Care Quality Commission

# Brancaster Care Homes Limited

# Cartmel Grange

## Inspection report

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## Ratings

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|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Outstanding** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Good** |

## Overall summary

This unannounced inspection took place on 30 June 2015. We last inspected Cartmel Grange Nursing Home on 6 October 2014. At that inspection we found that the service was in breach of some regulations. This was because the registered provider did not have appropriate arrangements in place to make sure possible abuse was recognised and responded to quickly and did not have a formal and verifiable system to assess people's capacity to make a decision and to gain and review consent. They were also in breach because some care planning information was unclear and planned actions had not always been followed. The registered provider had not effectively monitored all the systems in place to assess the quality and safety of the services provided.

We made requirement notices on these areas that required improvement. The registered provider wrote to us and gave us an action plan saying how and by what date they intended to have completed the required improvements. At this inspection on 30 June 2015 we found that the registered provider had made the improvements needed to meet the requirement notices from the previous visit. However at this inspection we found that there was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014 regarding some recruitment checks for new staff.

# Summary of findings

You can see what action we told the provider to take at the back of the full version of the report.

Cartmel Grange Nursing Home is set in its own grounds and people have access to safe, outdoor space. It is on the edge of the seaside town of Grange-Over-Sands, overlooking the surrounding countryside and with views across Morecambe Bay. Cartmel Grange Nursing Home provides accommodation for up to 73 people who require nursing and personal care, some of whom are living with dementia. There are three units in the home over three floors and there is a passenger lift to assist people to access the accommodation on the upper floors. All the bedrooms in the home are for single occupancy.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in Cartmel Grange told us that they felt safe living there and friends and relatives we spoke with were satisfied with the care provided. We spoke with people in their own rooms and those who were sitting in the communal areas and were told by people that they felt "Well cared for" and "comfortable".

The home had received accreditation for the Gold Standard Framework (GSF**)** in End of Life Care. The focus of this framework was to promote high quality care, proactive planning, working with GPs and other health professionals and more advance care planning and reduced hospital deaths. This was to improve the quality of care for patients nearing the end of their lives.

The staff we spoke with were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home.

The service had worked well with health care professionals and external agencies such as social services and mental health services and the Care Home Education and Support Service to provide appropriate care to meet people's different physical, psychological and emotional needs.

People living there were able to see their friends and families as they wanted, participate in planned activities in the home and go out into the community with support. There were no restrictions on when people could visit the home. The visiting relatives we spoke with told us that the manager was "approachable" and that staff were "helpful" and kept them up to date about their loved ones.

The service followed the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

We saw that people were supported to maintain their independence and control over their lives as much as possible. People had a choice of meals and drinks, which they told us were good and that they enjoyed. We saw that people who needed support to eat and drink received this in a supportive and discreet manner.

There were quality monitoring systems in place to assess and review the quality of the services provided.

# 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?**
The service was not safe.

Appropriate pre-employment checks had not always been carried out effectively.

There were sufficient staff to provide the support people needed, at the time they required it.

Medicines were handled safely and people received their medicines appropriately.

**Requires improvement**

**Is the service effective?**
The service was effective.

Nursing and care staff working in the home had received training and supervision relevant to their roles and to make sure they were competent to provide the support people needed.

There were system in place to assess people's individual nursing and personal care needs and we saw evidence that people's needs were regularly assessed so they received the right care.

People's rights were protected because the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were being followed.

**Good**

**Is the service caring?**
This service was caring.

People told us that they felt well looked after and we saw that the staff treated people in a supportive and respectful way and that their independence, privacy and dignity were promoted.

Information was available on how to access advocacy services for people who needed someone to speak up on their behalf.

Staff demonstrated good knowledge about the people they were supporting and the importance of holistic care at the end of life.

**Outstanding**

**Is the service responsive?**
The service was responsive.

Care plans and records showed that people were being seen by appropriate professionals to meet their physical and mental health needs.

A range of activities were available within the home and people were able to follow their own faiths and beliefs.

**Good**

# Summary of findings

There was a system in place to receive and handle complaints or concerns raised.

**Is the service well-led?**

Good

The home was being well led.

Processes were in place to monitor the quality of the service and action had been taken when it was identified that improvements were required.

Staff told us they felt supported and listened to by the registered manager.

People living there and their relatives were able to give their views and take part in meetings and discussions about the service.

