The Granville Care Home Limited

Granville Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 June 2017 and was unannounced. This was the homes first inspection and rating.

Granville Lodge is a care home with nursing care for up to 81 predominately older people. People have general nursing care needs and some are living with dementia. At the time of our visit there were 75 people living at the home.

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 of the Health and Social Care Act 2008.

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

Appropriate moving and handling techniques were not used by staff. Moving and handling equipment was not used safely by staff.

Checks were not always carried out on some equipment within the premises. Some safety equipment had not been maintained and repaired in a timely manner.

We observed poor care practices in relation to dignity and respect. People's dignity and wishes were not always respected by staff.

We found that the home had systems in place to assess and monitor the quality of service. However, they were not always effective. We had identified areas that require improvement, which were not picked up by the quality assurance processes.

Staff were knowledgeable about recognising the signs of abuse. All staff had received training in safeguarding adults.

Medicines were administered to people safely by staff that had been trained.

There were sufficient numbers of staff to ensure people's needs were met. The registered manager carried out pre-employment checks on staff before they worked with people to assess their suitability.

The home was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had received appropriate training, and had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff received induction and training. A training programme was in place and staff had been encouraged to complete all mandatory refresher training. Staff had supervision meetings and team meetings were held to support them in their role.

People were satisfied with the quality of the food and drinks provided. Food and fluid intake was monitored where risks of weight loss or dehydration had been identified. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

People said they were treated in a kind and caring manner. People were able to make choices about the way they were cared for.

Activities were personalised for each person. People made suggestions about activities they wanted to participate in each day.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Manual handling techniques and the equipment used for providing care or treatment to people was not always safe or used in a safe way.

Required checks carried out on the equipment within the premises were not always carried out. Some safety equipment had not been maintained.

There were sufficient numbers of staff on duty to meet people's needs. Recruitment procedures were robust.

People were protected by staff who knew how to recognise and report suspected abuse.

People received their medicines safely as prescribed.

Is the service effective?

Good

The home was effective.

People were supported by staff who received an appropriate induction and ongoing training and support.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. The registered manager knew their responsibility under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to protect people.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

People had access to healthcare services and had their healthcare needs met.

Is the service caring?

Requires Improvement

The home was not always caring.

People's privacy and dignity was not always respected by staff.

People told us they were happy with the care they received and with the caring approach taken by staff.

People had choices about their care. People were supported to maintain relationships that were important to them.

Staff supported people to maintain their independence.

Is the service responsive?

Good

The home was responsive.

People had plans of care in place that detailed the care and support they needed. These were regularly reviewed.

The care and support people received was person centred and focussed on an individual needs and wishes.

People were supported to participate in activities, interests and hobbies important to them.

People had access to the home's complaints procedure should they have wished to of made a complaint. There was a formal complaints process in place and people knew what to do if they were concerned or worried about anything.

Is the service well-led?

Requires Improvement

The home was not always well-led.

The provider had systems and processes for assessing and monitoring the quality of the home, however these were not always effective. Audits undertaken had failed to identify the shortfalls within the home.

There was good management and leadership at the home.

There were systems in place to gain feedback from people and we saw examples of where necessary improvements had been made.

Granville Lodge

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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 20 and 21 June 2017 and was unannounced. The inspection team consisted of three inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spent time on both floors. The upstairs was called the Nightingale unit and was for people with nursing needs. The downstairs was home to people living with dementia and called the Kingfisher unit.

Prior to the inspection we looked at the information we had about the home. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the home is required to send us by law. We had not requested the provider to complete the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give information about the service, tells us what the service does well and the improvements they plan to make.

We contacted four health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We received a response back from four professionals. Their comments have been included in the main body of the report.

Some people were able to talk with us about the care they received. We spoke with 12 people who lived at the home. We also spoke with the relatives of two people. We sat and observed other people who were unable to communicate.

