Grace Manor Care Limited

Grace Manor 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 21 July 2015. Our inspection was unannounced.

Grace Manor Care Centre is a care home which is registered to provide accommodation, personal and nursing care for up to 60 people. In 2014 the home was refurbished. The home now has a reduced capacity to care for up to 52 people as everyone is offered a single room. The home is a listed building which has been extended. Accommodation is set out over two floors with lift access to the first floor. On the day of our inspection there were 51 people living at the home. People had a variety of complex needs including people with mental health and physical health needs and people living with dementia. Some people had limited mobility, pressures ulcers and some people received care in bed.

The service did not have a registered manager. The previous registered manager had ceased working at the service in March 2015. The new manager had made an application to become registered with the Care Quality Commission.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated Regulations about how the service is run.

At our previous inspection on 07 August 2014 we found a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. We asked the provider to take action in relation to safe recruitment practice.

The provider sent us an action plan on 06 November 2014 which stated that they would comply with the regulations by 14 November 2014.

At this inspection we found that improvements had been made within the timescales they had given us. However, the improvements had not been sustained. As a result, they were breaching regulations relating to fundamental standards of care.

Effective recruitment procedures were not in place to ensure that potential new staff employed were of good character and had the skills and experience needed to carry out their roles.

There were not enough staff deployed to ensure that people received care and support in an effective and timely manner.

Accident and incidents were not always thoroughly monitored and investigated appropriately. Risk assessments lacked detail and did not give staff guidance about any action staff needed to take to make sure people were protected from harm.

Medicines administered were not adequately recorded to ensure that people received their medicines in a safe manner.

The training staff received did not give them the skills to support people effectively. For example, moving and handling practice we observed was not safe and put staff and people at risk of harm. Staff did not have access to all the information they needed about how to report abuse.

Meals and mealtimes did not promote people's wellbeing. People's health care was not planned or delivered effectively. People were not treated with dignity and respect or provided with personalised care. Staff were not responsive to people's needs or choices. People were not provided with meaningful activities. People were at risk of social isolation, they had limited contact with the local community. There was an institutional culture.

Decoration for the home did not follow NICE good practice guidelines for supporting people who live with dementia.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority and had been approved.

People were supported and helped to maintain their health and to access health services when they needed them.

People and their relatives knew who to talk to if they were unhappy about the service.

Relatives and staff told us that the home was well run. Staff were positive about the support they received from the senior managers within the organisation. They felt they could raise concerns and they would be listened to.

Communication between staff within the home was good. They were made aware of significant events and any changes in people's behaviour. Handovers between staff going off shift and those coming on shift were documented.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

Risks to people's safety and welfare were not well managed to make sure they were protected from harm.

There were not enough staff deployed in the home to meet people's needs. Staff did not have all the information they needed to safeguard people from abuse.

Effective recruitment procedures were not always in place.

People's medicines were not well managed and recorded.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have all the essential and specific training and updates they needed. Staff did receive supervision and said they were supported in their role.

Meals and mealtimes did not promote people's wellbeing.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not treated with dignity and respect. Some staff spoke to people in a demeaning manner. People's confidential information was displayed in communal areas of the home.

People were not consulted about how they wanted their care delivered.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

People's and relatives views were gathered but feedback had not always been acted on.

Summary of findings

The home had a complaints policy, this was not on display in the home. The provider had responded to complaints in an appropriate manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was an institutional culture within the home.

Systems to monitor the quality of the service were not effective.

Records relating to people's care and the management of the service were not well organised or complete.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately. However, poor practice relating to moving and handling and treating people with dignity and respect had not been reported.

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

This inspection took place on 21 July 2015 and was unannounced.

The inspection team consisted of three inspectors, a specialist advisor who was a nurse with expertise in pressure area care and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law.

We spent time speaking with 13 people. Some people were not able to verbally express their experiences of living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas. We spoke with three relatives and two visitors. We also spoke with eight staff including the cook and the manager. We also spoke with the Operational Manager and Chief Compliance Officer.

We contacted health and social care professionals to obtain feedback about their experience of the service.

We looked at records held by the provider and care records held in the home. These included 10 people's care records, risk assessments, four weeks of staff rotas, eight staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

We asked the manager to send additional information after the inspection visit, including some quality assurance records and audits. The information we requested was sent to us in a timely manner.

Inadequate

Is the service safe?

Our findings

At our last inspection on 07 August 2014, we identified a breach of Regulations 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not followed safe recruitment practice. We asked the provider to take action to make improvements to staff recruitment. The provider sent us an action plan which stated they would meet the regulations by 14 November 2014.

At this inspection we found that the provider had made improvements to recruitment records but these had not been sustained.

People told us they felt safe living in the home and they thought the home was kept clean. One person told us, "The staff are brilliant I have clean sheets every day. The cleaner cleans my room every day". Another person told us "I have a lovely room it's cleaned every day". One person said, "It's great here I cannot walk far on my own, the staff walk behind with my chair. When I need to sit down they are there. It's not home but it's marvellous here". Another person told us, "I feel very safe here. It's my home and I am settled in here". People told us they got their medicine on time from the nurse and that they knew why they were taking them. One person told us "The nurse gives me my medication every day I have it for blood pressure. I also have to take iron tablets. Doctor says I am a bit anaemic".