# Cartmel Grange

**Detailed findings**

## Background to this inspection

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

We visited the home on 30 June 2015. Our visit was unannounced and the inspection team consisted of two Adult Social Care (ASC) Inspectors and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with 16 people who lived in the home, seven relatives/visitors, five nurses, five care staff, three ancillary staff, including domestic staff and activities staff. We spoke with the registered manager and the clinical lead nurse. We observed the care and support staff provided to people in the communal areas of the home. We spoke with people in communal areas and in private in their bedrooms. We looked in detail at the care plans and records for 12 people and tracked their care. We looked at records that related to how the home was being managed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the home, including information we had asked the registered provider to send to us. We also contacted local commissioners of the services provided by Cartmel Grange to obtain their views of the home. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards.

Requires improvement

# Is the service safe?

## Our findings

All of the people we spoke with who lived in the home told us that they felt "comfortable" and also "secure" living at the home and with the staff who supported and cared for them. One person told us "I feel very safe in this home and with the other people who live here". Another person told us "I have a comfortable room and have everything I need. I do not have to ring my call bell often but when I do they come very quickly".

Relatives we spoke with told us that they felt their loved ones were safe living there. We were told, "People are very safe in the home" and "The staff are highly trained" and also "The staff are brilliant, there seems to be plenty around".

At our last inspection 6 October 2015 we found that accidents and incidents were not always being properly reported and followed up appropriately to keep people safe. At this inspection we found effective systems in place and being used to make sure people living there were protected from abuse and avoidable harm were being followed. We saw that incidents had been reported promptly and to the relevant agencies. Staff told us they had received training in safeguarding adults and whistle blowing and training records supported this.

The nursing and care staff we spoke with could tell us of what may constitute abuse and how to report it and how to raise concerns about poor practice. All those we spoke with were confident that any allegations or concerns raised would be fully investigated and action would be taken to make sure people were kept safe. When there had been any safeguarding incidents or accidents at the home the registered manager had referred incidents to the appropriate agencies and informed CQC as appropriate.

At our last inspection 6 October 2014 we found planned actions in care plans had not always been followed. We looked at 17 care plan records and supporting documents. We found only one instance where positional changes for a person had not been consistently carried out. This was investigated by the registered manager on the day we inspected. We could see that this person had changed position during the time we were there and they were sat in the lounge, visited the bathroom and been hoisted into a wheelchair at mealtimes. Staff had not recorded these changes on the chart. The manager addressed this.

During this inspection 30 June 2015 we looked at nine recruitment records for staff employed since our last inspection. This was to see how the registered provider's recruitment procedures were being followed and monitored to help make sure people working in the home had all relevant checks to help make sure they were suitable for their roles before starting work.

We found that there were aspects of the registered provider's recruitment process were not being followed and monitored to make sure the process was as effective as possible to help keep people safe. For example we found that although two references had always been requested the registered manager had not made sure that the person supplying a reference was the employer and not just a senior colleague or co-worker. We saw references done by unit managers not the employer, one was not done by the person it had been sent to and one had not been signed by the person giving the reference. This was not in line with Cartmel Grange's own recruitment policies and procedures.

We also found that a person employed in a position of responsibility had not had a Disclosure and Barring Service [DBS] check done when they came to work there seven months previously. The services own procedures also required such a check was undertaken when the person came to work for them. We noted there was no procedural guidance on obtaining references for staff involved in recruitment to follow. We also found that information with regard to concerns about staff raised by security checks were not followed up or reasons for suitability recorded for reference. The recruitment systems had been audited but the omission had not been found. However, once aware the registered manager began the DBS process on the day of the inspection. These inconsistencies in following the service's own policies and procedures on recruitment and the current legislation on the employment of fit and proper persons could put people living in the home at risk.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014, Fit and proper person's employed. This was because the registered provider was not operating robust recruitment procedures, including undertaking relevant security checks, and gathering all available information to confirm a person was of good character.

As part of this inspection we looked at medicines records, storage, supplies and care plans relating to the use of medicines. Medicines storage was neat and tidy and

Requires improvement

# Is the service safe?

clinical room and refrigerator temperatures were being monitored. This helped to make sure that the medicines were in good condition for use. We looked at the handling of medicines liable to misuse, called controlled drugs. These were stored safely and recorded correctly and this reduced the risk of mishandling.

