Grenham Bay Care Limited

Grenham Bay Court

Inspection report

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Ratings

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

Overall summary

This inspection was carried out on 30 and 31 July 2015 and was unannounced.

Grenham Bay Court provides accommodation and personal care for up to 31 older people some of whom are living with dementia. Accommodation is arranged over two floors. A shaft lift and stair lift is available to assist people to get to the second floor. The service has 31 bedrooms, some of which are en-suite. There were 31 people living at the service at the time of our inspection.

There was a registered manager in place. 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.

Potential risks to people were not always assessed thoroughly. Individual risk assessments did not give staff guidance about how to help people safely. There were no clear instructions about how to use equipment properly. Staff had not been trained in practical areas of moving and handling and did not always know how to use equipment safely. There had been accidents involving

Summary of findings

hoists where people had suffered minor injuries. Accidents and incidents were not looked at in detail to identify patterns or trends which could help prevent or reduce the likelihood of further harm.

Checks were carried out on the quality of the service, but these did not always effectively identify shortfalls such as safe storage of some medicines and the risk of cross infection due to procedures in the laundry. Following our inspection a new system for audits was introduced to ensure any shortfalls were identified.

Staff were not recruited safely. There were gaps in the recruitment records and not all information required by Schedule three of the Regulated Activity Regulations had been obtained. Some staff had not received the induction and training they needed to develop their skills and knowledge. The training plan did not prioritise staff training needs and most staff had not completed all the training they needed. Staff felt the training did not meet their needs and felt unsupported. Staff had limited opportunity to meet with the manager or senior staff to discuss their role, practices and any concerns they had. Staff said that morale was low, and although staff attended regular staff meetings they did not feel supported on a day-to-day basis. Some people had noticed that staff were unhappy. Following our inspection the training plan was reviewed and a supervision programme was put in place.

Staffing levels had not consistently met the needs of the people using the service. This had been reviewed and two new agency staff had been recruited to support the service while new permanent staff were recruited.

There were systems and processes to support people and their relatives to make a complaint or raise concerns. Complaints were acted on when they were brought to the registered manager's attention, but some relatives felt that any improvements made following a complaint were not always maintained leading to further complaints.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Applications had been made for authorisations for people who were at risk of having their liberty deprived unlawfully, however, recommendations from the DoLS authority were not always acted on. Systems to obtain consent from people or from those who were legally able to make decisions on their behalf were not in line with the Mental Capacity Act 2005.

Medicines were not always managed safely. There were unsafe systems for the storage of prescribed skin creams. There were no protocols for 'as and when' (PRN) medicines and the management of 'over the counter' medicines did not follow the provider's policy.

Some areas of the environment were not clean and free from the risk of cross infection. There was a refurbishment programme in place, although this had not taken into account some safeguards to the environment such as hand rails in the new bathrooms and appropriate signage to help people find their way around. Other areas of the service were free from clutter and there were ample communal spaces where people could choose to spend their time. There were procedures in place in case of any emergency situations such as a fire. Equipment and appliances were regularly checked and maintenance repairs were carried out quickly.

Some of the care plans did not give staff clear guidance about how to support people. Care plans, also, lacked information about people's life histories, likes, dislikes and preferences, but staff knew what people did and did not like. There were clear lines of communication including the systems for handovers which had detailed information about people's key support needs, when staff shared information about people's needs and staff knew how to care for people.

People felt they were treated with dignity and respect and that staff were kind and caring. People who were supported with end of life care had their wishes and preferences taken into account. There were opportunities for people to take part in activities and some people attended day centres.

People were offered and received a healthy and balanced diet. There were a range of different meals to choose from and everyone we spoke with thought the food was, 'very good'. People could choose where to have their meals and the time they wanted them. People's nutritional needs were assessed and dieticians were contacted if

Summary of findings

there were any concerns about people's weights. People received appropriate health care support. People's health needs were monitored and referrals made to health care professionals if any concerns were identified.

Staff, were confident to 'blow the whistle' if they had any concerns about poor practice by other members of staff. Any concerns raised were acted on by the registered manager. Staff knew the possible signs of abuse and who to report any concerns to.

Staff valued people and made sure they were at the centre of the care they provided. People and their relatives felt the registered manager and staff were approachable and supportive.