Relatives told us that their family members were safe. A relative told us, "Yes. I feel she is safe. Plenty of people about popping in and out keeping an eye on her". Another relative said, "Yes he is safe. I am quite confident with the permanent staff. I cannot fault them". One relative said, "The home always looks well looked after. I often see men working here doing the maintenance. They have recently opened up the front door again and put in a new reception area at the front".

A visitor who visited their friend weekly told us "Every time I visit the home it always looks clean and well looked after. Her room always smells fresh and looks clean" and "She hasn't said anything to us. If she didn't feel safe she would soon tell us. I think staff are very good. We always see them show respect to everyone".

At the last inspection we found that home did not follow safe recruitment procedures. The provider stated in their action plan that they would carry out weekly meetings and checks to ensure that all of the necessary recruitment information was retained on staff files. The previous registered manager had made improvements and had ensured that the relevant documents were in place. However the provider had employed new staff since the registered manager had left and had not checked reasons for gaps in employment. One new staff member who had been employed in March 2015 had a gap of five years in their employment history which had not been explored. Another application form highlighted several gaps, of up to one year. Which meant that the provider had not carried out checks to ensure the staff member was suitable to work around people who needed safeguarding from harm. References had been received by the provider for all new employees. It was not possible to identify if they were up to date and current as the provider had not followed good practice by dating them when received.

The examples above were a breach of Regulation 19 (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff deployed on shift to keep people safe at all times. On the day of our inspection three staff had gone off sick. The manager had contacted staffing agencies who had supplied three staff members. During the inspection, we observed that 34 out of 51 people living in the home received their care in bed. Some people's bedrooms were isolated away from the main communal areas. We heard people calling and shouting for help during our inspection. We observed that some people were distressed and upset because their calls for help had not been responded to. Some staff did not have time to respond to people so ignored people's distressed calls and shouts. We spoke with staff about people calling and asked them to respond and check that people were ok.

Relatives and people told us they thought there was enough staff during the week however felt that the weekend staff were rushed. One person told us "Not really enough staff, staff are overworked they are always rushing around seeing to everyone. Harder for them at the weekend". A visitor said, "We come in every other weekend and have a meal with our friend. The staff are rushed off their feet, buzzers are going and they have to be answered and they are serving food, there doesn't seem enough

Is the service safe?

staff". A staff member told us "There's not enough staff on shift. You haven't got time to do the extra things like sitting in the garden with people. There is so much paperwork and tasks to do. Its task orientated. Sometimes people are sick and only six staff might be on". The manager told us that when staff went off sick, cover was arranged normally through agency staff. The manager told us that they were reviewing staffing levels in the home. The examples above evidence that there were not enough staff deployed to keep people safe at all times.

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

The provider had a safeguarding policy that was dated March 2015. This detailed the types of abuse and signs and symptoms of abuse and gave staff guidance about who to report their concerns to. However, the policy did not list contact numbers that staff would need to report abuse. The policy did not reference or the local authorities safeguarding adult's policy, protocols and guidance. We spoke with the manager about this, they confirmed that the local authorities safeguarding policy was kept in their office. They recognised this meant that staff did not have access to this when the manager was not there. However, most staff members we spoke with had a good understanding of abuse and how to report it. This meant that staff did not have access to all the information they needed about how to report abuse, including contact details for the Local Authority safeguarding team.

We recommend that staff have access to safeguarding policies and procedures which provides them full details of what to do should they suspect abuse.

People who were not able to move around independently were supported by staff. We observed people being helped to move in an unsafe way. We spoke with the manager about this and reported our concerns to the local authorities safeguarding department.

One person was sitting in the lounge in an armchair, the person's clothing had become untucked. A staff member tried to pull the person out of the chair by holding them under their armpits. This was not successful so they enlisted the help of another staff member and the person was stood up by two staff pulling them under the armpits. This meant unnecessary pressure was put on the person's shoulders. Another person was supported by staff to transfer from an armchair to a wheelchair using a hoist and sling. The sling had not been fitted correctly around the person which meant their arms were forced upwards into an awkward position placing considerable strain on their shoulders. We asked staff if the person had their own sling which they had been assessed for. The staff member told us that the sling was a communal sling used for a number of people. People were not protected from unsafe practice because they shared slings. The provider's moving and handling policy dated March 2015 stated that hoists and slings should be selected for the individual. Staff had not followed the moving and handling policy.

We checked people's moving and handling risk assessments, these were in place for each person but were not suitably detailed and were not based on each individuals assessed need. The moving and handling risk assessments did not identify what equipment should be used and what techniques should be used to support people safely. During the inspection we saw that several staff wore rings with stones in, bracelets, wrist watches, necklaces and drop hoop earrings, these could pose a risk of injury to people and to staff. The manager had spoken with staff about wearing facial jewellery in a staff meeting in May 2015 but had not challenged other jewellery that could cause injury.

We checked the accident and incident records for 2015. We found there had been seven accidents to people and staff since February 2015 relating to moving and handling. People had suffered skin tears and other injuries because they had been injured when staff had used hoists. Although the manager had reviewed the accidents and incidents. The review had not addressed issues of poor training and techniques.