We spoke with 13 staff which included the registered manager, deputy manager, two care managers, two senior care staff, activities coordinator, care staff and domestic staff.

We looked at the care records of eight people living at the home, six staff personnel files, training records for

all staff, staff duty rotas and other records relating to the management of the home. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the home. Comments included, "I feel safe anywhere it's the company here that's the good thing", "Yes, I do"," Safe yes there's nothing to make you feel unsafe when we both came here we had a feeling that this is where we should be", and "Yes, I feel safe the staff look after me very well". We observed the care and support they were provided with throughout the day. People look relaxed in the company of staff. Health care professionals expressed no concerns about the care of their patients.

People did not always receive safe care and treatment and steps were not always taken to mitigate the risks. We spent time observing people and listened to staff interactions. We witnessed on three separate occasions staff that worked on the Kingfisher floor had used inappropriate and unsafe manual handling techniques. We observed people being assisted to transfer by pulling them up from under their arms. This technique should no longer be used in practice as this can cause injury or harm to people. On another occasion, we observed staff had used a shower chair to wheel one person from upstairs to the downstairs shower room. The distance to the shower room was lengthy and the shower chair did not have a belt fitted to the chair. This could have caused injury to the person. We immediately brought this to the attention of the home's management team who spoke to the staff involved and debriefed them on reasons why this was unsafe. All staff that worked at the home had received manual handling training and the registered manager was also a manual handling trainer. Although the home had taken responsive action at the time to address the concerns we raised this was reactive to our findings. This meant manual handling techniques and equipment used for providing care or treatment to people was not always safe or used in a safe way.

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

Maintenance records were checked regularly by the home including water supply, fire safety, electrical and gas.

Whilst looking at the maintenance records of the premises we checked how regularly the emergency lighting at the home was tested. Emergency lighting is lighting for an emergency situation when the main power supply is cut and any normal illumination fails. The loss of mains electricity could be the result of a fire or a power cut when normal lighting supplies fail. The emergency lighting was tested by a contractor in October 2016 and 50% of the emergency lighting was found not to be working. The provider asked the contractor for a quote to have the work completed and to have new emergency lighting units fitted.

Due to a communication error the contractor did not respond to the email from the provider to carry out the essential work. As a result the home had also not tested the emergency lighting themselves since October 2016. We highlighted our concerns to the provider who immediately contacted the contractor to find out what happened. The contractor sent out a maintenance person to the home the next day who ordered the replacement light fittings.

Due to our findings in relation of the failure to regularly test the emergency lighting or carry out essential works without delay we contacted the local fire service to share are concerns with them.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about safeguarding vulnerable adults and how to report concerns. All staff we spoke with were able to explain how they would report any concerns they may have. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made to the Local Authority.

We observed visitors to the home were required to sign the 'visitor's book' kept in the reception area. Visitors recorded their name, the time they arrived and left the home. The reception desk was also manned by staff during day time to oversee visitors coming and going. Outside of this time an intercom system was used to communicate with staff.

Systems were in place to monitor any accidents and incidents. We looked at accident and incident reporting within the home and found that these were reported and recorded appropriately. Accidents and falls were recorded in people's care records. When people had fallen a 24 hour falls monitoring assessment was put into place and that recorded observations of people closely. Post fall action plans were also put into place to reduce the risk of further falls and to identify any trends.

We spoke with the registered manager about staffing levels at the home. They showed us the dependency assessment tool that the provider had introduced to the home. The dependency tool had been used to determine the number of staff required to meet people's needs. The registered manager told us that they used the dependency tool monthly to identify if staffing levels were sufficient. We looked at the staffing rota for the past month prior to the inspection and found staffing had been planned in advance to ensure sufficient staff were available to support people.