People and their relatives had some opportunities to contribute to the service and had attended meetings.

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.

We have made a recommendation for the provider to consider improving the service.

We recommend that the provider seeks guidance and advice about best practice in ensuring the environment supports people living with dementia.

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 were not always assessed and staff were not always given guidance about how to reduce risks to people.

People were not protected because recruitment procedures were not being followed. There were not always enough staff on duty to make sure people received the care and support they needed at all times. Staffing levels had, however, recently been reassessed.

Systems were not in place to ensure people's medicines were managed safely.

Some areas of the service were not kept clean.

Staff knew about different signs of abuse and how to report any concerns.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not been given induction and training to enable them to deliver safe and effective care. Staff were not given the support they needed.

People's capacity to give their consent was not always assessed in line with the Mental Capacity Act (2005). Applications had been made for Deprivation of Liberty authorisations, but recommendations on the authorisations were not always acted on.

People received a variety and choice of nutritious and suitable foods that met their preferred choices. People's health care needs were monitored and they were supported to access health care professionals as needed.

Some newly refurbished areas of the service did not have appropriate equipment in place to help prevent the risk of falls.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some care plans lacked information about people's backgrounds, likes and dislikes. Staff communicated well with people and knew people's individual preferences.

Staff treated people with kindness and people felt staff were caring. People's privacy and dignity were respected.

People's wishes for their end of life care and support were acknowledged and acted on.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's needs were assessed before they moved in and plans of care were developed to support people with their needs. There was limited information recorded about people's life histories and backgrounds.

People could take part in different activities and were able to access local community resources.

Complaints were acted on, but resolutions to problems were not always sustained leading to further complaints.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Staff morale was low and staff did not feel they were supported on a daily basis. Staff, however, attended meetings and were able to have a say about the plans for the service.

There were audits and checks to monitor the quality of the service. These did not always identify areas of concern and address shortfalls.

The registered manager and staff knew and understood the values of the service and placed people at the centre of the care they provided.

People and their relatives had some opportunities to have their say and were kept informed of changes at the service.

Grenham Bay Court

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.

The inspection took place on 30 and 31 July 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor, who had clinical knowledge and experience of working with people, who are living with dementia and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service and had knowledge of people living with dementia.

We normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to do this because we carried out the inspection at short notice. Before the visit we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We looked at information received from social care professionals.

During our inspection we met and spoke with eight people. As some people had difficulties in verbal communication, 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 spoke with four relatives, nine members of staff, including the activities coordinator and the cook. We also spoke with the registered manager and a senior manager for the organisation.

We observed how staff supported and spoke with people. We observed the lunchtime meal and observed how people spent their day. We looked around the service including shared facilities, in people's bedrooms with their permission. We looked at a range of records including the care plans and monitoring records for seven people, medicine administration records, staff records for recruitment and training, accident and incident records, records for monitoring the quality of the service provided including audits, complaints records and staff, relatives and resident meeting minutes.

The last inspection was carried out in May 2013. There were no concerns identified.

Inadequate

Is the service safe?

Our findings

People said they felt safe. People told us, "I feel safe with my Zimmer frame which I do need. It is always near me so I can use it when I want". "Staff treat me well and I get the help I need" and, "The staff are magnificent and take great care of me". Visitors told us that their relatives were kept safe. Two visitors said they had chosen this service because there was a lift and they thought people could walk around safely.

Some people needed the support of staff and the use of specialist equipment to help them get in and out of bed or transfer to a chair. Moving and handling risks were not assessed or managed properly. There were moving and handling risk assessments but they were not specific to the person and did not give staff guidance about how to use equipment safely. For example, a risk assessment stated to use 'full hoist and appropriate sling' and 'to ensure that manoeuvre is carried out safely'. There was no instruction for staff about what the safest way to help the person move was or which type of hoist and sling should be used. None of the staff had been trained how to use the equipment including hoists. Some people had suffered minor injuries, such as bruises to their arms or legs, when staff had used this equipment and had not been supported safely.

