

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Date of inspection visit:
10 April 2018
11 April 2018

Date of publication:
31 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a responsive unannounced inspection of this home on 10 and 11 April 2018 following concerns which had been raised by the local authority about the safety and welfare of people. At our last inspection of this home we had rated it Good with some areas of leadership and governance in the home requiring improvement. At this inspection we found some concerns for the safety and welfare of people. The registered provider had failed to be compliant with all of the required Regulations.

The home provides accommodation and personal care for up to 64 older people, some of whom live with mental health problems or dementia. Accommodation is arranged over three floors with stair and lift access to all areas. At the time of our inspection 55 people lived at the home.

A registered manager was 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.

During our inspection we found there was a lack of effective management and leadership in the home. Communication was not always open and transparent in the management of the home and areas of concern we had identified during our inspection had not always been identified by the governance processes in the home.

Whilst there were safe recruitment practices in the home, there were not always sufficient staff deployed in the home to meet the needs of people.

Risk assessments had not always been completed to support staff in mitigating the risks associated with people's care, including those associated with falls and behaviours which may be challenging or distressing for people. Care records were not always up to date to ensure staff had information on how to meet people's needs. This was of particular importance with the use of agency staff in the home.

People did not always receive care which was person centred and responsive to their individual needs.

Systems were in place to support staff in recognising and reporting any signs of abuse. The registered manager worked closely with the local safeguarding authority to address any concerns.

People were cared for in a kind and empathetic and most staff knew people well. There were meaningful activities and interactions in the home to reduce the risk of social isolation for people.

Where people could not consent to their care, staff had sought appropriate guidance and followed legislation designed to protect people's rights and freedom.

There was a system in place to allow people to express any concerns or complaints they may have.

People enjoyed the food they received foods in line with their preferences and choices.

The home was clean and maintenance was completed in a timely way.

At this inspection we found four breaches of the Health and Social care Act 2004 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take in the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

All reasonably practicable steps had not been taken to recognise and mitigate the risks associated with falls, incidents and accidents in the home.

Risks associated with people's care, including those in relation to the use of some medicines, had not always been identified and assessments made to reduce these risks for people.

There were not always sufficient staff with appropriate skills and knowledge deployed to meet people's needs and ensure their safety and welfare.

Staff recruited to the home had been assessed as to their suitability to work with people.

Systems were in place to recognise and report allegations of abuse and staff had a good understanding of these.

The home was clean and maintenance was completed in a timely way.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst staff had received some training to enable them to meet the needs of people this was not consistent. Staff did not always receive sufficient support and supervision to complete their roles effectively.

People's choices were respected. Where people could not consent to their care, staff had followed appropriate guidance and legislation designed to protect people's rights and freedom.

Staff had a good understanding of people's nutritional needs. People received and enjoyed a wide variety of meals in line with their needs and preferences.

Is the service caring?

Good

The service remained caring.

People and their relatives were involved in the running of the home and their care planning although records did not always reflect this.

People said staff were caring and supportive of their needs. Staff knew people well and cared for people in a kind and empathetic way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care which was person centred and individual to their specific needs.

There were meaningful activities and interactions in the home to reduce the risk of social isolation for people.

Complaints made in the home were addressed in line with the registered provider's policies and procedures.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of effective management and leadership in the home. Communication was not always open and transparent in the management of the home.

Staff did not receive sufficient support and guidance in the home to have a clear understanding of their roles and responsibilities.

Some care records were poor and lacked up to date information although the registered provider was addressing some of this concern through the introduction of an electronic record system.

Whilst the registered provider had systems in place to monitor and review the quality and effectiveness of the service provided at the home, these had not been used effectively. Audits in place did not identify the concerns we noted at our inspection.

St Cross Grange

Detailed findings

Background to this inspection

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

This inspection visit was unannounced and took place over two days. On 10 April 2018 two inspectors and an expert by experience visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 11 April 2018 two inspectors visited the home to complete the inspection.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and one whistleblowing concern which had been sent to CQC in December 2017. We reviewed notifications of incidents and events which had occurred in the home since our last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with thirteen people and one relative to gain their views of the home. We observed care and support being delivered by staff and their interactions with people in communal areas of the home.