Our observations during the inspection showed us there were sufficient numbers of staff on duty to meet people's needs in a timely way. For instance, call bells were answered quickly, people were not rushed with their meals and we observed staff sitting and talking with people throughout the inspection. We spent time on both floors during the two day inspection and found that staff were present most of the time. A member of staff told us they were unable to leave the lounge on Kingfisher. They said there should always be one member of staff in this area to ensure people were safe and to support them when they needed assistance.

People's medicines were stored and administered safely. Medicines were stored securely following current guidelines for the storage of medicines. There was a dedicated room for storing people's medicines. The room was clean and well organised. A fridge was available to store medicines which required lower storage temperatures.

As part of the inspection we looked at the Medication Administration Records (MAR), and associated medicines records in the care plans and daily care notes of 12 people. We saw that when people were administered medicines prescribed with a variable dose that the actual dose administered and the reason for administering a particular dose was recorded. The home had a syringe driver (devices to administer medicines automatically over a set period of time), which belonged to the provider. This syringe driver was labelled as last tested in April 2017 and there was a service agreement in place for this. If the home needed more than one of these devices then they had an agreement with another local provider to borrow these.

We found that there were weekly checks of the MAR charts to identify errors and gaps in recording. These checks had not picked up all of the recording discrepancies that we identified but had identified the majority. On the second day of the inspection the recording discrepancies had been put right and the MAR charts audited. A plan had been put into place to audit the MAR daily.

We looked at six staff recruitment records and spoke with staff about their recruitment. We found that recruitment practices were safe and the relevant checks were completed before staff worked at the home. The provider had recently recruited a number of staff from overseas through a recruitment agency. A minimum of two references had been requested and checked. Disclosure and Barring Service checks (DBS) had been completed and evidence of people's identification, the right to work in the UK and medical fitness had also been obtained. A DBS check allows employers to check whether the staff had any convictions which may prevent them working with vulnerable people. A number of staff employed had transferred over from the previous provider. To ensure the provider had a good insight into the staff's recruitment prior to taking over the home all staff recruitment records had been audited. This was to ensure that staff had been safely recruited.

Good

Is the service effective?

Our findings

Staff said they felt supported by the registered manager and they attended on-going training on a regular basis. Comments included "I feel very much supported in my role by the manager and by the staff", "We are continually encouraged to learn and develop within are role", "Yes I am supported well by my manager. I know what is expected of me and training is high on the agenda".

Staff received an induction when they started working at the home. Staff said their induction had consisted of completing mandatory training. New staff shadowed experienced members of the team until both parties felt confident they could carry out their role competently. A number of staff employed had transferred over from the previous provider. The registered manager and provider had put a plan into place for existing staff to receive an induction under the new provider. We spoke to the registered manager about if staff that were new to care had completed the Care Certificate. The Care Certificate is a nationally recognised training programme for care staff, which required the completion of work books and practical assessments. At the time of our inspection new staff had not completed the Care Certificate however an action plan was in place and staff were signed up to undertake this in July 2017 through a reputable training provider.

Records confirmed that staff had undertaken training on key areas that would give them the knowledge and skills required to support the people who lived at the home. Training records confirmed that staff had completed moving and handling, dementia awareness, infection control, first aid, safeguarding vulnerable adults, mental capacity, health and safety, communication, equality and diversity. The registered manager had developed a staff training spreadsheet, which clearly detailed what training staff had completed, the date of when the training had been completed and the date of when the refresher training was next required.

Staff told us most of the training they completed was carried out through computerised programmes. Some training was also by an external training company who carried out face to face training with the staff at the home. The registered manager told us staff could also access computerised training by downloading applications on their mobile phones. Administration staff told us computerised training programmes could be adjusted to suit staff. An example being the language spoken of the trainer could be changed to suit the different nationalities of staff. This meant training was planned and was appropriate to staff roles and responsibilities

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection two applications had been

authorised by the local authority. Records confirmed a further 52 application forms had been submitted and were awaiting assessment by the local authority. These were submitted as some people could not freely leave the home on their own, also because people required 24 hour supervision, treatment and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

Records we reviewed confirmed that a number of people were having their medicines administered covertly (in a way where they may not know that they were taking the medicines) and when this was happening this had been discussed as part of a best interests multi-disciplinary meeting and where necessary an application for a DoLS had been made to protect the person. Clear protocols were in place to support the staff administering medicines to make the decision on how to give medicines prescribed to be taken when required.

