Life Style Care plc

The Grange Care Centre

Inspection report

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Ratings

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

Overall summary

The inspection was carried out on 25, 26 and 27 November 2014 and the first day of the inspection was unannounced. During the last inspection on 6 March 2014 the provider was meeting the regulations we checked.

The Grange Care Centre provides accommodation for people requiring nursing or personal care for up to 160 people. The service has eight units, each with single en suite bedrooms, dining and sitting rooms and bath and shower facilities. Two units accommodate people with general nursing care needs, one unit accommodates people with personal care and dementia care needs, one unit accommodates people with physical disabilities, one unit accommodates people with end of life nursing care needs, one unit accommodates people with behavioural and nursing needs and two units accommodate people with nursing and dementia care needs. At the time of the inspection there were 133 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service since August 2014. A registered manager is a person who

Summary of findings

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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People's safety was compromised in several areas. These included inadequate management of medicines, lack of understanding of some staff about safeguarding and whistleblowing procedures, and recruitment processes not being robustly followed.

There was an ongoing issue with staff shortages, and although the manager had been actively recruiting staff, shortages continued to occur and this impacted on the quality of care people received. Activities were provided, however these were affected by staff shortages and meant there were not enough meaningful activities to meet people's group and individual needs.

We identified shortfalls with risk management for individuals, so areas of risk had not always been identified. Remedial action to address shortfalls identified by servicing and maintenance checks was not always taken in a timely way, which could have placed people at risk.

Shortfalls with staff training and support were identified and staff did not always have the skills and knowledge to meet people's individual needs effectively.

Staff were not always clear about acting in people's best interests and had not received training in Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Where people were at risk and unable to make decisions in their own best interest, they had been appropriately referred for assessment under DoLS.

Meal choices were available, however these were not always offered, so people's individual needs and preferences were not always being met. Staff were available to provide people with support and assistance at mealtimes and with drinks throughout the day.

Staff monitored people's condition and referred them for input from healthcare professionals when they needed it.

People and their relatives told us they were happy with the care provided. Most staff were caring and respectful to people and people could make choices about their care, however we observed occasions where staff did not demonstrate respect for people. People were not involved with reviews and changes to their care records, so did not have the opportunity to express their views. Most care records were general in content and not reflective of people's individual needs and wishes.

The manager investigated and responded to complaints in a timely way. People and their relatives said they would raise any concerns, but were not aware of the complaints procedure. The manager had recognised this and was taking action to address it so people were aware of the procedure to be followed.

The process for monitoring the quality of care had not been effective in identifying shortfalls within the service. The provider had recognised this and was reviewing their monitoring processes.

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?

Inadequate

The service was not safe.

Medicines were not being safely managed in the service.

Staff told us they were aware of safeguarding procedures and said they would report any safeguarding concerns, however this was not always demonstrated by staff. Staff did not always know what outside agencies they could contact to report concerns if necessary.

Although required recruitment checks had been carried out prior to people being employed at the service, gaps in information on application forms and discrepancies in reference information provided meant the recruitment process was not being followed robustly.

There were issues with staff shortages. Staffing levels had regularly fallen below those assessed as being required to meet people's needs. People were therefore at risk of not having their needs met.

Assessments to identify areas of risk were not in place for some risks identified during the inspection, so action was not planned to minimise risks.

The shortfalls identified meant people's safety was at risk.

Is the service effective?

Inadequate

The service was not effective.

Whilst some staff demonstrated an understanding of people's needs and how to meet them, staff had not always received the training and support they needed.

While staff understood people's right to make choices, where people were limited in their ability to make choices for themselves, staff did not always demonstrate an understanding of acting in people's best interests and had not received training in Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

Meals to meet people's individual needs or preferences were not always identified and it was not always clear how people chose the meal they wanted. Meals for people with specific dietary requirements were available but staff were not always aware of this and so options were limited. Staff were available to provide people with support and assistance at mealtimes and with drinks throughout the day.

People received input from healthcare professionals when they needed it. If someone's condition changed they were being referred appropriately to see the GP or other healthcare professional and the outcome was recorded so staff were able to take the action required to meet their needs.