We spoke with the registered manager, the operations manager, the deputy manager and ten members of staff including an activities coordinator, the cook, the maintenance manager, three senior carers and four members of care staff. We provided feedback of our findings following the inspection to the registered manager, operations manager, regional manager and a peripatetic manager for the registered provider.

We looked at the care plans and associated records for fifteen people and the medicine administration records for 22 people. We looked at a range of records relating to the management of the service including records of; accidents and incidents, quality assurance documents, eight staff recruitment files, complaints, policies and procedures.

Following our inspection we liaised with the local authority and local commissioning groups to provide feedback on our findings and gain their views on the service.

Inadequate

Is the service safe?

Our findings

People said they generally felt the home was safe. One person said, "I can't fault the place, absolutely [I feel safe here]. I haven't come across anything that makes me feel otherwise." A second person told us, "I do feel safe." They went on to tell us staff responded to their calls promptly unless they were very busy. A relative told us their loved one was safe in the home. Staff told us they felt people were safe in the home however they felt more staff were needed to meet people's needs. Whilst people felt they were safe, we were concerned that the registered provider had not taken steps to ensure the safety and welfare of people at all times.

We had received information from the local authority about one person who had fallen on several occasions and whose care was the subject of an on-going investigation in the home. We did not examine the circumstances of this event. However, the information shared with CQC about this incident, and others which had occurred in the home, indicated potential concerns about the management of falls in the home. The registered provider and staff had been working closely with the local authority to address these concerns and ensure the safety and welfare of people. However, we found the registered provider had not always ensured actions which had been agreed would be taken to ensure the safety and welfare of people were completed. Further areas of improvement were required in the management of falls and monitoring of patterns of falls in the home to reduce the risks for people.

Care records held information about the falls risks for people and how these could be addressed however, these were not always updated following falls. For example, one person fell on 5 April 2018 and received a serious head and facial injury. Care records and risk assessments had not been updated following this fall to identify the severity of the injuries the person had received, their attendance at hospital for these injuries or any further actions to take to ensure their safety and welfare. There was no information on a daily handover sheet to update staff on this incident or any learning or actions which were required to ensure the safety and welfare of this person. This incident of a fall resulting in a serious injury had not been reported to the local authority as a safeguarding matter.

Whilst patterns of falls were identified for individuals in the home, the registered manager did not collate information sufficiently to identify any trends in the patterns of falls in the home or identify any actions which could be taken to reduce the risks of these falls. Whilst the number of falls which had occurred in the home had decreased in the six months before our inspection, we were concerned people remained at risk of harm due to the poor management of falls and the lack of learning from these incidents in the service.

Incidents and accidents were reported to the registered manager by staff and these documents were reviewed and then filed in people's care records. Whilst a log of these incidents was kept, there was no review of any patterns and trends completed for these and no learning outcomes identified from these. Incident and accident forms, including those in relation to people who had fallen, often lacked clear information on actions taken, learning outcomes and any further information used to inform plans of care for the person.

Staff meetings did not reflect any information was shared with staff about incidents and accidents in the home, particularly falls. Whilst it was noted on a 24 hours handover sheet when people had a fall, this was not followed up on this documentation to ensure a continuity of information for staff on the associated risks for this person. Daily handover sheets did not contain information about recent falls which would have an impact on the care and support people may require. We observed two daily handover meetings between senior staff and noted there was a lack of information shared about incidents of falls or any learning from these.

All reasonably practicable steps had not been taken to mitigate the risks associated with incidents and accidents in the home and in particular in relation to falls. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The risks associated with the care needs of most people had been assessed and informed their plans of care to ensure their safety and welfare. This included assessments on the risks of poor nutrition, mobility, the use of bed rails and the maintenance of skin integrity. However, the assessment of individual risks associated with people's care needs in the home was not consistent. This meant some people were at risk of receiving care which was not appropriate to their needs as staff did not have clear direction or understanding on how to meet these needs.