Staff communicated effectively within the team and shared information through regular, daily handovers. Staff confirmed they received essential information and discussion was held regarding people's health needs. This supported staff to have the relevant information they required to support people. Care records showed it was common practice to make referrals to relevant healthcare services quickly when changes to health or wellbeing had been identified. Notes evidenced where health care professional's advice had been obtained regarding specific guidance about delivery of care.

Health professionals who were involved within peoples care at the home included chiropodists, opticians, dentists, dementia wellbeing team, mental health team, district nurses and the tissue viability nurse. The local GP surgery provided an in-house weekly surgery. Outside of this time they would visit the home when needed. Professionals involved with the home made the following comments, "We endeavour to do teaching/give feedback to staff and are often joined by more junior staff at Granville Lodge who are keen to gain experience", and "I really like this care home it has a nice atmosphere".

People living at the home spoke highly of the food at Granville Lodge and considered there was enough choice and variety of wholesome nutritional food. Comments included, "Food is very nice and we get a good choice and if we don't like it we would say", "Food is very good I eat too much and I've put on weight", "We get a choice of two main meals and my favourite meal is Lasagne. I never get hungry at night", and "The food is a good standard I'm an ex chef and I get two choices of menu and my favourite meal is steak and kidney pie and I get that here".

The home had a rolling menu plan, copies of which were displayed for people to view. Downstairs on the Kingfisher unit pictorial menus were displayed along with photos of the daily food options. The menus offered a choice of two options at every meal time. During the inspection we observed two lunchtime meal sittings. People were given a choice of a main meal, dessert and drink. People that required assistance from staff with eating or drinking were given this in a timely manner. The mealtimes were relaxed with a calm atmosphere and exchanges of conversation between people. The chef was able to accommodate special dietary requirements such as people who were diabetic or were at risking of choking. Some people had food supplements to meet their nutritional needs. Those at risk of poor nutrition were observed closely, had food and fluid charts in place which were completed accurately and they were weighed regularly.

Requires Improvement

Is the service caring?

Our findings

We asked people if they were happy living at the home and if they were happy with the care they received. Comments included," Yes, it's very nice. The staff they are very thoughtful and helpful. They find out our needs before they come to us"," Oh yes I love it you couldn't get a better lot of staff if you tried". One relative we spoke with said they always felt welcome and staff were polite. They spoke positively about staff at the home.

There were mixed observations about people being cared for in a dignified way throughout our inspection.

People's dignity was not always respected. During both days of the inspection, inspectors observed several occasions within the Kingfisher unit where staff had assisted people. This was to either stand up or to support people to walk into the lounge to sit down. We noted some people appeared to have been incontinent as their clothing appeared visibly soiled and looked wet. On all of the occasions, we brought this to the attention of the staff who immediately assisted each person with personal care. Although responsive action was taken by staff this was reactive to our observations and findings.

On the second day of our inspection we observed one person was being assisted to the shower room by one staff member. The person was clearly distressed and told staff they did not want a shower. Although the person was covered over in some areas of their body we observed this was not dignified. Some other areas of their body were exposed as they were being wheeled through the corridor. The staff member continued to assist the person into the shower and closed the door. We could hear from a distance that the person remained distressed. We checked the person's care records, which clearly recorded that when the person was distressed two staff were to assist the person. This person on the day of the inspection was supported by one member of staff. We asked the registered manager to intervene as it was evident this person was not happy being showered. On a separate occasion we observed another staff member had wheeled a person through the corridor to the shower room. They also had areas exposed. Staff were not aware of their actions until we spoke with them. They then recognised that this did not respect people's dignity.