Summary of findings

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People and their relatives told us the majority of staff provided good care and treated people with dignity and respect. Some individual staff were seen to be working in a task led way and not always respecting people, for example, entering bedrooms without knocking.

People and their relatives had been involved in pre-admission assessments so people's needs had been identified and discussed prior to admission to the service. Care records were quite general and not person centred.

Where people were able to make choices, for example, waking and retiring times, people told us they could do so and staff respected these.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People and their relatives had not been involved in reviews of their care, so they were not given the opportunity to express their opinions and wishes. Care records had not always been updated following a change in a person's needs, which could place people at risk of not receiving the care they required.

Activities were provided, however due to staff shortages the activities coordinators were often deployed on other duties such as acting as escorts for people attending appointments, and the activities provision was reduced.

People and their relatives said they were able to raise any concerns, however they were not clear on the complaints procedure for the service. This was because the service had not provided people or their relatives with information about the complaints procedure. Complaints that had been received had been responded to in a timely way.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

There had been several changes of manager and the present manager had been in post since August 2014. The service had a high turnover of staff, which had an impact on the continuity of care, the quality of the care provided, positive relationship building and stability. We received positive feedback about the manager and people had confidence in her ability to make improvements to the service.

Apart from meetings with people and relatives, there was little evidence that people were involved in the running of the service. Best practice guidance was not being followed by staff when planning people's care and care plans for specialist care needs, for example, end of life care plans were incomplete, leaving people at risk of not having their needs met.

Summary of findings

Quality monitoring processes were not robust enough to identify issues promptly so they could be addressed. The provider had accepted several shortfalls with the service and a management team was working in the service to address the areas of concern.

The Grange Care Centre

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25, 26 and 27 November 2014 and the first day of inspection was unannounced.

The inspection team consisted of four inspectors, including a pharmacist inspector. Before the inspection we reviewed the information we held about the service and information we received from the local authority. The local authority informed us prior to the inspection that they had made the decision to restrict further admissions of people into the service.

During the inspection we viewed a variety of records including 26 people's care records, some in detail and some looking at specific areas, 47 medicines administration record charts, eight staff files, servicing and maintenance records for equipment and the premises, audit reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the mealtime experience for people in three other units and interaction between people using the service and staff on all units.

We spoke with 25 people using the service, 20 relatives and two other visitors, the registered manager, the clinical operations director for the provider, one regional manager, one support manager, one quality support lead, one senior clinical lead, 13 registered nurses, 22 care staff, two activities coordinators, two domestic staff, a GP and a local authority care manager. When we spoke with the registered manager and other managers, we have referred to them as 'the management team' in the report.

Inadequate

Is the service safe?

Our findings

We checked storage for medicines and medicines records on four units. We found that medicines were stored securely, and at the correct temperatures to remain suitable for use, however we found that people did not always receive their medicines as prescribed. Medicines were not managed safely on two units. The provider had already identified shortfalls prior to our inspection with how they were managing medicines and had begun to take action on two of the units to address this. We assessed how medicines were being managed on these two units and found that medicines were managed safely. The provider showed us an action plan for addressing the issues on the other six units.

When we looked at people's medicines administration records, we saw that five medicines for five people had run out during November 2014. This meant that these people had missed doses of their medicines for between 1 and 8 days, which included a medicine for epilepsy and a medicine for breathing difficulties. We saw that staff did not always make accurate entries on medicines records as staff had recorded that they had given one of these medicines on 22, 23 and 24 November 2014, although there was none in stock. Four medicines had not been used as often as prescribed. For example, an eye drop to treat an eye infection which was prescribed to be administered four times a day was only being administered three times a day, and a pain-relieving gel prescribed to be applied three times a day had only been used twice in November 2014. This meant that some people were placed at risk because they were not receiving their medicines as prescribed.

One person was prescribed a sedating medicine to be administered only when needed for managing behaviours that challenged the service. We saw that this had been administered 23 times since 01 November 2014. When we inspected medicines records and daily notes to see why this medicine had been administered to this person, we saw that staff did not always record the reasons for giving this medicine. On some occasions, staff had recorded that the reason they had administered this medicine was because the person was "restless" and not because the person was exhibiting challenging behaviour. Therefore this person was placed at risk of receiving this medicine inappropriately and excessively.