For example, three people could display behaviours which may cause distress or harm to themselves or others, including verbal and physical aggression. There were no risk assessments in place to identify how these behaviours may present or how staff should support people to manage them. Staff were aware these people could present with these behaviours however, they had not received training to support this and had no guidance on how to support and manage these risks. These people were at risk of receiving care which was not in line with their needs and which ensured their safety and welfare and that of others. For one of these people we were concerned they had not received sufficient support to meet their mental health needs and we made a referral to the local authority safeguarding team to raise this matter.

The risks associated with some people's medicines had not been assessed and used to inform plans of care. Three people received a medicine to thin their blood (anticoagulants), which can put people at risk of bleeding and bruising easily. These risks had not been assessed and used to inform plans of care for people. One person required a medicine to reduce the risks of seizures. There was no information in care records to identify why this person was on this medicine or the risks associated with this medicine and the medical conditions it supports.

For two people we saw they required the administration of medicines which needed to be given regularly at set times of the day to manage a health condition. If not given in a timely way these medicines can have a significant impact on people's health and care needs. The risks associated with these medicines not being given correctly had not been identified and care records did not reflect the impact this risk could have on people.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

At our inspection in August 2017 the manager (who subsequently became the registered manager of the home) and deputy manager told us they had recognised staffing levels in the home required further review due to the layout of the home. They told us a dependency tool would be implemented to ensure staffing levels met the needs of people in the home. A dependency tool is a tool used to identify the needs of people and give guidance on the number of staff required to meet these needs.

On 8 January 2018, we received information from the local authority about concerns which had been raised about the staffing levels in the home. We sought further assurances from the registered manager and deputy manager about the implementation of a dependency tool in the home to clearly establish staffing levels in the home to meet the needs of people and ensure their safety and welfare. We did not receive a response to this request.

At this inspection the registered manager told us a dependency tool was not yet in use in the home as this would be in place once a new computerised records system was in full use. They told us they believed the number of staff available in the home at any time was sufficient to meet people's needs. The registered provider was not able to demonstrate that the needs of people had been assessed and the appropriate number of staff made available to meet these needs.

Staff rotas showed there was a consistent number of staff and senior staff available to meet the needs of people though the day and night. This included the use of frequent external agency staff, although the registered provider was actively recruiting staff to reduce the use of agency staff. However, the lay out of the home meant it was often difficult for staff to observe people to ensure their safety and where people required the support of two care staff at a time this meant areas of the home were unsupervised for long periods of time.

For example, in one communal area on the first floor of the home, we observed people had no interaction or support from staff for long periods of time. On 10 April 2018 eight people sat in this area for an hour with a television playing loudly and with no staff presence; on 11 April 2018 seven people sat in the same room for an hour with the television playing loudly and no staff presence. People did not have access to a call bell to request support from staff during this time.

Staff had little or no time to spend with people particularly in the mornings. In another communal area of the home on the ground floor staff were busy providing support for people in their rooms and left people sat in front of a television without any interactions. One person sat at the breakfast table looking at their unfinished meal for over 45 minutes before a member of staff noticed they were there and supported them to move to a more comfortable chair.

Senior staff were very busy all the time coordinating staff on the floor they were in charge of. They were constantly rushing around and offering support to care staff who were also rushing around. Call bells were constantly ringing and we observed on three occasions one person had to wait in excess of 15 minutes after using their call bell to get support from staff. This person could not mobilise independently and suffered from a need to use the toilet urgently which was not being met in a timely way when staff did not respond to their call.

We received mixed feedback from people and staff about the number of staff available to meet people's needs. One person told us, "No, [there's not enough staff]. It's worse at night." Another person said, "We've had lots of agency staff which doesn't work well. Of course they don't know you." A member of staff said, "No, there aren't [enough staff]….. I work with agency on most [days]. You never really get the chance to finish. Sometimes, I have to give a person a wash one day, even though they might want a shower or bath. I might get the chance to do it the next day". Another member of staff told us, "We're always short staffed. If staff ring in sick, they're not replaced. I can understand if it's short notice that it might be later we get staff but they don't come at all sometimes". A third told us, "If everybody's in and there's no sickness, then it's okay. Sometimes staff ring in sick at the last moment and that's difficult". A professional told us whilst there were staff available to support them when they visited, often there were no staff visible on each floor of the home to support people and meet their needs.