Risk assessments were not person centred. Some risk assessments referred to he when the person was female. They had not always been reviewed and updated regularly. One person's bed rail risk assessment has been completed in June 2015, it detailed that the person was small in stature. This according to the form meant that bed rails were not appropriate to be used. There was no explanation in the person's care plan why the assessor had decided to use bed rails when the process within the assessment stated that they shouldn't be. The assessor had not considered alternative, less restrictive options and this could place the person at risk of harm of entrapment within the bedrails.

Inadequate

Is the service safe?

People's assessments had not always been updated when their circumstances changed. For example, people's skin integrity was monitored and the assessment was updated on a monthly basis for most people. However when the person's assessment score had changed the information had not been updated within the person's dependency assessment.

One person had a self inflating air flow mattress to reduce the pressure on their skin. The pump to the 'Bi Wave air mattress' had a sticker detailing the weight of the person and which was dated 13 April 2015. Despite the air wave mattress being self inflating to the person's weight the weight recorded on the sticker was not accurate.

Each person's had been assessed to see what care and support they needed to evacuate the home in an emergency. A personal emergency evacuation plan (PEEP) was in place within the fire file. We checked the fire file at the other end of the building. It only contained seven people's PEEP's. This meant in an emergency, staff and the emergency services may not have all of the information they need to keep people safe.

The examples above showed the provider was not assessing or mitigating risks to people's safety effectively. This was a breach of Regulation 12 (2) (a)(b)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived at the home, the outer door to the entrance was open. We entered the building and signed in and pressed what we thought was a door bell. This released the door to the home and enabled us to walk in. We were immediately greeted by the reception staff. We were concerned that other people could walk straight in too, especially during times when the receptionist was away from their desk or during the evening when there was no reception staff. We spoke with the manager and the provider about this and they agreed to review the door security. Whilst we were walking around the home we identified a number of repairs and hazards that had not been identified by the manager and staff. For example trip hazards where flooring had split, automatic door closure devices were not working correctly in some rooms which meant that staff had propped open fire doors with tables or bedside furniture. One fire door upstairs was not able to close as the hinge had come away from the frame. Other doors such as doors to sluice rooms could not be closed. Staff notified the maintenance staff of repairs and maintenance issues by leaving messages in a repairs book. We looked at the home's maintenance log and examined documentation related to the safety and suitability of the premises. The buildings and repairs issues we found during our inspection had not been reported to the manager or maintenance staff.

Whilst we were walking around the home during the morning with the manager we found a mobile hoist that had been blocking a fire exit on the ground floor. The manager moved the hoist to another location. We found the hoist blocking the fire exit twice later in the day causing a hazard.

The examples above showed the provider was not ensuring that premises and equipment was properly maintained, used and secure. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored in the medicines room, which was securely locked. The room temperature had not been recorded for two days. The room was very hot, a fan was on but this was circulating hot air. The manager explained that the medicines room was new and an air conditioning unit had been ordered to ensure the room was kept at the correct temperature for storing medicines. The room was too hot on the day we inspected to safely store medicines in, the manager agreed that the room was excessively hot.

We observed a nurse administering people's medicines during the evening medicines round. The nurse checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were asked if they were in pain and whether they required PRN (as and when required) medicines. Medicines were given safely. The nurse discreetly observed people taking their medicines to ensure that they had taken them. MAR charts for people who were prescribed creams and other topical solutions did not state that the person had been administered their prescribed creams. The MAR chart had been recorded with a 'T' there was not a code for T recorded on the MAR chart to evidence what T meant. The nurse told us that T meant that the medicine is Topical. They explained where the medicine should be applied. The MAR chart did not state

Inadequate

Is the service safe?

where the medicine should be applied. The nurse addressed this issue straight away with the MAR charts we checked, to ensure that it was clear where the medicine should be applied and what T meant.

The examples above showed that medicines had not been properly managed. This was a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had undergone extensive redecoration and improvement since we last inspected. The entrance had moved and rooms within the building had changed use. Handypersons were employed by the provider to carry out maintenance work and redecoration.

We found up-to date and relevant certificates in the following areas; the fire alarm had been tested weekly. Gas and electric installations had been checked. The furniture had been checked to ensure that it was appropriate and flame retardant. Hoists and slings underwent a weekly check and regular service.

Inadequate

Is the service effective?

Our findings

People told us they were confident with the way that staff looked after them. One person told us, "Staff seem to be well trained nothing is ever too much trouble for them". Another person told us "Staff are good here, they know how to look after me and how I am moved". People told us that the staff help them the way they wanted and could choose what they wanted to do. One person told us, "I like to wash myself. I use my frame to get to the sink and I stand up in front of the sink using the frame. Staff help me with washing my back. I have a shower once a week".

Relatives told us that the food was good and met their family member's needs. One relative said, "The food here is A1, cannot fault it. The staff are always encouraging him to drink and now record it on a fluid chart. It has improved immensely since the new manager came". Another relative told us, "Food seems very good. Mum hasn't lost her appetite. It's very varied and fresh and hot always looks appetising. She always eats in the lounge and staff help her. She does love her puddings here". Relatives told us that they had been involved in making best interest decisions when their family member lacked capacity to make important decisions.

Most staff had received training and guidance relevant to their roles. Training records evidenced that 45 out of 51 staff had attended safeguarding adults training and 45 staff had attended infection control training. The training records showed that some staff had not attended training because they were off sick or on maternity leave and the records showed that a number of courses had been booked for staff. Records showed that 44 out of 51 staff had attended dementia training, the provider was waiting for certificates for 12 of these 44 staff. Only 11 out of 51 staff had attended 'Person centred care, dignity and respect' training. Our observations during the inspection showed that people were not always treated with dignity and respect and people's care was not always person centred. This evidenced that people did not always receive care and support from staff who had been trained to meet their needs.