Medicines records and care plans related to medicines were not always kept up to date. Three people had allergies to medicines; however this was not recorded on their medicines administration records, which may have placed these people at risk of receiving medicines they were allergic to. One person was having their medicines administered covertly. Their covert administration care plan was out of date, as it listed three medicines that this person was no longer prescribed, and did not list two currently prescribed medicines. Several people had out of date care plans for medicines prescribed "as required". When medicines or doses had changed, these plans had not been updated. This meant that staff did not have up to date information on how to administer these medicines which may have placed people at risk of receiving their medicines incorrectly.

This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Policies and procedures were in place for safeguarding and whistle blowing. We asked staff about safeguarding and the action they would take if they suspected someone was being abused. Staff said they knew about the safeguarding procedures and said they would report any suspicions of abuse to the senior person on duty or to the manager. However, one incident had not been recognised by staff as being reportable under safeguarding procedures and this was addressed at the time of inspection. Whilst some of the staff were very clear on safeguarding and whistleblowing procedures, half of those we spoke with were not aware of outside agencies they could contact to report concerns, such as the Care Quality Commission (CQC) and the local authority safeguarding team. Three of the staff who had been employed in the last three months said they had not yet received training in safeguarding adults and others said they had received training but had not been told about contacting outside agencies. The manager said training and updates in safeguarding would be arranged for staff.

This is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Recruitment procedures had not been adequately followed. Staff records showed the provider had carried out checks including Disclosure and Barring Service (DBS) checks, proof of identity and right to work in the UK. There was a photo on the file of each member of staff and all had completed health questionnaires. Application forms had been completed, however in two instances reasons for

Is the service safe?

gaps in employment histories had not been recorded or explored with the staff, so no explanation had been identified. One staff member had not listed their education details and the dates of employment listed on their application form differed from those supplied by the referee, and no explanation was recorded for this. For one member of staff who listed they had previously worked in a care setting in the UK, no referee had been given from that employer, and no explanation for this had been recorded. The most recent home audit carried out on behalf of the provider had identified the shortfalls with staff records and the manager said an audit of all staff records was to be carried out, so any shortfalls could be addressed.

This is a breach of Regulation 21 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

We spoke with staff, visitors and people using the service about the staffing in the service. In all units we were told about staff shortages over a period of some months and the impact this had on people using the service. Comments from people included, "They are often short of staff in the day. For me this means I might not get the chance of a wash.", "In the afternoon there is only one carer on duty, plus the nurse, so it's difficult to get out", "There are not enough staff. I can't use the loo but I have to wait too long quite often for help." and "They need more staff on in the morning."

Comments from relatives included, "the fact of the matter is that there are not enough staff. The staff they have are very good, caring and they are working very hard. They do not have a bank and when they are short they just move staff from other units. Activities do not happen. The relatives and service users get familiar with the staff, they then get moved and there is no consistency" and "When I am in the lounge, staff leave and we are left to supervise the service users."

Comments from staff included, "shortages of staff are a regular occurrence," "We are always short of staff and being moved from unit to unit to cover shortages," "No proper plans in place when service users require an escort to attend an appointment, or if we have training," "If there are enough staff we can give people a shower, if not we just give them a wash," "If we have all the staff we are meant to have we manage well. Otherwise it is hard. Some days there have only been three care staff. We need the fourth. But this is not as often recently" and "The activities coordinator is sent on escort duty and that means no organised activities take place."

On the first day of inspection two staff went to escort people to appointments, leaving two units short of a member of staff. We were told one escort duty was for a 'quick appointment' but the member of staff was away from the unit for four hours. The staff left on duty were rushed and there was little engagement with people. On one unit several people were sitting in the lounge, sleeping in their chairs. There was minimal interaction from staff other than when it related to a task being carried out. Breakfast was late on one unit, and later on people were not ready in the dining room for their lunch, which was disorganised and rushed.