The lack of staff availability to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had been informed by a member of the public of concerns about inappropriate references being provided for new staff at the home. The operations manager was aware of these concerns and told us these had been addressed. There were safe and efficient methods of recruitment in place. Recruitment records we reviewed included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. Recruitment checks and information was available for all agency staff who worked in the home.

People received their medicines in a safe and effective way from staff who had been trained to do this. There was a system of audit and review in place for the administration of regular medicines. Medicines were stored and administered safely. However, for medicines which were prescribed as required (PRN), protocols were not always in place to support staff in the safe administration and monitoring of these medicines. For example, for one person who may require a medicine to reduce anxiety or agitation, there was no protocol in place for the use of this medicine and staff did not monitor the need, use or effectiveness of this medicine. We discussed this with the registered manager who told us this would be addressed.

Safeguarding policies and procedures were in place to protect people from abuse and avoidable harm. The staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. Staff were confident any concerns they raised would be dealt with swiftly by the registered manager and they were aware of the registered provider's whistleblowing policy.

The registered provider and registered manager were working with the local authority to address areas of concern which had been identified since our last inspection. They continued to work with the local authority and commissioners at the time of our report to address matters which had not yet been fully addressed such as falls management. One staff member said, "I'd make sure it was referred onto Safeguarding if someone was mistreated".

The risks associated with moving people in the event of an emergency in the home had been assessed. A business continuity plan was in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure. Personal evacuation plans were in place and readily available in the event of an evacuation of the home. However, for three people these records did not give clear guidance for staff. We have addressed this poor record keeping in the well led domain of this report.

The home was clean and well maintained. Electrical, gas, and water checks were completed routinely in the home to ensure this equipment was safe to use. There were effective systems in place to identify maintenance issues in the home and how or when these were addressed. Equipment in use in the home such as hoists and wheelchairs were well maintained.

Requires Improvement

Is the service effective?

Our findings

People were encouraged and felt supported to express their wishes and had choices in their daily lives including what they wanted to eat and what activities they participated in during the day. One person told us they were able to do as they wished and were very happy in the home. They said, "It's 100% as far as I am concerned." Staff felt they offered people support to choose how they lived in the home although they did not always feel they were supported in their own roles.

The registered provider had a programme of induction and training in place to provide staff with the skills to ensure they could meet the needs of people. However, a record of all training showed staff had not always completed or updated this training. Most staff had completed all training which was identified as mandatory for their role. However, the registered provider identified courses which were a requirement of some staff roles and these had not always been identified as completed. For example of 67 members of staff these records showed only 11 had completed any training on equality and diversity and only 38 had completed training on dementia awareness; both of these courses had been identified by the registered provider as being a requirement of their role.

We asked staff about the training they had received. None were able to describe to us the training they had received in addition to those deemed mandatory by the registered provider, such as safeguarding adults and moving and handling. One staff member said, "They do help people with NVQs but I've already done mine so there's nothing else I've done". Staff records showed some staff had been encouraged and provided with opportunities to further develop their skills through the use of external qualifications such as nationally accredited qualifications.

We asked staff about the supervision and support they received. One staff member said, "To be honest, I haven't had supervision for at least nine months. I don't even know who my supervisor is or when it will be done." Another staff member told us, "I think it's okay [supervision]. I haven't had it for a while but I wouldn't wait if I had a problem anyway". However a third member of staff said, "I have supervision every month." The registered manager acknowledged that staff supervision was important but had not taken place in a timely way.