Training records evidenced that 46 out of 51 staff had attended moving and handling training. The manager told us that staff had attended moving and handling training through a trainer employed by the organisation. Our observations of unsafe moving and handling practice and the inaccurate information in people's moving and handling assessments, called into question the effectiveness of the training to provide staff with sufficient knowledge to safely move people, carry out risk assessments and challenge poor practice.

The examples above showed the provider had not provided suitable training for staff. This was a breach of Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received regular supervision from their manager. One staff member said, "I have supervisions with the senior she is very good and knows a lot. If the nurses need advice they go to her". Another staff member told us, "At supervision we suggested twilight. On a Sunday it's really busy as we have to do all the paperwork and look after people. And we got a twilight worker on the Sunday which was good and the manager listened to us". Supervision records were documented and signed by both the staff member and their line manager.

New staff received induction into their role. One staff member told us, "The induction was good. I completed all of my training before I began and shadowed someone for a few day shifts so I could get to know the residents. I also shadowed at night time". We looked at two induction records these showed that new staff were expected to complete modules relating to key areas of care and support. This mirrored the care certificate, which was launched by Skills For Care in April 2015. The manager confirmed that there were no documented observations of new staff to evidence that the staff had learnt from the induction modules and were working with the right values and behaviours.

Some people living with dementia were disorientated in the environment. During the inspection we were asked several times by people how to get to different areas of the home such as the dining room and bedrooms. Most of the doors within the home did not have signage to show people what was behind the door. The corridors were mostly painted cream, which meant that they all looked the same. There were no signs in communal lounges, or the dining area to help people find their way to other areas.

This was a breach of Regulation 15 (1)(c)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Before we inspected the home we received information of concern from relatives about food portion size and lack of choice. During the inspection we saw that people were offered more food at lunch time and were offered dessert. One person had chosen to have a salad at lunch time, they were not given their choice and were served sausages instead. When the staff member served the persons meal, the person told the staff member that they had ordered salad. The staff member did not take the meal away and give them their ordered meal. We heard the staff member say, "Do you mind having this instead". The person began to eat their meal and found it was cold. They complained to staff who took the meal away. Whilst staff were gone, the person chatted to other people eating their meals and said they hoped the staff would return with the salad they had ordered. However, the staff returned with sausages that had been heated up. At tea time people were not always given the choice to have more. Some people had been given half a sandwich and a yoghurt. We spoke with people about their tea time meal and they told us it was sufficient.

People told us the food was good and they got choices. One person told us "The food is good here, you get plenty of it. You are able to make a choice. When It is served and if I decide I have made the wrong choice they give me something else to eat". "They give you plenty to drink I always got a jug of water or juice in the room". Another person told us "The food is very good if you don't like the choices you have only to ask and they will get you whatever you want. Today I am having a ham salad. There is plenty of food here. Whatever you want they will do it for you. For tea we usually have a choice of burger, sandwiches, soup, and toasted cheese sandwich". Another person told us "I am vegetarian and I'm having quiche instead of the meat dish today".

We observed that no one ate their breakfast in the dining room. We asked the manager about this, they told us that people chose to have their breakfast in their bedrooms. However we could not be confident that all 51 people living in the home had chosen to have their breakfast in bed on the same day.

We carried out a discreet observation during lunch time. There was not enough space to ensure that people could eat their meals together (if they chose). One person had been frequently asking staff to go to the dining room, when the person was supported to get to the dining room there was no space as there were 12 people eating their lunch in the dining room filling all of the available tables, so the person was taken into another room. We heard this person calling and shouting asking to go to the dining room for 25 minutes during lunch. There was no plan to how meals were delivered. Staff delivered meals to one person on a table and then delivered another meal to another person. This meant that people had to sit and wait, whilst watching other people eat. We observed several people waiting for up to 20 minutes for their meal whilst other people on the same table ate their dinner. This caused anxiety and distress to one person who didn't understand why they had to wait. This person became so agitated they were repeatedly hitting a staff member who was trying to keep them calm and they also threw cutlery at other people eating their meals. The lunch time meal was not relaxed and pleasant.

People had 'eating and drinking' care plans which detailed their weights and type of diet. The care plans also recorded people's likes and dislikes and whether they needed additional calories from fortified drinks and meals. Care plans stated people should be encouraged to drink 'plenty' of fluids. They did not say what 'plenty' was. Food and fluid had not been recorded effectively. Amounts eaten hadn't always been recorded and drinks had not always been documented.

The examples above evidence that the provider is failing to meet people's nutritional and hydration needs. This was a breach of Regulation 9 (1)(a)(b)(c)(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was plenty of food in stock. This included fresh fruit and vegetables, meat, tinned food, dried food, frozen and dairy foods. The cook had a good understanding of people's dietary requirements because they had a log which recorded people's like and dislikes, the texture of food such as finger food, soft meal and pureed. Nutritional needs and food likes and dislikes had been recorded within most people's care files.

The chef said that they visited everyone in the home to ask what they wanted to eat. The chef said told us that they didn't use other methods to explain what the meal time choices were. Such as, using photographs.