Some people could become distressed or agitated and displayed behaviours that could be challenging. One person was anxious and upset. Different members of staff tried to support this person and they told each member of staff what they were upset about. The person repeated their concerns on a number of occasions. Staff could not console the person. The registered manager had accessed support for this person from the Mental Health Team to make sure the person had appropriate support. Staff were aware that the person needed constant support. However the risk assessment for the person did not give staff guidance about how to support, comfort and reassure them in this situation and only stated that safety checks should be carried out.. Staff told us another person became upset when staff supported them with personal care. Staff said that this person could scratch and hit out and they did not know how to support the person without the risk of getting an injury. We asked the registered manager how staff could support this person safely. She told us, "It helps if (this person) has something in their hands such as a blanket". This would occupy the person and reduced the risk of injury to staff. However two members of staff we spoke with were unaware of this procedure and did not know how to support the person safely. There was no information in the care plan about how to reduce the risk of injury to the person or staff. The provider has told us that the care plan has now been updated to tell staff how to support this person safely.

There was a system for recording how many accidents and incidents had occurred. However, the information was not checked to identify any patterns or trends, such as the bruising caused by the use of hoists so action could be taken to prevent further accidents and reduce the risk of further harm.

The provider had not assessed all of the risks to people's health and safety and failed to mitigate any such risks. This is a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks were managed safely. Some people were at risk of their skin breaking down and developing pressure sores. There were risk assessments that gave staff guidance about managing people's skin care and people were given the appropriate equipment to reduce the risk of sores developing including specialist mattresses and chair cushions. There were nutritional risk assessments to identify if people were at risk of losing weight. If people were at risk of falls, they were provided with walking aids to help them walk around safely.

Personal Emergency Evacuation Plans (PEEPs) were in place for people. These identified equipment needed to aid evacuation and the safest route for staff and people to follow if they needed to leave the building. There was a fire alarm maintenance contract and regular checks were carried out on emergency lighting and fire extinguishers. There was an emergency contingency plan in place which addressed a variety of possible situations and contained emergency contact numbers. Regular health and safety checks had been carried out including checks on hoisting equipment, water temperatures, scales calibrations, nurse call system, wheelchairs and window restrictors. Maintenance logs were reviewed and showed that when staff reported items for repair, these were addressed promptly and actions were recorded.

Staff recruitment did not always protect people from staff who were not safe to work in a care service. Recruitment

procedures must ensure that prospective members of staff are of good character and that there are appropriate checks carried out such as a Disclosure and Barring Service (DBS) criminal records check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Not all records were in place for new members of staff as required by Schedule three of the Regulated Activity Regulations. The records for one member of staff showed that gaps in employment history had not been questioned and recorded at interview. There was only one written reference in place instead of two and although a Disclosure and Barring Service (DBS) criminal records check had been carried out this had not been received and checked before the member of staff started work. Since our visit the provider has given us assurances that a new process had been put in place to monitor the progress of the DBS checks, which would further protect people. Poor practices had been identified for a new member of staff, but appropriate checks had not been carried out and other staff had whistle blown because they had concerns about their poor care practices.

The provider had not ensured that staff were recruited safely. This was a breach of Regulation 19 (1) (a) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines and prescribed creams were not always managed safely. A medicines trolley was unattended and there were medicines left on top of the trolley accessible to everyone. Bottled medicines and a bottle of an eye drop solution inside the trolley had not always been dated to show when they were first opened. Eye drops, in particular, are often meant to be disposed of 28 days after opening because there is a risk that the eye drop solution will no longer be safe to use. As the items had not been dated by staff when they had been opened, there was no way of knowing whether the drops had been administered after that 28 day period.

Bottles of creams had been left in an unlocked cupboard in a communal hallway. We were told that these creams should not have been stored there 'under any circumstances'. Some creams were kept in people's bedrooms so staff could access them easily; staff confirmed that they were not locked away. Many of the people were living with dementia and the failure to store medicines and creams securely placed them at risk. Following our inspection the provider took steps to make sure that creams and sprays were stored safely so people were protected.

Some people had been prescribed medicines to be taken as and when necessary (PRN). Staff asked people if they needed any pain relief and people's pain levels were checked and documented by staff throughout the day. Staff followed the prescribing instructions given by the GP, so people received these medicines safely. At the time of inspection there were no individual protocols. However since our inspection the provider has informed us that these would be put in place for each person.