The lack of effective supervision and training for staff meant we were not assured people received care from staff who had the right skills and competencies to meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in August 2017 we found records did not always reflect the principles of the Mental Capacity Act 2005 (MCA) were being followed when people had fluctuating capacity or lacked capacity to make decisions for themselves. At this inspection we found people's ability to make decisions had been assessed. We noted this was done in the process of care planning and review. Where a person did not possess mental capacity, we noted up to date mental capacity assessments were in place, in addition to evidence of best interests meetings with relevant parties present.
The MCA provides a legal framework for making particular decisions on behalf of people who may lack the

mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people had the mental capacity to make decisions about their care we saw staff respected their wishes and supported them to remain independent. For example, one person liked to rise from bed early in the morning and they told us, "The night staff get me up just after six, which is what I like." They went on to tell us how staff respected their decisions when they liked to watch television instead of attending activities which were going on.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For 10 people who lived at the home an application had been approved by the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. A further 14 applications were pending with the local authority or were being submitted at the time of our inspection. Staff we spoke with understood the implications of the MCA and the Deprivation of Liberty Safeguards had for the people they were caring for.

The home was not purpose built and as such the layout of each floor presented the registered provider with challenges as to how best accommodate people's needs. A large secure communal area on the ground floor of the home was very open with large areas for people to mobilise in. However, the lay out of this area had been identified by staff and relatives as a possible concern for people at high risk of falls. Other areas of the home on the first and second floor were also not easily viewed by staff for people who were at high risk of falls or needed closer observation. The registered manager and operations manager discussed with us the need for a review of the layout of some areas of the home and the suitability of rooms for people. This work was on-going at the time of our inspection to ensure the safety and welfare of people was promoted in a suitable environment. There were well maintained outdoor garden areas for people to enjoy including a balcony area for people on the first floor.

People we spoke with said the food provided at the home was good and there was a variety of foods available for people each day. One person said, "The food is very good, lovely breakfasts, porridge and prunes and toast." Another person said, "The food is lovely, you get a choice. I go to the dining room for lunch." The menu was based on a five week rota, there was a choice of meals on offer and kitchen staff would prepare other food for people on request. There were usually two chefs on duty, offering a seven day a week service and they were aware of people's likes, dislikes and preferences as well as any special dietary requirements.

The staff we spoke with, including the cook and kitchen staff, were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves. Drink dispensers were available around the home to allow people to independently choose what they drank. The care plans we looked at reflected this although some daily records of food and fluid intake were not always accurate.

The kitchen was clean and well managed and the home had received a five star rating by the Food Standards Agency in May 2017.

Care plans showed people were able to access a wide variety of core and specialist external health care professionals. For example, referrals had been made on behalf of people to professionals such as GP's,

community nurses, Tissue Viability Nurses, dieticians and speech and language therapists.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person told us staff were, "Very good," whilst another said, "The staff are marvellous," and a third told us, "The girls are very good, they don't pester me." A relative told us, "Nine out of ten staff are very empathetic and caring." Staff felt they offered good care for people. One told us, "It definitely is [caring]. We work really hard but it's hard when you don't have the staff". Another told us, "We [staff] really do care, they [people] are all lovely and we really want the best for them." A health professional told us they felt staff were always kind and caring.

Although staff were often busy and constantly on the go, people were supported in a kind and caring manner. Staff were knowledgeable about the people they were caring for and it was clear they recognised people as individuals. Staff took time to allow people to express themselves and participate in their care and activities as they preferred. People responded well to staff who knew them well and understood how to meet their needs. For example, for one person who was very reluctant to take fluids staff took time to chat with them and find out what they wanted to drink and provide this for them. They were kind and patient with the person, encouraging them to take the fluids. Staff we spoke with understood how important it was to embrace people's previous experiences in their daily lives and allow them to reflect on these. For example, there was a high prevalence of people living in the home who had a military background and staff encouraged people to speak of this and activities reflected this.

People who lived at St Cross Grange were able to express their views on how they wished to be supported or involved in the management of any changes of the home although records did not always reflect this. Staff were proactive in speaking with people and their relatives when they visited to ensure their views were respected and also to encourage them to involve people in discussions about their care and the home. A relative we spoke with felt their views and those of their loved one were respected.

People felt staff were respectful of their privacy and dignity. Doors remained closed when people were being supported with personal care. When one person became distressed in a communal area of the home staff supported them in a kind and respectful way to move to their room and be comforted before returning to join in an activity they enjoyed. Staff asked permission before supporting people to move or participate in any activity and were courteous and respectful at all times.