Although responsive action was taken by the registered manager to speak with the staff involved this was reactive to our observations of poor practices. This meant people's dignity was not always respected.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One professional that visited the home told us, "As far as I can interpret all the care staff and the management at Granville Lodge have a caring attitude towards residents and their relatives. I have observed that this ethos runs throughout the home and cooks, receptionist, cleaners and maintenance staff offer an acknowledgement and a positive conversation to residents in passing".

People's privacy was respected. People told us that staff respected their privacy. Comments we received included, "They knock every time they come into our room and they always make sure the doors are closed

and the curtains are closed", "Yes, they always knock on the door before they come into my room and they always close the curtains and the door before they do anything for me". We observed that staff respected people's privacy and routinely knocked on people's bedroom doors before entering. Staff addressed people by their preferred name which was often not there first name.

We observed people being offered the opportunity to attend the visiting hairdresser in the home's hair salon. Those who attended told us they enjoyed this experience. Some people having their hair done by the hairdresser required extra support and reassurance from staff as they were anxious. Staff spoke to people in a supportive and reassuring way that helped reduce any anxiety.

People were offered choices and encouraged to retain their independence .One person we spoke with told us how when they moved into the home they had limited independence due to an injury. They told us how the staff had worked with them offering support and encouragement which had led to them gaining independence. They spoke positively of staff and were proud of the staff for not giving up on them.

People were supported to maintain their preferred faith or religion. The local church held a service at the home the first Thursday of every month. People we spoke with confirmed that they were offered support to attend the service and were made aware when this was taking place.

Staff regularly communicated with those living at the home verbally but also with the aid of pictures and communication cards to translate languages. For some people living in the home their first language was not English however the staff had worked hard in finding effective ways to communicate with people. For example, staff communicated with people by using words of their preferred language. Staff referred to communication cards, which contained pictures which enabled people to show staff their choices and preference. This demonstrated how staff involved people in their own care; helped to support and establish choice and preference as well as ensuring that those living at the home were listened to and responded to.

The deputy manager told us that one person living at the home really missed their previous home as it had a nice garden and they specifically missed the roses growing in the garden. The deputy manager went over and above the call of duty and drove to the person's previous address to take a picture of the person's favourite flower. The deputy manager printed the photo and put into a photo frame for the person to keep in their room. They told us this meant a lot to the person who was overwhelmed with happiness in having a photo of their garden to cherish.

People were given support when making decisions about their preferences for end of life care. Arrangements were in place to ensure people, those who mattered to them and appropriate professionals contributed to their plan of care. The registered manager told us this ensured the staff were aware of people's wishes so they had their dignity, comfort and respect at the end of their life. Some families had chosen to remember their loved ones after they had passed away by donating a memorial to the home. An example being one family had donated a bench in memory of their loved one. Another family had asked the deputy manager if they could hold a themed party in the summer. This was to celebrate the memories of their relative's life.

Good

Is the service responsive?

Our findings

People told us they were listened to and the staff responded to their needs and concerns. We asked people if they had been involved in there care planning process. Comments included, "Yes, we have seen our care plans and it's my daughter that updates it for us" and "No, we never knew we had one". Care records confirmed that peoples care records were reviewed and people were asked to participate in review meetings.

We received the following comments from professionals, "All staff seem to demonstrate a caring interest in resident's wellbeing", "They always make me feel welcome and encourage their care staff to talk with me or my colleagues individually" and "I have felt assured that the appropriate line of enquiry/ action is taken".

Each person had their needs assessed before they moved into the home. Pre-admission assessments were then used in the formation of the person's care plan. Care records detailed the support people needed in the delivery of care in a range of areas. For example, people's needs in relation to eating and drinking, continence, mobility, personal care and emotional wellbeing were all described. Care records were person centred and contained information about people's needs and preferences. For example, information was recorded about what people liked to eat and drink and when they liked to go to bed.