The manager told us that three people had recently been assessed under the Mental Capacity Act (2005) Deprivation of Liberty Safeguards (DoLS), which had subsequently been

Is the service effective?

authorised by the local authority. We examined the care plans for these people. The requests for assessment had been made following mental capacity assessments by the provider. These assessments had involved relatives and representatives in the decision making process. Each care plan showed that the conditions to which the authorisation was subject to had been met. For example, subsequent and regular mental capacity assessments had been undertaken following one authorisation.

The manager and staff we spoke with had a clear understanding of the MCA and DoLS. They were able to explain to us the implications of the 2014 Supreme Court ruling. This stated that all people who lack the capacity to make decisions about their care and residence and, under the responsibility of the state, are subject to continuous supervision and control and lack the option to leave the care setting, are deprived of their liberty. We found mental capacity assessments in people's files where there was no evidence people lacked capacity. One person's assessment had been completed because the person had bed rails fitted to their bed. A consent form they had signed showed they had consented to using the bed rails. This consent form evidenced the person had capacity, therefore there was no need for staff to have completed a mental capacity assessment. Another person's file contained a mental capacity assessment dated 20 July 2015, this assessment had been made because the person needed to be nursed in bed for pressure relief. The person did not lack capacity to make the decision themselves so the assessment was not required.

People told us that if they were ill the staff would help and if they felt that they needed a doctor they would be called. One person told us "I had a fever recently I felt burning hot all over. The night staff used cold compresses' to make it bit more comfortable for me and called the doctor. They gave me lots to drink to get my temperature down. They also called my daughter who came straight away". Another person told us "I had a bad water infection and the doctor and my son were called". A relative told us that a, "Nurse was very good, they called med doc [out of hours medical help] when he suddenly became very unwell".

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Pain assessments had been carried out and evidence showed that people had received pain relief when it was required. Staff had sought medical advice from the GP when required. Referrals had been made to speech and language therapist (SALT) for people who needed it. Records demonstrated that staff had contacted the GP, ambulance service, dementia specialists, hospital and relatives when necessary. People had seen an optician on a regular basis to check the health of their eyes.

The handovers between staff going off shift and staff coming on shift were documented. This included information about any medical concerns and the emotional wellbeing of people who lived in the home. This ensured that information was passed on and documented appropriately.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff are kind and caring. One person told us, "Staff are very good, they treat everyone very fairly and with care". Another person said, "Staff are very kind here. I have not noticed anyone being treated any differently. Everyone is treated the same, we are all treated with courtesy". One person told us, "The staff are very respectful. They always tell you what they would like to do and ask if that is okay". Another person said, "They always call me by my first name. I respect them and they treat everyone the same". Another person said, "The staff treat me nicely, always speak with respect". One person told us, "Staff are very kind and caring. Night staff are brilliant. I had a tummy ache last night. I pressed the buzzer and staff came straight away and helped me to the toilet. They kept popping in to see if I was okay".

Relatives told us that staff treated their family members with respect. One relative told us, "Nurses are definitely caring they are very attentive. The permanent staff are very caring they know how to handle him". Another relative said "She always looks happy when I come in. Staff are very caring".

During the inspection we observed staff knocking on doors and asking permission to enter. People told us; " I always have my door open Staff always knock before they come in" ; "Staff always knock and say hello and is it okay if I come in" ; "Staff always knock and speak at the same time which is good, you then know who is at the door. They usually say can I come in".

Despite the positive comments we received from people and their relatives. We found that people were not always treated with dignity and respect.

Throughout the day we observed some good practice and practice that was not always respectful. We heard people calling for help. They were distressed and were confused as to where they were. Staff were within range of hearing the calls and shouts for help. We witnessed staff ignoring these calls for help and on several occasions had to ask staff to go and check that people were ok. On one of these occasions an agency nurse responded to a person. We heard the person tell the staff member that they wanted to go home. The person became distressed and said "No I don't, I want to go home". The agency member of staff replied with "No, you live here" they did not offer the person reassurance, they tried to offer a distraction by offering a drink and chocolate. They left the person in their room despite the person asking them not to leave as they were "Frightened". One person told us that staff didn't respond quickly to the call bel. They said that staff didn't like them because they used the call bell to ask for help. People's requests for help and reassurance were not always met.

During tea time we observed another agency staff member supporting a person to eat soup. The staff member was offering encouragement and praise to the person. Then said, "Last one, finish up, good girl". The agency staff member was much younger than the lady they were supporting, it was inappropriate to refer to the person as a girl.

During the morning we observed one person asking for help. A staff member was in the room and sat three chairs away from the person who had been asking for help. The staff member was working with another person. The person called for help twelve times over several minutes before the staff member asked them what was wrong.

One person's care plan detailed that their first language was not English and the person regularly said different words and number in another language. The care plan did not offer guidance to staff about how to communicate with the person in a language they remembered and understood, which meant that staff did not have all the information they needed to listen to the person and understand them.

Relatives told us that they had not heard any confidential information about any one discussed in the communal areas. One relative said "I have never heard staff talk about residents' personal information in the lounge". Another relatives told us when confidential discussions took place they were "Taken in to a little room" to ensure the discussion was held in private.

During the inspection we found a white board upstairs in a corridor. This had 'shower days' written on it with two peoples names written on it. This showed confidential information about when people had last had a shower. We found some staff handover records in a communal area which were dated 02 July 2015, these detailed people's care and support and any changes to their health. This meant that people's personal information had not been kept private.