Some people refused to take their medicines and these needed to be administered covertly so that people's health did not deteriorate. Covert is the term used when medicines are administered in a disguised format, for example, in food or in a drink. There were no medicine risk assessments in place for people in the care files and no clear guidelines about how to administer these medicines. However advice had been sought from the GP to ensure that these medicines were safe to be given covertly.

One person had an over-the counter medicine which, staff told us, had been supplied by that person's relative. Advice had not been sought from a GP or pharmacist about any possible interactions with the person's prescribed medicines. The policy about over- the- counter or 'homely' medicines stated that a GP should sign and date a letter allowing the administration of homely remedies. A copy of this letter should be kept on the person's care file. This had not happened so staff had not followed the policy, placing people at potential risk of receiving medicines which were not suitable for them.

Care staff applied creams to people, but a senior carer recorded this on the medicine administration record (MAR) charts. They were not the member of staff who had applied the cream and told us, "We just trust that the carers have done it". The Royal Pharmaceutical Guidelines for care homes state that the person who administers medicine, in this case a prescribed cream, should be the person who signs the MAR. All other entries on the MAR charts had been completed and signed by staff to show that medicines had been administered as prescribed. Following our inspection the provider contacted the pharmacy and arranged for separate MAR charts to be supplied so that staff could record when they had administered creams.

Inadequate

Is the service safe?

Some medicines needed to be kept in fridges or special cupboards. These were stored and locked away appropriately. Temperatures were taken of the fridge and medicine room to ensure that medicines were maintained in a suitably cool environment and would work as they were supposed to. Audits and checks were carried out on medicines to make sure stocks were at the correct level. There were systems in place for the delivery and return of medicines. Only staff who had been trained administered medicines.

Overall the environment was clean, tidy and smelt fresh, but some areas needed attention. The laundry was untidy, cluttered and dirty. There was not a clear route in and out of the laundry to separate clean and dirty washing. Baskets of dirty washing were placed near clean laundry and clean blankets had been placed on a floor that was covered in dust and dirt. Bacteria and germs live in dust and pose a risk to frail older people. These all posed a risk of cross contamination and infection. Some of the toilets and commode pans were dirty and stained and a shower chair was not clean. Standards of hygiene were not being fully maintained, putting people at risk from cross infection. Actions were taken to clean the laundry but an audit had not identified the infection control risks in the laundry.

The lack of safe systems did not ensure that people's medicines were always managed safely and that people were protected from the risk of infection. This was a breach of Regulation 12 (2) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mixed opinions about the number of staff on duty. Staff told us that they had been short of staff during the previous weeks and this meant that they had not always been able to give people a bath or a shower when they wanted one. They said that when helping people with personal care they had to, 'sometimes rush people'. One person told us, "They are short staffed at times". The rotas showed that staffing levels had not been consistent and the number of staff on duty had not always met the assessed number of staff needed to meet people's needs. The registered manager had a process to help them decide how many staff were required and had recently recruited two additional agency members of staff to work at the service for a period of two months, to cover shortfalls. The registered manager told us that this would enable them to keep staffing levels at the correct levels and give them the opportunity to recruit permanent members of staff.

There were systems in place to protect people from the risk of abuse. There was a policy and procedure that gave staff the information they needed to ensure they knew what to do if they suspected any incidents of abuse. Staff knew and understood their responsibilities about how to keep people safe and knew how to recognise different types of abuse. Staff described different types of abuse and what they would do if they were worried about the safety of anyone at the service. The registered manager knew and understood their responsibilities and reported any concerns appropriately to the local authority who were responsible for carrying out any investigations.

Staff told us about whistle blowing procedures and what they would do if they were concerned about another member of staff's conduct. Two members of staff told us that they had used the whistle blowing procedure and that their concerns had been acted on. Staff said, "I would report anything straight away and I feel it would be dealt with properly" and "We can report anything and know it will be sorted out".

Requires improvement

Is the service effective?