Requires Improvement

Is the service responsive?

Our findings

Whilst most staff knew people well, we had received concerns from the local authority and professionals that people's care was not always responsive to their individual needs.

These concerns identified that staff had not always assessed people's needs on admission to the home. They were also concerned that staff did not always recognise when people's health condition or general abilities, particularly in relation to falls, had deteriorated. This meant staff did not always recognise in a timely way when people's care needs could not be able to be met in the home and people required additional support to maintain their independence.

The registered manager had been working with the local authority to address these concerns. No new admissions were being accepted into the home at the time of our inspection, in agreement with the local authority and the Commission. This was to allow the registered provider time to address concerns which had been raised about the care people received and embed new working practices in the home.

Care records we reviewed held information about assessments completed when people were admitted to the home and the information in these records had been used to inform plans of care for people. People and their relatives had been involved in these assessments.

Whilst most care plans had been updated monthly and some were person centred, we were not assured people's changing personal or clinical needs were always met and supported in line with their individual needs and preferences.

For example, for one person who lived with a neurological condition, we observed they suffered from suffered from involuntary movements and jerks, primarily in their upper body. Their care plan contained no confirmation of diagnosis; they had not been seen by an external specialist despite an entry from their GP in the care plan of 25 April 2017 stating they "would refer to neurologist re uncontrollable movements". We asked senior staff about this and were told the person had refused the referral. Whilst this was the right of the person to do so, this was not documented in the care plan. In addition, the care plan contained very little information about the practical and emotional impact of such a debilitating condition. There was also no mechanism in place to review this decision, should symptoms become worse. Whilst staff were aware this person needed support with this condition they had not taken steps to address and review this person's on-going changing needs to ensure they would be able to maintain their independence for as long as possible.

A second person had recently returned to the home from hospital, having been admitted by emergency ambulance on 5 April 2018. There was no evidence in their care plan about his condition on return to the home or what the future plan for their care would be. The only reference to their return from hospital was in their daily record of 8 April 2018 which stated, "[person] came back at supper time. Settled in [their] room, watching TV and had a cup of tea". This person's care plan had not been reviewed or updated since December 2016. We were aware this person had significant injuries following this admission to hospital. Staff

understood this person had been in hospital and that there was a need to monitor their mobility, however they were not aware of, or monitoring for any signs and symptom of deterioration in this person's wellbeing. Whilst a need to review the hospital discharge letter of this person was mentioned in a daily handover session on 10 April 2018, this was not completed and was discussed again at a handover meeting on 11 April 2018. We were not assured this person care was being monitored effectively in line with their needs. This was discussed with the operations manager who assured us this would be dealt with.

A third person had been placed on a fluid balance chart to monitor their fluid intake and urine output as they were running a high temperature and were at risk of dehydration. We looked at these charts over a three day period from 8 April 2018, which provided no meaningful indication of input or output. For example, most recordings of fluid intake were 'sips' with no indication of amount. Urine output measurements were described a 'wet pad', again with no information about amounts. We were not assured this person's care needs were being monitored effectively and in line with their needs.

The registered provider had failed to ensure people's on-going care and treatment was planned and addressed in line with their changing needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a variety of activities in the home to provide social interaction and stimulation for people. There were no daily activities advertised in the home at the time of our inspection but the activities coordinator told us this would be addressed. They told us a weekly plan was usually posted for people to see on noticeboards around the home and also taken to people's rooms. Planned activities available included games, quizzes, arts and crafts, music, films and reminiscence. Several large communal area in the home provided access to music, television and film activities and in one room people had access to a piano, library books and a pool table.

One communal room had been adapted to provide a 'Club Room'. This room had been decorated in a pub/bar theme to celebrate the military heritage of the home. The registered manager told us people were going to be encouraged to use this room to meet up with others and their families and have coffee and cake or an alcoholic beverage on occasions.