People's care records included information about their personal life history. Personal life histories tell the life story and memories of each person and help staff deliver person centred care. They enable the person or relative to talk about their past and give staff and other professionals and understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

People were provided with personalised care that was responsive to their needs. People were assisted with their personal care at flexible times during the day. An example being one person asked staff for assistance to have a shave. Staff told us the person preferred to have their breakfast first before they shaved. People got up at different times during the day and had access to the outside garden. We observed people were sat outside in the garden enjoying the warm weather. Staff appeared attentive towards people and offered them regular drinks. When the weather started to become very hot during the day we observed staff advising people of this and the risks of staying out in the sun. People were offered assistance to come back inside of the home. People were encouraged to wear sun cream. A relative told us they had been requested to bring in a sun hat, which would afford them protection from the sun. Staff were also encouraging people to sit in the shade.

Where people had wounds the records contained a treatment plan, which included when the wound should be attended to Records were detailed and evidenced the progress of the wound. Wounds were regularly measured and photographed. The information recorded was comprehensive and reviewed on a regular basis. Where changes were noted to the person's needs, records were adjusted accordingly. Records confirmed staff had received the appropriate training in managing people's skin and wound care.

The home operated a key-worker system where each person had a named member of staff who led on writing and updating their care plans. People who were able to were encouraged to sign their care plan to acknowledge they were happy with the information recorded. People's needs and care plans were discussed with their relatives where consent had been given and they had the appropriate delegated legal responsibility.

There was a nominated 'resident of the day' each day. This meant that on that day the chosen 'resident' had their care plans reviewed by staff which involved the person. Staff also spent time with the person with one to one time during the day and carried out extra duties for the person such as tidying their room.

There was a varied programme of activities on offer that the people enjoyed. The activities plan was set out monthly by the home's activities coordinator and took into account people's interest. They included group activities such as; skittles, arts and crafts, ball games, parachute games, reminiscence and exercises. People were enthusiastic about joining in with the activities. For example, we observed seven people taking part in quiz which involved people throwing a bean bag on to the mat. Where this landed meant people had to answer a question about the different decade. People seemed to thoroughly enjoy this activity. Records confirmed during the month of June the home had a BBQ with a live entertainer. Some people also went on a trip to Bristol harbour side and photographs of this outing were displayed within the home. A musical activity was planned for people.

We asked people if they enjoyed participating in activities within the home. Comments we received included, "I like bowls and my favourite is reading or if there's a good film", "Yes, we like to play bingo and we get involved in other things". Another person told us "Yes, I like to play skittles but I can't move very well". One professional that visited the home regularly told us," I regularly see staff interacting with patients with games/music, which is good to see".

The home had a dedicated upstairs activities room that was full of activities for people to participate in such as games and arts and crafts. The registered manager had signed up to a two year programme to undertake an activities project within the home. This was to find ways in improving people's wellbeing and to strengthen links between the home with the local community.

People who lived at the home knew how to make a complaint and who to go to if they had concerns. People told us, "No, I have no concerns living here", "Staff are excellent and I cannot fault them. You won't find any complaints" and "I have no complaints and feel very happy here". Another person told us, "I am asked my opinion regularly but have only praise to give".

There was a complaints system in place and the registered manager had considered the circumstances of the complaint before providing a response. Since June 2016 there had been eight complaints raised about the home. Records were kept about each complaint received along with information about how each complaint was investigated and the outcome. Records confirmed that when required complaints had been escalated to senior management to investigate. We were told complaints were used as a way to look at improvements within the home. Details on how to make a complaint were available in the reception area and copies were kept on both units.

Requires Improvement

Is the service well-led?