Requires Improvement

Is the service caring?

The manager told us that they were a 'Dignity champion'. We asked the manager to explain their role as the home's Dignity Champion. The manager had undertaken training in this area through an external provider. The manager explained that the role was to ensure people's dignity and privacy were maintained and to ensure all staff were aware of their responsibilities in this area. Staff told us that the manager used a tannoy system to request staff to do tasks. We did not hear this in use on the day of our inspection. We asked the chief compliance officer about the tannoy, they confirmed that the tannoy was used on occasions through the telephone system. The use of a tannoy in the home does not show people that the manager respects them and their home and does not present a homely feel. The use of a voice over a tannoy system could be confusing and disorientating to people who live with dementia.

The examples above evidence that the people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had been involved in making decisions and planning their care. They were asked how they want to be cared for and about their likes and dislikes. One person told us "Before I came here staff asked me all about my medication and what I was able to do for myself and what I wanted help with". Another person said "I was asked if I liked to wash myself or if I would like help. Staff pretty good here". One relative told us, "Mum isn't able to tell you much and we were asked what likes and any dislikes she had. Her favourite music, food she liked to eat, did she prefer a bath or shower. (The staff member) took lots of notes and asked us lots of questions".

Some of the care plans we viewed evidenced that people had been involved, people or their relatives had signed them. Many of the care plans we viewed were the same with standard phrases found throughout them. Female care plans and risk assessments referred to the person as 'He' and some male care plans and risk assessments referred to the person as 'She' which evidenced that the content of the documents had been cut and pasted from other people's documents. This meant that care plans were not individualised.

This was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that they were able to visit their family members at any reasonable time. One relative explained that they visited their family member at different times of the day and they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People told us they knew how to make a complaint if they had a complaint. One person told us, “When I first came here I had a room downstairs. It was quite noisy and I just couldn’t get my sleep. I told the staff and they got the manager to speak to me. I was quickly moved up to this room this is quite a quiet corner. I get a good night sleep now”. Another person told us “My bedside cabinet lock broke and I reported it to staff, it got fixed very quickly”. Another person said, “I have never had to make a complaint but I would speak to the manager”.

Relatives told us they knew who to speak to if they were unhappy and wanted to complain. One relative had been unhappy with the care their family member had received during our inspection, they went straight to the manager to sort it out. They told us, “Today is a blip the home is usually very good”.

We had mixed feedback from people about their activities. One person told us, “I like knitting, I am knitting squares at the moment, using different colours and they will be sown together to make a blanket. I also read a lot it keeps my mind occupied”. Another person told us “I love knitting. I am knitting this matinee coat. I have just finished two coats for staff. I was asked to run a knitting class. There was about six of us It wasn’t easy I had to pick up their dropped stitches”. Another person told us, “I like watching TV and reading. I am attached to this oxygen cylinder so it has to be close by. People always stop and talk. I like the entertainers when they come. When the Elvis guy came I threw my knickers at him, all a bit of fun, my daughter said mum you didn’t, did you?” One person said, “There’s nothing to do if I had a paper I would read it. My son lives abroad so I don’t often see him. I liked playing golf when I was home I used to play every Saturday but nobody takes me now”. One person told us that they were frightened to join in activities in the lounges. They explained that there were often lots of people who live with dementia using the lounges, because they were confused they could be aggressive towards other people.

One relative told us, “When I am here and he is able to get up and sit in a wheelchair I take him downstairs. They have had singing, bingo, Name that Tune and Family Fortunes .These activities are very good” They also said “ At the weekend there is no entertainment, some people could do with more individual attention rather than left sitting in the lounge with no interaction”.

People didn’t always have enough to keep them occupied, especially those people that were cared for in bed. The activities plan for the week was displayed on notice boards. The activities planned for the day of the inspection were hairdressers and manicures in the morning and karaoke in the afternoon. Activities were on offer in the home every day, including knitting and crocheting sessions, bowling and bingo.

We spoke with the manager, the activities co-ordinator and examined the activities calendar to see how people were supported to engage in social, educational or occupational activities. The home had introduced a system called ‘People like me’, where people with mutual interests could be brought together and undertake activities suited to them. This also extended to staff interests, where appropriate. One morning a week had been set aside on the activities calendar for one-to-one activities. This time was often cut short because the activities co-ordinator was needed to assist people at lunchtime. People were not supported to frequently access their local community. The only external activity the home arranged was an annual trip to Herne Bay. One person told us “I like sitting out in the garden. They have taken me out to hospital and we are going on an outing to Herne Bay next week”. Another person told us, “My friends come and we go out shopping and we have tea while we are out”. Another person said “We are going to Herne Bay soon I am looking forward to that trip”. A relative told us that the only trip outside of the home their family had was a trip to Herne Bay in August 2014.

People’s personal histories were not always recorded in their care files. This meant that when people were unable to remember important information about their past, staff were unable to help them remember. The care plans were not person centred in nature and did not clearly evidence a discussion had taken place with each person, about their preferences or wishes.

The manager had stated within the provider information return (PIR) that people were subject to "Monthly reviews to ensure that residents needs are met”. We did not find evidence to support that these reviews happened on a monthly basis. One person’s care plan for skin integrity was

Is the service responsive?

last reviewed on 23 May 2015. Another person's catheter risk assessment had been completed on 10 November 2014, and no reviews had been documented to have taken place.