Activities were available seven days per week and for people who remained in bed, one to one activities allowed them time to socially interact and have personalised activities to meet their needs. The home welcomed families to join them on activities throughout the year including an open day for The National Care Home Day and a summer fete. The activities coordinator told us they were looking to get bus passes for some people who would enjoy a trip into Winchester city and that the home had hired a vintage bus recently to take people on a drive around the city.

Most people told us there were activities for them to participate in if they wanted to. One person told us, "I like carpet bowls. I keep the score." Another told us, "I don't get bored. I go down and play the piano. They have 'Music with [person's name], and I play". However one person told us, "It's not as good as it used to be [activities]." They went on to tell us activities were not as well planned as they had been and there were less of them.

The complaints policy was displayed in the entrance and around the home. People and their relatives were aware of the policy and felt confident any concerns they raised would be addressed promptly by the registered manager or other staff. There were no complaints records available for us to review at the time of our inspection. Records of two formal complaints received in the home since our last inspection were forwarded to us following our inspection and these had been responded to in a timely way.

Meetings had been held with people and their relatives. Minutes from these meetings showed they were well attended and people and their relatives were asked their views of the home and made suggestions for improvements such as new activities or ideas for meals. For example, at a meeting on 6 February 2018 the registered manager had discussed with people and their relatives the new changes to the reception area of the home, and staffing levels in the home. New activities and planned events were discussed and any other matters of concern for people.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The home was complying with this Standard, although some improvements could be made in the provision of literature for people who live with dementia. The registered provider displayed some information about the home, how to make complaints and other documents such as menus in the home in a way which allowed people to easily access this.

Whilst there were no people at St Cross Grange receiving end of life care at the time of our inspection, there was feedback from families of people who had died displayed in the home. This showed staff were kind, compassionate and supportive throughout this difficult tie for people and their families. We spoke with one family member who had recently been bereaved. They told us, "The staff were amazing and nothing was too much trouble for any of them. I would definitely recommend the home." Care records held information on people's end of life wishes and a senior carer told us these would be updated further when new electronic care records were completed.

Requires Improvement

Is the service well-led?

Our findings

People thought the home was well run. They knew who the registered manager was and spoke highly of all the staff team. One person told us, "I have seen plenty of changes in managers. [Registered manager] is ok." However staff did not always feel their views were taken into account in the home. One member of staff told us, "It's always the same [with managers] We're always short staffed and I don't see anyone doing anything about it." Another told us, I don't see much of the [registered] manager." A third member of staff told us the deputy manager was not approachable. Health and social care professionals told us senior care staff had excellent understanding of their roles and worked hard with care staff to ensure people received care in line with their needs. However, there was a lack of effective senior leadership in the home to ensure care was well coordinated and met the needs and preferences of people.

There was 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 our last inspection of the home in August 2017, the registered manager had been new to the home and told us of the changes they planned to implement in the home to ensure the safety and welfare of people. However, during our inspection we found there were several areas of care which had deteriorated since our last inspection as identified in this report. We found there was a serious lack of guidance and leadership in the home to ensure all staff had a good understanding of their roles and responsibilities in maintaining the safety and welfare of people who lived in the home.

There was a lack of clarity in job roles and accountability between the registered manager and deputy manager. For example, when we requested any information of the registered manager or deputy manager they frequently told us this information was collated by or held by the other manager and they could not currently access this. The registered manager had recently moved from their office into a temporary room and had failed to ensure all records were available as required. As a result of this poor communication and information sharing we were unable to collate a lot of the information we required to complete our inspection. We requested additional information from the registered manager by email on several occasions following our inspection, however we did not always receive the information we required.

A staff structure in place meant a senior carer took day to day responsibility for managing the care on a designated floor of the home. Whilst senior care staff had a good understanding of their responsibilities in managing the care on their allocated floor and carried out their duties efficiently, there was a lack of management leadership to coordinate care around the home. Professionals told us whilst senior carers had a very good understanding of the needs of the people they cared for, there was a lack of coordination in care across the home and this often led to professionals having to liaise with different people across the home on each visit. This led to confusion and could cause miscommunication about people's care needs.