Where people were on observation charts and being observed every 15 minutes to ensure their safety and wellbeing within the unit, staff were not recording this until after the lunchtime, so did not evidence the checks were taking place. We visited one of the units again on the second day of inspection, when it was fully staffed, and saw staff had time to spend with people, the lunchtime experience was positive and activities were taking place. On one unit people's call bells were not always given to them and people also told us they had to wait at times for their bells to be answered, giving staff shortage as the reason for this. We brought the call bell issue to the attention of staff who addressed it at the time of inspection.

We found a shortage of one or two staff in the mornings on each day of inspection, and the reasons given were short notice absence. The service employed agency staff to help cover, however it was not always possible to get someone at very short notice and we saw staff were deployed to other units to assist. The activities coordinators helped with escorting people and a member of the laundry staff was assisting with breakfasts on one unit, whilst waiting for a carer to come in at 09:00 to assist.

We viewed the staff rotas for November 2014 and noted many alterations and shifts when staff numbers for nurses and/or care staff were less than those stated on the staff build up document. This was a document which laid out how many staff should be on duty for each unit, based on dependency levels and on the numbers of people living there. The service had an ongoing recruitment drive and

Inadequate

Is the service safe?

had recently recruited 21 new members of staff, several of whom had started working at the service. The management were aware of the impact staff shortages were having on staff morale and practice, with staff becoming task driven and not providing care in a person centred way. The management had sent an action plan in respect of staffing to CQC shortly before the inspection and were continuing to work to ensure enough staff were appointed. People, visitors and staff we spoke with were aware of the recruitment, and some acknowledged there had been improvements in staffing.

This is a breach of Regulation 22 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Assessments were in place for areas of risk, including moving and handling, nutrition, falls, challenging behaviour and skin integrity. For one person no specific risk assessment had been carried out regarding smoking and the use of oxygen. For another bedrails were in use and no risk assessment was in place and no assessment of the person's capacity to consent had been undertaken. For another person with bedrails the assessment had been completed but was not signed or dated, so it was not possible to identify how current the assessment was. This indicated risks were not always being assessed so the action to be taken to minimise any risks was not identified. Moving and handling assessments had been completed and we saw staff using equipment appropriately to move people safely. Where people were using wheelchairs, we observed that all had footplates and people's feet were correctly placed, so they were being supported safely.

We viewed a sample of maintenance and servicing records, and these were up to date. Weekly fire alarm and extinguishing equipment checks had been recorded and monthly checks had been done for emergency lighting, bedrails and window restrictors to ensure they were in good working order.

Inadequate

Is the service effective?

Our findings

Three new staff we spoke with had received induction training of varying lengths. One had received a four day induction training, however two others had only received one day, as the service had been short staffed and they were rostered to work shifts thereafter. We viewed the training record for staff at the service and spoke to staff about the training they had undertaken. Staff said they had undertaken training in health and safety topics, however the training statistics for these were between 30% and 52%, based on the frequency of attendance stipulated by the provider, some of which were every 6 months and others annually. We saw only 10% of staff had undertaken training in dementia care, and the majority of staff we asked confirmed they had not received this training. No staff were identified as having received customer care training, which is listed on the training documents as training for staff to complete. Some of the approaches we observed were not in line with best practice. For example, staff not speaking to people when carrying out a task or engaging with them at mealtimes. Some of the people we spoke with said staff did not understand their specific diagnoses and how to therefore care for them effectively. For example, one person said, "Staff don't know about [diagnosis]. I have to tell them information – such as the type of diet that's best for the condition." The manager had already identified shortfalls in training and informed us a trainer for the provider would be working at the service from the following week to identify staff training needs and introduce a training programme to address them.

We viewed the staff supervision timetable. It recorded staff had received between one and four supervisions in 2014, with most having one or two and some not listed as having received any. Two staff said they did not know what we meant when we asked if they had received supervision and five other staff said they had not had any. Others confirmed they had received one to one supervision. The manager was aware the supervision needs of staff were not being met, and that work was needed to address this.