Our findings

People living at the home were positive about the registered manager and deputy manager. Comments included, "The manager and the assistant manager are very nice people and I've spoken to them both and yes honestly they do a good job" and "That's no lie and the staff are brilliant they really are. They really look after the residents".

We received the following comments from professionals, "They seem well-led by the manager and deputy manager. Granville Lodge seem to have a good retention of care staff" and "Overall during the last 6-12 months there appears a marked improvement in organisation, with the new owners closely involved in day to day running".

The registered provider had taken over the home in June 2016 from another provider. Most staff had transferred over to the provider whilst other staff had left. The registered manager and staff had worked hard to implement changes to the home. The registered manager prioritised the changes that needed to be made and focused on the most urgent actions first. This included putting into place care plans for people as the previous provider had taken peoples care records with them. An action plan was put into place and the provider referred to the previous provider's last inspection report for guidance. It was clear from our conversations with the registered manager and provider that they were keen to learn and develop the service going forwards.

The registered manager was open and transparent and had clear visions and values of the home. They told us the main aim of the home was to continue to provide a high standard of care to people. They told us their focus for the next 12 months was to refurbish Nightingale unit in the home which was upstairs. This included turning a bathroom into a wet room. Plans were in place to redecorate corridors and some bedrooms along with replacing flooring. The Kingfisher unit had recently been redecorated and this looked homely and welcoming. The registered manager told us they involved people in choosing the colour themes.

Systems were in place to check on the standards within the home. Regular reviews of care records and risk assessments were undertaken by care staff. The registered manager undertook a range of audits to monitor the quality and service delivery. These included audits of medicine administration records and health and safety.

However, some of the audits undertaken had not been effective as we had identified areas that required improvement that were not picked up by the provider or registered manager. This was in relation to the poor manual handling practices of staff, safety of equipment and its maintenance and the poor care practices of staff in relation to people's dignity and respect. Audits had also not identified that moving and handling equipment such as hoists were not clean. This meant the registered manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

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

Staff said there was a personalised and open culture within the home. They spoke positively about the registered manager and deputy manager. Staff felt their approach was open and honest. The registered manager spoke passionately about the home. They told us they enjoyed their role and took pride in their work. Staff said they felt confident in the leadership of the registered manager. Staff we spoke we told us, "I feel valued in my job and enjoy coming to work" and "Things have really improved since the new owner has taken over. The residents and staff seem happy".

People's views about the care they received were sought and acted on. The last quality assurance survey was completed in January 2017 by people and their relatives. Positive comments were received about the home and their overall satisfaction. Comments included "Can visit anytime", "Kept fully involved" and "They all make you feel welcome". Results had been analysed by the registered manager and the overall results were shared with the staff, relatives and the people living at the home. Where negative comments had been made the registered manager took the time to meet with the person or their relative and actions were put into place. An example being guidance was given to staff around helping a person to shave daily.

There were also a number of written compliments received from people and their relatives. Comments included, "Your person centred care is amazing and would not hesitate to recommend your care services. Cannot thank you for the excellent care", "Mum was always clean, well fed and treated with perfect mix of dignity and respect" and "Thanking staff for excellent care, cannot thank them enough. The staff were kind and care and communicated readily with us". The registered manager kept a compliments book within the entrance area of the home. We noted that relatives and professionals had left positive feedback about their experience whilst visiting the home.

The registered manager appropriately notified the CQC of incidents and events which occurred within the service which they were legally obliged to inform us about. These showed us the registered manager had an understanding of their role and responsibilities. This enabled us to decide if the service had acted appropriately to ensure people were protected against the risk of inappropriate and unsafe care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person failed to ensure people were treated with dignity and respect. 10. (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Manual handling techniques and the equipment used for providing care or treatment to people was not always safe or used in a safe way. This meant the risks to the health and safety of people of receiving care or treatment had not always been considered. 12. (2) (c), (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Checks carried out on the equipment within the premises were not always carried out. Some safety equipment had not been maintained. 15. (1), (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a).