Staff were not always responsive to people's assessed needs. One person's care plan stated that they should be repositioned every two hours. The person's repositioning chart stated that the person was moved at 08:00, 12:00 and 15:00 hours on the day of Inspection. There was nothing recorded from 01:00 to 08:00 hours. This meant that staff had not followed the guidance given by the Tissue Viability Nurse (TVN) of two hourly repositioning to make sure they were protected from developing pressure ulcers.

Entries in the care file and daily records relating to pressure area care showed that one person's pressure ulcer on their heel had been seen by the TVN on 17 June 2015. There were no entries made by the nursing staff after this date to evidence what the ulcer looked like. This meant that staff would not be able to assess whether the pressure ulcer had improved or deteriorated. The daily notes contained entries about the dressing changes. The last entry was dated 12 July 2015, this stated that the dressing needed to be reviewed on 14 July 2015, there was no written evidence to confirm that this had been done. The moving and handling care plan did not state that the person had chosen to spend periods of up to 12 hours per day in their wheelchair and the person had chosen to decline to spend an hour in bed in the afternoon as advised by the TVN. Another person's elimination care plan did not contain any information about how often the person's catheter should be changed, or what staff should do if it blocks or bypasses, which meant the person could be at risk of discomfort, pain or infection.

People's daily records didn't always detail what care people had been provided. Some entries consisted of general statements such as 'assisted on/off toilet' and 'washed and dressed herself'.

The examples above showed that the provider was not providing care or activities for people in a responsive or person centred way. This was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's birthdays were celebrated in the home. On the day of our inspection 14 out of 51 people celebrated another person's birthday with a karaoke session. People looked as if they were enjoying the activity either singing along or clapping to the music and people readily chose to take the microphones. The chef had prepared chocolate cake to celebrate the birthday and every person in the home was offered a piece with their afternoon drinks.

People told us that they had been given a choice on who could do their personal care. One person told us, "When they asked me if I had a preference I told them I don't mind I am too old to worry about what they think about my body. I have got the best carer possible he makes sure I am always clean and well dressed. He always makes sure that I look good". Another person told us they were asked about their preferences. They told us they had "asked for a female. We know we can always refuse if we don't like something".

The provider had a complaints policy and procedures which included clear guidelines on how and by when issues should be resolved. It contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. However, the complaints procedure was not displayed in a prominent communal area, which meant that people and their relatives may not know how to formally complain.

The provider had received one recent complaint. This had been resolved in a timely and satisfactory manner. Most of the staff we spoke with were clear about their responsibilities in the management of concerns and complaints. However, one staff member said, "I don't know the policy about complaints. I wouldn't know what to do or how to record a complaint in the right way".

'Residents' meetings were held. We looked at the last meeting records which had taken place on 30 April 2015. People and their relatives and representatives were able to contribute to the meeting and to make suggestions concerning their welfare and future service provision. The meeting minutes did not contain a review of the minutes of the previous meeting. In addition, it did not contain a plan to decide what action would be taken as a result of the current meeting, by when and by whom. Therefore it was not possible to judge the effectiveness of the meeting or to know if people's concerns or requests had been dealt with.

We looked at the results of the provider's latest satisfaction questionnaires, which had been completed and returned by staff and people's relatives. The questionnaires covered

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Is the service responsive?

areas such as consent to care and treatment, the quality of care and involvement in social and occupational activities. Ten relatives had returned forms and eight staff members. We noted that, though there was broad satisfaction in most areas, a number of relatives and staff had expressed dissatisfaction in areas such as the provision of social activities and the management of complaints. We asked the operational manager how this information was used to improve the service. They told us that they did not have a formal system in place to audit findings from the questionnaires and had not put an action plan in place to address the issues raised. The operational manager told us that individual issues were dealt with at resident and staff meetings as they arose. The provider had not taken the views of people, their relatives and staff into account to improve the quality of care.

The example above evidence that the provider has failed to act on feedback. This was a breach of Regulation 17 (1)(2)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

People told us that they felt that management listened to them. One person told us, "Yes I think they listen to me. They cannot alter anything if we don't let them know. They cannot tell what we are feeling unless we tell them". Another person said, "I cannot remember being asked for my views, but it is brilliant here, everyone very happy". Another person told us, "We are asked about the service at the residents meetings. Last time I said about the visitor's toilet. There's no signs on the door so no one knows which one to use" and "The managers door is always open, he always listens to what you say and asks what you think about the home". Most people told us there had been improvements recently. One person told us, "Some of the changes have been good. The main front door has been reopened. We had a celebration tea party with singers. It was an enjoyable afternoon". Another person told us that staff were, "Overworked".

Visitors told us, "The manager is very helpful, he directs you to the right person you really need to deal with. He is always polite and knows who I am and always calls me by my first name", "It is very well run. When we come down here and we always find the place very relaxed". One relative told us, "I think the management is a lot better now. They are very approachable even the ones from head office who are here today. I know them all. There are no managers on at the weekends. The new manager is very good. This blip today with the agency staff was a one off. The manager is always around and often here quite late into the evening. If I go to the office he will always say come in and have a seat". Another relative said, "It's very well managed, plenty of room and space. They're always doing some maintenance. I went to the residents meeting and the manager told us about the plans they have for the home. Opening up the front entrance which has just been done, sensory garden at the back which is now started and that they were changing the dining area. They asked for our views at the meeting" and "We are always made welcome at the meetings and at the opening celebrations".