Covert or hidden medication protocols were in place and there were medicines being administered covertly on Arnside unit. Covert administration relates to the administration of medicines a person needs in their food or drink who are unable to give their consent to, or refuse, treatment. There was a multidisciplinary procedure being used to promote the best interest process involving the person's doctor, the dispensing pharmacist, nursing staff and the person's family. The care plan stated why a person needed this and the advice obtained from the GP and pharmacist to do so safely was recorded

Medicines were safely administered. We saw nursing staff preparing and giving medicines to people and found that this was done carefully. We looked at care plans for people with complex healthcare needs and saw that these had been regularly reviewed so that people continued to receive appropriate care. We saw guidance in place for 'when required' medicines so that people received safe and effective treatment when they needed it.

We found there were sufficient staff on duty to provide nursing and personal care to the people living there. The numbers of staff on each of the units was as stated on the rotas and there was a registered nurse on each of the three units 24 hours a day. On the ground floor nursing unit there were two registered nurses. A person living there told us told us "I feel safe, it is a nice place and there are plenty of staff on duty". A relative told us, staff knew their family member well and said "[Relative] has the same core carers all the time looking after them". A person living there told us "I don't see enough of the carers to confide in them but I do have the same carers all the time".

An additional three nurses had been recruited and undergoing recruitment checks. When they were in post there would be two nurses on the units all day as well. Staff told us that would be a great improvement at busier times of the day and give staff more time for reviews and monitoring.

We looked at the risk assessments in place for people that identified actual and potential risks and the control measures put in place to try to minimise them. People's care plans included risk assessments for skin and pressure care, use of equipment and bedrails, falls, moving and handling, mobility and nutrition. The risk assessments we saw had been regularly reviewed so that any risks could be minimised and so that people received appropriate support to stay safe.

We looked around the home and saw that all areas were being kept clean and fresh. There were hand gel dispensers located around the home and we saw staff using protective clothing and gloves when giving personal care. The home had sufficient housekeeping and laundry staff to maintain a clean and hygienic environment. The maintenance and gardening staff kept the garden and premises in good order and there was a full complement of kitchen staff to make sure people had a variety of food they enjoyed.

Good

# Is the service effective?

## Our findings

People we spoke with who lived in the home spoke positively about the care and support they received from the nursing and care staff. We were told "I receive all the care I require. The food is very good I enjoyed my breakfast this morning, it is all freshly cooked". Another person told us, "The staff know what to do for me and would bring in a GP/Dentist if I required them. I had my eyes tested the other day. The food is OK and if you do not like a meal you have a choice".

A visitor told us that "The food in the home is very good" and a relative who was visiting told us "As far as I know the food is good, [relative] can find some dishes rather rich but they have always been a plain eater".

At our last inspection 6 October 2014 we found that health care needs, such as nutrition and hydration needs were not always clearly stated so staff could not be sure they were always meeting people's assessed healthcare risks and needs. At this inspection we found that health care needs were being clearly stated in care plans so staff could be sure they were meeting people's assessed healthcare needs. Nutrition and fluid charts were being completed and we saw this being done after a meal.

We saw that all the care plans we looked at contained a nutritional assessment and a regular check was being kept on people's weight for any changes. We saw that if someone found it difficult to eat or swallow advice had been requested from the dietician or the speech and language therapist (SALT). Where the home had concerns about a person's nutrition their care records showed they had involved appropriate professionals to help make sure people received the correct type of diet.

We observed what was happening during meal times in the main dining room and how people were supported as they had their lunch. The environment in the main dining room was light and airy and very clean. We used the Short Observational Framework for inspection, (SOFI) to observe how people on Arnside unit who were living with dementia were supported as they had their midday meal.

We saw that in both dining areas lunch was a relaxed occasion and staff spoke with and encouraged people as they served or helped them with their meals. We saw that care staff assisted people who needed help to eat their meals in an unhurried way and also prompted and encouraged people, where appropriate, with their meals. We saw there was a choice of food at all mealtimes in the home and a varied menu on display for people to see and choose from. We saw there was a choice of hot and cold drinks available throughout the day and noted staff were frequently prompting people to drink throughout the day.

Some people were not well enough to come to the dining rooms and others had chosen to have their meals in their rooms. We saw that staff took their meals out to them promptly and stayed and assisted people to eat the meal if they needed this support.