Our findings

People and their relatives had mixed views about the way they were cared for. One person said, "I don't think the staff have the right skills". Another person said, "The staff work long hours and they get tired". A relative told us, "When I ask staff anything they often tell me they don't know or they weren't on shift. Staff don't always take responsibility". Other people and their relatives were happy with the care they received. People commented that if they asked for help, then, 'nothing was too much trouble' for staff. People said, "They (the staff) take great care of me" and, "I just need help getting around sometimes and staff always help me".

Staff did not have the skills and knowledge they needed to always meet peoples' needs. Some people needed support to help them get in and out of bed or into wheelchairs and chairs. Some people also needed help with the use of specialist equipment such as hoists. In order for this to be done safely, staff need to be trained in the practical use of moving and handling techniques and be taught how to use any equipment to ensure people were moved safely. Staff had completed a workbook and a test to show that they understood the theory of how to move people safely but none of the staff had received practical training in moving and handling people safely. Staff told us they had been shown how to use equipment by other members of staff but had, "No proper training". Some staff said that they had seen other members of staff using equipment inappropriately and they felt some staff were, "Not competent to use lifting belts and hoists". One member of staff had been shown how to use equipment by another member of staff who had not been trained in how to use this equipment. The accident and incident records showed that some people had sustained minor injuries, such as bruises, whilst being hoisted. People were not being moved safely because staff had not received the training they needed. Following our inspection arrangements were made to provide staff with the training they needed to make sure they had the competency and skills to help people move safely.

The majority of training was delivered through a system where staff were given a work book to read through and they then completed a questionnaire. On completion of this they were awarded a certificate. Staff told us that the majority of training they received was unsupervised and said the training was in their opinion, "Terrible". Some staff told us they could not absorb the information in this way and thought the training was, "Completely inadequate for practical areas such as moving and handling".

There was a training programme in place for the year, but the training plan did not take into account the shortfalls in training and prioritise training needs. Most people had dementia related conditions, some people lacked capacity and some people could become agitated at times. Training in dementia awareness and 'coping with aggression' had taken place, but only a small percentage of staff had completed this. Additional training in these areas was not booked until later in 2015, meaning many staff had not had the opportunity to complete this training. Less than a quarter of staff had completed training in the Mental Capacity Act (2005) and managing challenging behaviours and neither of these courses were booked to take place before the end of 2015. Some staff told us they 'struggled' to support one person who could be aggressive when they helped them with personal care. The provider informed us that the training plan had been reviewed and the training would be prioritised to ensure that staff were supported with their training needs.

Some staff were allocated as mentors in specific areas of training. This was so they could support other staff. Staff who had been appointed as mentors had not received training in some of the areas they had been given responsibility for. Therefore, they had not been supported to gain the skills and knowledge to enable them to support and coach other staff.

Staff were not given the support they needed when they first started working at Grenham Bay Court. There was an induction process in place, but new members of staff did not always complete this induction when they started work. Three new members of staff had not completed any induction and another member of staff had only completed a basic induction. Training in key areas such as moving and handling had not been organised for new staff and new members of staff were being shown how to use equipment by staff who were not qualified to use it. New members of staff said they had not received any induction and one member of staff told us, "I haven't had any induction at all or been shown how to use the equipment". Following our visit the provider reviewed the induction programme and assured us that new staff have completed induction and that the new induction would include the Care Certificate.

Requires improvement

Is the service effective?

Staff had not met with the manager or a senior member of staff for supervision on a regular basis. Most staff had only received one supervision session during 2015 and told us they felt unsupported. They said they did not have many opportunities for supervision and felt if they did have any questions they did not like to ask for help. Some staff told us that sometimes they felt they 'weren't good enough', but were not given the support to help them improve. Following our visit a supervision programme was put in place to ensure staff were given the support they needed.

Staff were not supported to gain the skills and knowledge they needed through appropriate support, training, professional development and supervision to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Applications had been made to the DoLS office for people who had been assessed as having their liberty restricted. Some people had a DoLS application authorised. However, when a DoLS application is authorised, recommendations are made so staff can support each person in the least restrictive way. Recommendations made by the DoLS office had not been acted on. For example, it had been recommended that one person should be supported to have regular supervised access to the community. Although this person could go on outings with other people, there was no information in the care plan about how to ensure this person was supported to go out on a regular basis. Staff were not aware of this. It had also been recommended that another person should be helped with 'appropriate tasks', which reminded them of their occupation when they were working. This was not happening. Staff could not find the authorisation for a third person and there so was no information available in the care plan to show what recommendations had been made.