This is a breach of Regulation 23 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people's freedom was not unduly restricted. Where restrictions have been put in place for a person's safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. Staff had a varied knowledge of the Mental Capacity Act 2005 (MCA) and DoLS. One nurse was able to describe what it meant to act in someone's best interest and other staff knew people had the right to leave the units if they were able to make the decision for themselves, but staff had not received training in MCA and DoLS and were unable to describe DoLS to us. Staff understanding of the use of capacity assessment documentation was limited. On one unit we viewed two capacity assessment documents. One stated, "he lacks capacity to make decisions." Another, "suffers from vascular dementia/confusion." No specific decisions had been assessed and recorded. We found similar issues on two more units with the capacity documents we viewed. We also found forms to record people's wish not to be actively resuscitated (DNAR forms) had not always been completed in full, so it was not clear if people or those with the legal right to act on their behalf had been involved in making such decisions. The manager was aware of this and action was being taken with the GP to address this, so people's wishes were known. Two forms were updated and completed during our inspection, so the people's wishes were recorded and could be respected. On one unit where people had the capacity and ability to access the kitchen area for drinks and snacks, there was a gate preventing them accessing the room. We discussed this with staff who said people could not access the area as they could harm themselves. Whilst staff were demonstrating a wish to protect people from harm, this indicated people were not being assessed and allowed to take acceptable risks to maintain their independence.

This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Policies and procedures in relation to the MCA and DoLS were in place and the manager understood the criteria and process for making a DoLS application. We spoke with the manager and saw applications for DoLS assessments had been made and we viewed completed documents for four people using the service. This showed where it had been identified people lacked the capacity to make decisions for themselves, action had been taken to follow correct

protocols to address this. We asked the manager about advocacy services and she said she would contact the independent mental capacity advocate to seek advice should this be required.

We observed the lunchtime meals during the inspection. Overall people appeared to enjoy the meals that were provided. One relative commented "the food is ok, they seem to have a lot of repetition of the same food. They could make more of afternoon tea, with some nice cakes that are soft and not like the rock hard scones that were served today." Apart from people who had diets to meet their cultural or healthcare needs, the menu choices appeared to be the main meal only, so it was not clear how people's individual choices were ascertained. There were no picture menus shown to people and staff did not serve both options to show people what choices were available. We saw meal choice forms had been completed for some units, and staff said they asked people what they wanted, however people we asked were not always aware of this. The chef said he met with people when they came to live at the service and discussed their meal preferences, however he said when the menu forms were not completed it was difficult to provide people with meals of their choice. When we asked a member of staff how they knew what someone wanted to eat they said, "this person always chooses the main option." Comments from people about this included, "We don't get asked about the menu but if you don't like something you can ask for something else and they will provide it if they have it.", "I choose what I want.", "I am happy with what they give you." and "There is a choice but it's very limited."

Where people required support at mealtimes this was undertaken respectfully with staff sitting down with people and providing assistance in an unhurried manner, even when the units were short of staff. Drinks were offered throughout the day. We noted that in the early evening, some people on one unit were being served with supper at 16:30. Staff explained this was in order to have time to assist all those who needed it. When we questioned how people with limited or no ability to communicate would be able to indicate if they were hungry during the night, staff said there were drinks including milky drinks available overnight. We viewed a sample of the food and drink records, and noted people had been recorded as having drinks at 22:00 the previous evening. We fed back the mealtime issue to the manager who said the mealtimes would be reviewed so people who could not communicate their wishes were not left at risk of being hungry.

We discussed the provision of meals to meet people's cultural needs. The chef was aware of those that required specialist diets, for example, a halal diet. Where some people did not eat certain meats, they were ordered a vegetarian diet, rather than a meal to meet their specific needs. The chef said he was happy to provide meals to meet people's needs, however he needed the staff to supply this information accurately on the menu choice forms, and we saw forms had not always been completed. We were also told that some meals for people requiring special diets were the same for lunch and supper, which the chef confirmed. The manager said this would be reviewed to vary the two meals provided. We observed that nutritional supplements were provided for people that had been assessed as needing them. Nutritional assessments had been carried out and care plans for eating and drinking were in place. Where people were identified as being at nutritional risk, food and fluid charts were being completed to monitor their intake. People were weighed monthly and where a significant change was noted referrals had been made for them to be seen by the dietitian and GP, so their weight loss was monitored.