We spoke with people visiting the home who had relatives living there about how their loved one's care and nursing needs were being met. We received positive comments on this, including, "We're happy with the care we are receiving, the staff are knowledgeable and well trained".

There were records of the completed training nursing and care staff had attended and what was planned for the year. Training and development was overseen by a training coordinator to help maintain consistent standards of training and to help make sure all training was kept up to date to meet the needs of people living in the home. Supervision records were being kept and staff told us they were receiving this in a more structured way now. We were told by staff "The training is good here".

Training records indicated that staff were being given the opportunity to do a range of training in addition to that required by legislation. We saw that staff had been able to access training on specific conditions for the people they supported such as Motor Neurone Disease, Parkinson's Disease and Strokes.

Nurses had been able to attend professional development training courses and conferences to help maintain their knowledge. They had received training relevant to their on clinical role to maintain their skills such as on wound management and palliative care. Nurses had received training on the use of syringe drivers [a syringe driver is a pump that delivers a measured dose of a medication] for the provision of effective palliative care. They had also done courses to give them the skills for verification of death and to take part in advanced care planning with people.

We saw that staff received a structured induction when they started working in the home. We saw that the registered manager was incorporating the 'Care Certificate Standards' and self assessment tool into staff's induction

Good

# Is the service effective?

into the home. The 'Care Certificate' is an identified set of standards that health and social care workers need to adhere to in daily working life. Its aim is to try to make sure all support workers have the same introductory skills, knowledge and behaviours to provide high quality care and support.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The staff we spoke with knew why a Deprivation of Liberty Safeguard would be required for a person and who was subject to this on their unit. All staff we spoke with demonstrated an awareness of the MCA code of practice and the processes involved.

The registered manager knew when a Deprivation of Liberty Safeguard was required to protect an individual's rights. We saw that people living in the home were assessed to make sure there were no restrictions or potential for restrictions on their liberty. We saw that the registered manager had raised potential restrictions with the managing authority to make sure they were acting in line with the legislation.

We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. We saw that mental capacity assessment s were being done to support people with some specific decisions, such as around safety and end of life in their 'best interests'. This was for people who were not able to make important decisions about their care or lives due to living with dementia or mental health needs. We saw that discussions with families and representatives had been recorded

We saw that a new verification system had been introduced regarding who held Power of Attorney (PoA) for an individual. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or also care and welfare needs. This new verification was to help make sure that staff could be certain if a person making a decision on someone's behalf had the legal authority to do so. This was not yet fully embedded and some records of this were clearer than others as to whether it was financial or welfare needs people had authority for or just financial.

We looked at care plans to see how decisions had been made and people around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). We could see examples of team discussion around this involving family and PoA and with advanced care planning. However we saw in some cases that the doctor had made a clinical decision about resuscitation but ticking incorrect statements such as a person had a PoA involved when they did not. This led to contradictory information. This needed to be brought to the doctor's attention and we discussed this with the registered manager who confirmed this would be monitored with doctors in future.

We saw that improvements to the environment had been made to improve the bathing experience of people in the home. Refurbished bathrooms on the ground and first floor, new baths and relaxing décor all contributed to a better experience for people.

Outstanding ☆

# Is the service caring?

## Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. We were told by one person, "The staff here are kind and caring. I would recommend this home to my friends". One person told us "They [staff] are thoughtful; they always bring me a cup of tea first thing. They know I wake up early".

We were told "They [staff] always knock before entering my room and do respect my privacy when they are helping me to bath, I can get up and go to bed when I like". Another person told us. "They [staff] all respect my dignity because there is so little I can do for myself now. It does not matter to me what gender the carer is".

A relative told us "I think the home is really good. I'm very happy about how they are here". We were also told "[Relative] likes their privacy and staff do respect that. [Relative] says there is too much going on for them". Relatives told us they could visit at "any time" and that "I can discuss anything with the nurses, they always tell me what is happening with [relative]".

We spoke with a visiting health care professional who told us that they had found the staff "Very knowledgeable" about the people living there and "Staff do seem genuinely caring and really make an effort".

As we spent time in different communal areas of the home throughout the inspection we saw that the staff took up opportunities to engage positively with people and we saw people enjoyed talking with the staff. Bedrooms we saw had been personalised with people's own belongings, such as family photographs and momentos to help people to feel at home. We saw staff talking to people in a polite and friendly manner. They called people by their preferred names as stated in their care plans.