Senior carers completed a 24 hour handover record to provide to the deputy manager or registered

manager each morning. This information was then reviewed and discussed between the deputy manager, registered manager and senior carers each day at a morning handover meeting. We found actions from these meetings were not effective in ensuring staff had the information, advice and support they required to meet the needs of people.

For example, for one person who had returned from hospital with significant injuries this was not followed up by the deputy manager or registered manager to ensure the person was receiving the correct support and treatment to meet their needs. The deputy manager requested a copy of a discharge summary for this person on Tuesday 10 April 2018 at the morning meeting to review their care needs. On Wednesday 11 April 2018 this discharge document was requested again and had not been reviewed by the deputy manager and so no actions had been taken to ensure the safety and welfare of the person in line with their needs.

For another person who had been unwell over a weekend period and staff had requested a GP visit for, information was not shared at this meeting to discuss the deterioration in this person's condition until the inspector present at the meeting shared their findings about this person's condition. This person was then reviewed by a senior carer supported by the operations manager and it was ascertained a more urgent GP referral was required for the person. We were not assured senior staff would have received this support had the inspector not intervened and requested a further review of this person. The deputy manager and registered manager did not provide appropriate support to the senior carers to ensure the safety and welfare of people.

Records for these meetings lacked clarity and information on guidance and support provided to staff to ensure people's safety and welfare. Many sections made a minor comment only on the quality of the day a person had had.

Whilst we recognised care records were in a period of transition between paper and electronic records in the home, we found some of these were not up to date or an accurate reflection of people's needs. We were particularly concerned that agency staff working in the home did not have access to up to date records on people's needs and preferences. For example, three personal evacuation plans we reviewed showed people would become confused or aggressive during an emergency but they contained no guidance on how staff or emergency personnel could support the person at this time. For people who had fallen or received injuries care records had not always been updated following these events to ensure staff had accurate and up to date information about people's needs. However, some newer care records on the electronic system showed staff had a good understanding of how to document clear, person centred care plans to support staff in meeting people's needs.

Care records did not always hold consistent information about the care staff had provided for the person. For example, for two people who had become unwell and staff had recorded their blood pressure, pulse, blood oxygen levels and temperature, these records were not stored consistently. For each of these people we were unable to identify where these records had been held when care records stated they had been recorded. Staff told us three different areas where these recordings may be stored but were unable to locate them for us. For another person, the GP had requested a medicine be stopped and their pulse be recorded daily for one week to monitor this and report any concerns. There were no documented recordings of these pulse readings and staff were unable to locate any readings of these although they did assure us they had been recorded.

We received concerns from a whistle-blower in December 2017 about the lack of effective handover documentation and information for staff who started shifts at different times of the day. The registered manager responded to this concern and assured us staff received information about the care needs of

people when they started their shift. We found daily handover sheets were not always up to date for care staff; for example, for a person who fell and had a serious head injury, daily handover records did not reflect this. Staff did not always have accurate information about people's needs and so handovers could not have been effective.

Whilst the registered provider had ensured accurate and up to date audits of the health and safety in the home, maintenance and equipment were completed, there was a lack of robust and effective audits in the home to identify the concerns we had raised during our inspection. For example, incidents and accidents were not reviewed across the service to identify causality or common themes emerging from these. Most care plans had been reviewed however the concerns about the risks associated with people's care we had identified during our inspection had not always been identified.

Whilst the registered manager told us they had regular meetings with all staff and records of these meetings were held in a file which all staff had access to, we found they had not shared a lot of the concerns which had been identified in the home with staff. Staff told us they had not attended recent staff meetings and there were limited records of any staff meetings. Whilst senior staff had a weekly meeting with the deputy manager, these meeting notes were poor and lacked any clear information on how practices in the home should be improved following any learning.

Whilst the registered manager met with people and their relatives, there was no record they had shared the on-going local authority concerns with people and their relatives. The last relatives meeting was held on 6 February 2018. We were concerned there was a lack of open and transparent communications in the home to ensure people and their relatives had a good understanding of issues being addressed in the home.

The lack of consistent and effective leadership, poor record keeping and poor governance in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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