This is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

We saw people received input from healthcare professionals including a GP, dietician, chiropodist and optician. Where people's needs changed we saw that referrals were made to the appropriate healthcare professionals. For example, the tissue viability nurse was involved in offering support to people who had wounds, the palliative care nurses worked with the service to support people with their end of life care needs and where people had been seen by the dietician, instructions for meeting people's specific dietary needs were recorded in the care plans, which were being followed. The GP visited twice a week and provided significant input for the service. All the care records viewed detailed the outcomes of any healthcare appointments and any changes to care required. People confirmed they received input from healthcare professionals when they needed it and relatives said they were kept up to date with healthcare concerns

Inadequate

Is the service effective?

and input from healthcare professionals. We spoke with the GP who confirmed staff followed instructions for changes in treating people's healthcare needs, so their changing needs were met.

Requires Improvement

Is the service caring?

Our findings

We observed staff interacting with people and the majority of the time this was positive and staff listened to people and responded to them appropriately. Staff were seen conversing with people in a gentle and caring manner, showing respect, and people responded positively to staff. We observed three staff who did not always treat people with respect, for example, walking into people's rooms without knocking or not communicating with people when providing them with help and support. We observed positive interactions when someone wanted to go to bed in the middle of the day and this was respected. Another person exhibited behaviour that challenged and staff managed the behaviour in a dignified and respectful manner. We observed some staff with a good understanding of individual's needs, however this was not reflected on all units and we observed some care was task driven and not personalised to the individual. For example, moving and handling tasks carried out with no interaction and one member of staff not communicating during activities.

On five of the units the majority of bedroom doors were kept open unless people were receiving care. Some people had stated a preference to have their doors open or closed and this was recorded, however we only saw this in a few of the care plans we viewed, so people's wishes had not always been sought. On one unit when we arrived at 07.30, most people were sleeping, however lights and televisions or radios were on in several of the rooms and cleaning staff were working in the corridors. We asked the nurse why doors were open and they told us "so we can monitor throughout the night without disturbing people with banging doors." They said that some people preferred the door to be left open but agreed that this was not the reason as most had not been asked. People we asked said they were able to get up and go to bed when they wished, and people's preferred waking and retiring times were recorded in the night care plan in some of the records we viewed. We spoke with the manager about our findings, who told us she had already identified customer care issues to be addressed through supervision and training session

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Feedback from people and their relatives was mainly positive about the staff and the care provision in the service. Comments from people included, "I like it here. Carers and nurses and cleaners are all lovely," "Staff are pleasant and nice, the whole place is good" and "I like everyone. The carers are good." Comments from relatives included, "The staff are very good, they check on my [relative] regularly and if they can't attend to her straight away they let us know," "I don't worry about [my relative] when I am leaving the home" and "The night staff are really on the ball. They select clothes and jewellery that match, [relative] likes to look nice" We spoke to staff about how they care for people and one night carer said, "We look after them as if they are our own, we put ourselves in their shoes." One social care professional we spoke with confirmed they were happy with the care being provided to their client.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they had been involved in assessments to identify the person's needs prior to coming to live at the service. Care plans were in place, however most of those viewed were very general, covering basic care to be given, and did not reflect clearly people's individual requirements and wishes for each aspect of their care. Care records had been reviewed monthly, however we did not see evidence of people being involved in these reviews, so their opinions were not being sought with regard to any changes in their needs or wishes. Reviews were often repetitive, for example, for someone with a care plan for behaviour that challenged, the comment, 'no challenging behaviour seen', had been repeated in the review for several months, and no other action had been taken to update the care plan to reflect the person's current condition. We observed one member of staff who did not follow the information in a care plan for a particular procedure and when we asked, they explained the person's needs had changed. We viewed the person's care plan and the information had not been updated. The staff member acknowledged they had not informed the nurse of this change and the records had not been updated.