Activities and conversations were going on in the lounges and it was a relaxed atmosphere. Throughout our inspection we saw that the staff gave people the time they needed to communicate their wishes. Some people did not want to come into communal areas so the activities staff spent time with them on a one to one basis so keep them involved in their own interests and what was going on in the home. The service also ran a newsletter to keep people informed and they could contribute to this.

We saw as we went around the home that people's privacy was being respected. We saw that bedroom and bathroom doors were all kept closed whilst personal care was taking place and staff knocked and waited before entering an occupied room. We saw that staff maintained people's personal dignity when assisting them with mobility and in using the mobility equipment they needed to promote their independence.

There was procedural guidance for staff to follow on maintaining confidentiality and data protection. We saw that all personal records about staff and people living there were held securely within a locked office on each floor or in lockable filing cabinets in the general office

There was information available on the end of life care the home could provide. The home had received accreditation for the Gold Standard Framework (GSF**)** in End of Life Care. The focus of this framework was to promote high quality care, proactive planning, working with GPs and other health professionals, involving more advanced care planning and reduced hospital deaths. The home had 14 'End of Life Champions'. The nursing and care staff we spoke with were very clear about the importance of providing holistic care at the end of a person's life. They also confirmed what we had found in the training records, that the provider made sure they had provided regular and relevant training to maintain a high standard in this area of care.

Staff had also been able to take part in 'The Six Steps' palliative care programme with a local hospice. This programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care.

The home also had seven 'Dignity Champions' across all levels of staff and six 'Dementia Champions' and their photographs were displayed in the home so they were recognisable to people living there and visitors. This was important as part of their role was to be available to advice and support people living there, relatives and staff.

The role of 'Champions' at Cartmel Grange was to try to make sure all staff upheld a high standard of care in each area. They attended training to keep their own knowledge up to date and to provide in house training to, and be a

# Is the service caring?

resource for, colleagues. We spoke with a member of staff who had recently run a training day for staff on dementia awareness and they were planning more. They told us they received all the resources they needed to do this.

We found that there was a range of information in leaflets and booklets that were available for people in the home to inform and support their choices. These were available throughout the home and as people entered. This included information about the registered providers, the services offered and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

Good

# Is the service responsive?

## Our findings

All of the people that we spoke with told us that daily routines in the home were flexible to meet their needs and choices about their lives. People told that where possible they were being supported to make their own daily choices and take part in activities outside the home as well as within. We were told by one person "My family can visit when they are able and at any time because they live away, I stay in my room quite a lot but that is by my own choice".

One relative told us that they believed their relative has "Improved massively while they have been here, they [staff] have worked with them to get their confidence back and now they can manage to come home for the afternoon".

We saw during the inspection people going out for the day with friends and family and taking part in activities. They told us they chose where to spent their time, where to see their visitors and how they wanted their care to be provided. People told us and we saw from the records, that people were able to follow their own beliefs. There was monthly multi denominational religious services for anyone who wanted to participate and people could see their own priests and ministers if they wanted.

Relatives told us that they had been able to take part in helping to develop life histories and comment on their relative's social and cultural preferences. Information on people's preferred social, recreational and religious preferences were recorded in individual care plans. This helped to give staff a more complete picture of the individuals they were supporting. Staff we spoke with did know about the person and who and what mattered to them not just about their nursing and personal care needs.

All of the people we spoke to were aware of the organised activities or said that that staff told them what was happening that day. The activities programme was advertised on the units as well. We saw that local Women's Institute meetings were advertised should anyone want to attend within the local community. There was also a letter writing service for those people who wanted to correspond by writing but needed some help.

We spoke with one of the three activities coordinators who confirmed they had no restrictions placed on their budget and could book any entertainments people wanted. They also explained they did "quieter sessions "with people who preferred to do thing that interested them and that was up to them. On the day we visited it was warm and some people had decided to have tea outside in the courtyard to make the most of the good weather.

People's care records showed that their individual needs had been assessed before coming to live in the home and continues after admission. This helped to make sure the home was able to meet the person's needs before they arrived. The information gathered before and on admission had been used to develop care plans. Records indicated that reviews had been carried out on people's assessed needs and any associated risks.