An accurate, complete and contemporaneous record was not being maintained for each person. People's records were stored in a locked office which staff accessed using a key card. This office was not always locked. When we arrived at the home, the door was propped open, there were no staff in the office. This meant that people's confidential records could have been accessed by anyone.

People's care plans and risk assessments contained conflicting information. For example, we found that assessments relating to pressure area risk that had been completed. However, the dependency assessments had not been updated when the pressure area risk had increased or decreased. People's malnutrition screening tool (MUST) had not always been correctly scored. One person's records did not accurately record their catheter support and care. Staff had not always recorded amounts of food and fluid that people had received.

One person's falls risk assessment indicated a high risk of falls. It was noted in the records that staff were to check the person 'Hourly, half hourly when agitated/confused'. We were unable to find where the checks were recorded. Repositioning charts did not always show that people had been repositioned regularly. Some assessments had not been dated. Some had not been signed to show who had completed them and some dates were not written in full, which meant we were unable to find out if they related to the current year. People's care plans referred to males as her and females as him.

The fridge located in the outside store had not been monitored. The chef said they had not recorded temperatures of this fridge. There was raw meat stored in the fridge. The chef said they would start recording temperatures straight away. Not all of the kitchen records such as temperatures, cleaning records had been maintained consistently.

The provider had monitoring tools and systems in place. We viewed the 'Home review audit' which was completed on the 10 June 2015. The audit looked at key areas such as; quality information, dignity, respect, activities, whistle blowing, safeguarding, nutritional management, care planning, recruitment, training and complaints. The provider had identified areas for improvement in seven key areas. A basic action plan had been put together to address the issues found. However, the audit had not picked up on the concerns we had found during the inspection relating to people's care, records, dignity and respect.

An infection control audit had been carried out in June 2015. This had picked up minor areas of concern. The audit

Requires Improvement

Is the service well-led?

had recorded that bins were foot operated, enclosed and suitable. However, we found a number of bins within the bathrooms that were not. This called into question the accuracy of the audit that had been completed.

There was no effective system to assess the number of staff required to ensure there were enough staff deployed to meet people's needs. There was no overall, up to date analysis of people's needs on which the numbers of staff needed was calculated. Dependency assessments within people's care files had not been updated and reviewed when people's needs changed.

The culture at Grace Manor Care Centre was institutional. Staff were focussed on tasks rather than on people's individual needs or wishes which meant that people did not receive a good service. People were not always offered choices, their requests were ignored and they were spoken to in an inappropriate manner.

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

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had not notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. The home had a clear whistleblowing policy on display which referred staff to the operational managers, the chief compliance officer and the chief executive of the organisation. Staff could also telephone a confidential telephone line. Effective procedures were in place to keep people safe from abuse and mistreatment.

Most staff told us that communication between staff within the home was good and they were made aware of significant events. Most staff said they had good support from the manager in order to carry out their roles. However, one staff said, "There's no support from the management. It's like talking to a brick wall. It's a good home when there is enough staff. When we moan about things at meetings things don't change". We viewed the previous three staff meeting minutes and saw that staff were confident in raising concerns and issues with the manager, the deputy manager and the operational manager. The minutes of the meetings showed that management team had listened and acted on information from staff. The meetings were generally well attended.

The manager told us about their vision for the future and their values of care at the home and how it would be achieved. They told us, "I would like this place to be a home from home. The people who come here have left their own homes and I would like to make sure this is the next best thing".

The manager told us that they felt well supported by the provider. They said, "I do feel supported. I can go to the management team if I need something and they will listen. I feel very lucky". The manager had been supported by the management team to attend meetings with external organisations. The chief compliance officer told us when we gave feedback at the end of our inspection that the provider was aware of some of the issues and concerns found during the inspection. They said that it was "Clear more support was needed". Although an action plan had been developed by the management team prior to the inspection to address issues, the action plan did not address all of the issues we found during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that people received appropriate care that met their needs and reflected their preferences.** **Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured that the premises and equipment was suitable for the purpose, properly used and maintained.** **Regulation 15 (1)(c)(d)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified CQC of events and incidents without delay.** **Regulation 18 (1)(2)(c)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with respect and dignity. Regulation 10 (1)(2)(a)(b)

The enforcement action we took:
We served the provider a warning notice and asked them to meet the regulation by 04 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks of unsafe care and treatment Regulation 12 (1)(2)(a)(b)(e)(g)(h)

The enforcement action we took:
We served the provider a warning notice and asked them to meet the regulation by 04 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that leadership and quality assurance systems were effective to make sure people were safe and they received a good service. Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:
We served the provider a warning notice and asked them to meet the regulation by 04 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured staff were suitably trained and competent to provide safe and appropriate care.

This section is primarily information for the provider

Enforcement actions

	Regulation 18(1)(2)(a)

The enforcement action we took:
We served the provider a warning notice and asked them to meet the regulation by 04 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not established and operated effective recruitment procedures. Regulation 19(2)(a)(3)(a)

The enforcement action we took:
We served the provider a warning notice and asked them to meet the regulation by 20 October 2015