We asked people and, where appropriate, their relatives if they had been involved in the development of their care plans, so they could identify the care and support they or their relative needed. Most people said they had not been involved and we did not see input from people or their relatives recorded in the care records we viewed. Some people had been involved in annual reviews, but the information recorded was sparse. Clear details about people's lives and interests had been included in several of the assessment and life history documents viewed, however the information had not always been transferred onto the care plans, so staff did not have this information easily available to them. The senior clinical lead said this issue had been identified and showed us a simple one page 'snap shot' document that was being introduced to provide staff with clear information about each person, their needs and interests.

Three care plans we viewed for end of life care were incomplete and needed further input to fully reflect the people's current needs and wishes. We spoke with some relatives of people receiving end of life care and they were pleased with the care being provided and praised the staff. This indicated the care being provided was appropriate, however the records were not up to date. This placed people at risk of receiving care that did not meet their current needs, as changes in their needs had not always been recorded.

This is a breach of Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

We viewed the complaints file and saw complaints received had been recorded, investigated and responded to in a timely way. We did not see a copy of the complaints procedure on display in the service. People and relatives we spoke with said they would feel able to complain, however they did not have a copy of the complaints procedure to refer to and did not know what to do if they were unhappy with the response to a complaint. We spoke with the manager who said she had identified people and their relatives did not know the process to follow to raise a concern with the service or with the provider, and felt this was partly why complaints were being received directly by the local authority and CQC. Prior to our inspection a relatives meeting had been arranged for 28 November and complaints were on the agenda for discussion at that meeting. The manager also had copies of the complaints procedure to give out to people and their relatives to provide them with the information they required to raise any concerns.

This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

We viewed three care plans for wound care. These included body mapping, assessments of skin, pain assessments, photographs, equipment in use including the type of mattress and frequency of dressings and condition of the wound. Where changes to the dressing products were required, the care plans had been updated to reflect this. Turning charts were in place for people identified at risk of developing pressure sores, so the frequency of changes of position was recorded and monitored.

We spoke with two activities coordinators. They were enthusiastic about their work and told us about the activities and outings they arranged to meet people's interests. However they were aware of the limitations on activities when the service was short of staff, as they then helped out with providing support to people. We noted activities coordinators being sent to escort people to hospital and there was then a limited programme of

Requires Improvement

Is the service responsive?

activities being provided, with little or no activities taking place on some units we visited. There was a hand written programme of activities on display on each unit which was not easily accessible for people to read. We saw out of date activities programmes had been left in people's rooms, which was confusing and did not provide people with an up to date programme to follow. On two occasions during the inspection we saw people in the sensory room enjoying a sing-along session. A game of bingo was played, however several of the people attending were not able to engage with the activity and there were not enough staff to support and encourage them.

We received comments from people and relatives about the lack of activities, including, "People are just sitting around all the time. There is no mental stimulation at all. There just is not enough for people to do in the day" and "Could do with more activities – there is not much to do." We observed a member of staff playing pool and doing art work with two people, however they did not speak with people whilst doing this. We saw people being engaged with making plans for the Christmas Fair and getting involved with deciding on prices of items for sale. A religious service took place during the inspection and people were told about this and were given the opportunity to attend. A movement class took place and we were told this was a regular event that took place every 2 weeks. People told us they enjoyed activities when they took place and they liked to get involved.

Requires Improvement

Is the service well-led?

Our findings

There had been several changes of manager and the registered manager had been in post since August 2014. The service had experienced a high turnover of staff, especially care staff, which had an impact on the continuity of care, the quality of the care provided, positive relationship building and stability. Staff we spoke with told us that the management of the home had been reactive rather than proactive. For example, one member of staff told us there were "no proper plans in place when service users require an escort to attend an appointment, or if we have training." Staff told us the new manager was visible and made a point of visiting all the units each day and asking staff about any issues/concerns for that day, so she was aware of them.