We looked at care plans for people with complex healthcare needs and saw that these had been regularly reviewed so that people continued to receive appropriate care. For example, wound care plans and medication changes. Care plans also contained up to date information about the care and treatment people wanted should their condition change or deteriorate

We could see in people's care plans that there was effective working with other health care professionals and support agencies such as local GPs, community mental health teams and social services. GPs attended weekly to do a 'clinic' so nursing staff could raise any issues or changes needing reassessment, see new people to the home and deal with any problems quickly. Staff told us that they called a doctor when they needed one but the weekly visits made that less likely to need to do so unexpectedly. We spoke with health care professionals who supported people who lived in the home. They told us that the staff kept in contact and asked for advice and support promptly and did not make inappropriate referrals.

We saw that there was regular involvement with the Care Home Education and Support Service [CHESS] in Cumbria. This involved CHESS working with care home staff and backing up learning with practical support. This was to improve the staff's ability to manage mental health needs and so improve the day to day lives of older people with mental health needs. Monthly 'clinics' were being held so the CHESS team could assess people promptly. Staff said it had the effect of making access to support for people "smoother" and "less disjointed" for people who needed this support.

The service had a complaints procedure that was available in the home. Complaints or concerns that had been raised

Good

# Is the service responsive?

with the manager or through staff had been logged and records of investigations and correspondence had been kept. People who lived there we spoke with told us they had not felt the need to make a complaint but would feel comfortable raising anything they were not happy about. We were told "I would complain to the manager". A relative told us "If we had any complaints we would go to the manager or the senior person on duty". Some people were less sure about the process for making a formal complaint but did believe they would be listened to if they were not happy with something.

Good

# Is the service well-led?

## Our findings

We spoke to people living at Cartmel Grange and their visitors/relatives about how the home was run for them and their involvement in this. We were told "I know who the manager of the home is" and also that "The carers worked well as a team". Another said they felt all the staff worked well "For the benefit of the residents" although they were not sure who the registered manager was. Another said they did not know who the manager was but they knew who their key worker was as they supported them all the time.

A visiting relative told us that in their opinion "The home's management is absolutely fantastic" and they were always available to speak with them. One relative told us about how information was spread in the home, about the newsletter and that "The Voice is run monthly" and that this was a meeting for people living there and their relatives to attend and to discuss what they thought and wanted in their home. One relative told us "I do know about the residents and family meeting but have not been. Another we spoke to did not know about the meetings and said they had not been asked for their views on the service. Some people seemed better informed than others about these matters. We did see that notice boards carried information on forthcoming events that relatives might want to be part of.

At our last inspection in October 2014 we found that the registered provider had not effectively monitored all the systems in place to assess the quality and safety of the services provided. We also found that that some notifications which should have been submitted to the Care Quality Commission (CQC) had not been. Since our last inspection the registered manager had been notifying CQC of all incidents and events that were required under the regulations.

At this inspection 30 June 2015 we found that quality monitoring systems were being applied to monitor quality and service outcomes. We saw that care plans and medication records and staff training and supervision were being checked or 'audited' to make sure the home's procedures were being followed to promote safe and effective practices. Recruitment procedures had also been audited. We discussed with the registered manager that this check had not identified when a procedure had not been properly followed to highlight a staff member still needed a new DBS check. They had begun to address this on the day of the visit to make sure their audit questions were in line with the new regulations.

We could see that any actions or improvements that had been identified in care plans and medication had been followed up and training was being well monitored and promoted. This was to help to make sure the care plans and records were accurate and up to date. The organisations operation's manager also visited regularly to support the manager and speak with people living there and check records. Brief records had been kept of the visits.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All the staff we spoke with told us that they supported by the registered manager and clinical manager in the home. We were told, that the registered manager was "Open to new ideas" and that "It's a good organisation to work for, they look after you". Staff we spoke with told us they felt the registered manager and provider listened to them and that they had regular staff meetings to promote communication and discussion.

Maintenance checks were being done regularly by staff and records had been kept and we could see that any repairs or faults had been highlighted and acted upon. There was a cleaning audit and records relating to premises and equipment checks to make sure they were clean and for the people living there.

There were processes in place for reporting incidents and we saw that these were being followed. Incidents were reviewed by the registered manager to identify any patterns that needed to be addressed. There was regular monitoring for individual risks to check if there was a theme or pattern emerging that needed to be addressed.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>How the regulation was not being met:<br><br>The registered manager had not made every effort to gather all available information to confirm that employees were of good character before employing them. |