People, relatives, staff and the healthcare professional we spoke with were positive about the new manager, and felt she was approachable, listened to them and was making changes to improve the service. We saw minutes of recent staff meetings and for meetings for people who used the service and their relatives. Issues and comments had been recorded and also any actions to be taken to respond to them. We viewed the audits carried out by the manager as part of the internal quality assurance monitoring for the service. These included reviewing accident records to look for trends, such as time of day when accidents occurred so action could be identified to try and minimise the risk of recurrence. Surveys had been carried out for relatives in the summer and comments had been collated at the end of September 2014. Staffing shortages and changes were raised as a concern by the majority of relatives who had made comments. Recruitment was ongoing at the time of inspection and agency staff were being used to cover staff absences and shortages. Comments from the surveys for other areas, for example, laundry and environmental issues, were included as agenda items for the forthcoming relatives meeting, showing the manager was aware of the concerns and would provide feedback to people on issues raised.

The latest fire risk assessment had been carried out in August 2014. There was an action plan for items to be addressed, and these were identified as high, medium or low priority. The high priority ones had been completed, however the medium and low risk ones were still to be addressed. A risk management review carried out in September 2014 identified the need to record the weekly flushing of water outlets in vacant rooms against the room number, so any concerns that might arise could be isolated to an area, however we found this still needed to be actioned. These points were discussed with the management team at the time of inspection, who said they would be addressed.

Other areas where we identified shortfalls including medicines management, staff training, staff knowledge of safeguarding and DoLS and the quality of the care records we viewed showed the auditing processes in place for quality and monitoring purposes had not been effective in identifying concerns so they could be addressed.

This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

We did not see evidence of best practice guidance being followed on the dementia units or for people that required palliative care. For example, the lack of activities taking place, and on one dementia care unit the television and music system playing at the same time, plus a clock showing the wrong time and no one had adjusted it, all of which could add to people's confusion. Three care plans viewed for people with end of life care needs were incomplete, placing them at risk of not having their needs met. Relatives we spoke with on the unit were complimentary about the care their family member was receiving. We discussed research based best practice and recognised guidance with the manager, who quoted the National Institute for Clinical Excellence (NICE), the Alzheimer's Society and the Gold Standards Framework for end of life care as sources of good practice guidance. However, at the time of inspection there was no evidence of best practice on the dementia units and for people that require palliative care. The manager was aware the staff needed to be given training in line with current good practice guidance in topics specific to people's individual needs and diagnoses, in order to enable them to meet people's individual needs effectively.

At the time of inspection there was additional management support in the service put in by the provider to support the registered manager. We spoke with the registered manager, the clinical operations director for the provider, regional and support managers for the provider and the service. Since starting work at the service the manager had identified several areas where improvements were required. For example, the need to recruit more staff and to

Requires Improvement

Is the service well-led?

provide staff with a comprehensive training programme. The management team were also aware of the issues that had been identified in the monthly provider's audits for quality assurance, for example the shortfalls in staff recruitment records. The clinical operations director agreed the auditing processes were not robust enough and said action was being taken to address this at provider level, to develop a more comprehensive monitoring process so issues were identified promptly and could be addressed. The clinical operations director said the provider was aware of the problems with the service and the need for a sustainable recovery plan to bring the service back up to a good level. We provided feedback from our inspection and the management team accepted our findings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have an effective system to regularly assess and monitor the quality of the services provided and to identify, assess and manage risks to the health, welfare and safety of people using the service. Regulation 10(a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not have suitable arrangements in place to safeguard people against the risk of abuse. Regulation 11(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not always protect people from the risk of inadequate nutrition and dehydration. Regulation 14(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure people were enabled to**

This section is primarily information for the provider

Action we have told the provider to take

participate in making decisions about their care and understand the choices available to them. The registered person did not always ensure people were treated with consideration and respect. Regulation 17(1)(a) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place to bring the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format. Regulation 19(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did not ensure people were protected against the risks of unsafe or inappropriate care and treatment because accurate records in relation to the care and treatment provided to people were not always maintained. Regulation 20(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not operate effective recruitment procedures to ensure that only suitable people were recruited to care for and support people who use the service. Regulation 21(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure staff received appropriate training and supervision to enable them to deliver care and treatment safety and to an appropriate standard. Regulation 23(1)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person failed to protect service users against the risks associated with the unsafe use and management of medicines.**

The enforcement action we took:
We served a Warning Notice on the Registered Provider on 5 February 2015, to become compliant with the regulation by 19 February 2015.