People were not protected from being deprived of their liberty because recommendations from DoLS authorisations were not being followed. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had limited understanding about the Mental Capacity Act (MCA) 2005 and how to apply the Act to every day practice. When people moved in a general assessment was made about their capacity to make decisions. This was a general assessment and not decision specific and had not been reviewed since people moved in even though capacity to consent can fluctuate and change for people living with dementia.

Some people were receiving their medicines covertly, which is when medicine is given without their knowledge or consent and it was hidden in food or drink. For these people, there were letters of permission from relatives and G.P.'s to allow staff to crush tablets and place the medicines into food or drink. Two of the people receiving medicines covertly had been assessed as lacking capacity to make a decision; but not specifically in relation to the decision about whether to take their medicines. There was no capacity assessment in the third person's care file to check if they were able to make this decision. The MCA states that any assessments should be decision specific and not general. If a person is assessed as lacking the capacity to make a decision a 'best interest meeting' should be held with. There were no best interest meetings recorded. A best interest meeting is needed where the decisions facing the person are complex and people need to be supported to ensure that their rights were properly protected by decisions made on their behalf.

The provider did not have proper procedures in place to obtain consent from the relevant person for care and treatment. This was a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People enjoyed the meals and everyone we spoke with told us the food was, 'very good'. People commented, "There is plenty of food" and, "It is very nice". People thought there was plenty to choose from although some people told us they felt overwhelmed by the amount of choices.

Requires improvement

Is the service effective?

People were supported to eat their meals where they wanted to and could go to the dining room, sit in the lounge or stay in their rooms. People who needed assistance were helped discreetly by staff. Mealtimes were a leisurely affair and people were not rushed.

Breakfast was served when people got up and people could choose from cereals, toast or ask for something cooked. The lunch time meal consisted of three courses and people could choose from a starter of soup, melon or prawn cocktail. The main meal included a choice of between three and five different dishes and there was a choice of three or four desserts. The meals were freshly cooked each day and looked and smelt appetising. There was a range of hot and cold options for people to choose from for their evening meal. At other times snacks and drinks were offered on a regular basis.

The cook confirmed that diets were enriched with whole milk, creams and butter for people who needed additional fortification in their food to help keep them healthy. There was information in the kitchen about any specialist needs relating to people's nutrition such as any food allergies, specialist diets, enriched meals and any food supplements needed. This also recorded what people did not like so they would not be given something they did not want. This was kept up to date to ensure any changes in people's nutritional needs were met.

There were food and fluid charts in place for people who needed to be monitored to ensure they did not lose weight and drank enough. Some people had reduced appetites or needed additional support to make sure they drank enough. There was information in care plans and the handover records to make sure staff were reminded to encourage these people with their food and fluids. One person refused their meal at lunchtime, so staff offered a range of choices and options to try and encourage this person to eat their meal. The person did not want anything to eat, but this was recorded so staff were aware to try and offer a meal later in the day.

Nutritional assessments were completed on a monthly basis to monitor people's food and fluid needs. People were weighed and action was taken to address any weight loss such as contacting the dietician or doctor for advice. Some people could not use the weighing scales and staff made sure these people were monitored by using a recognised good practice method of regularly measuring around their arm. Some people had poor skin conditions and changes in their weight or nutritional needs had the potential to affect their skin. People's weights were used to check against potential issues that may affect their skin integrity such as increase in possible pressure sores. Actions were taken and district nurses were involved to ensure people were supported with the right equipment such as airflow mattresses and specialist cushions they could sit on to reduce the potential of developing sore skin.

Referrals were made to health professionals as needed such as the doctor, chiropodist, dentist, dietician and district nurses. Records were in place to show what people were allergic to and there were contact details for the G.P. or other healthcare professional support. Some people were being supported at end of their life and needed additional health care support. They were visited regularly by appropriate health care professionals.

The service was undergoing a refurbishment programme in order to make improvements to the environment. There were new bathrooms which were well fitted and modern with flush floor walk in showers and / or a large bath. However, there were no supporting grab rails to help people keep their balance and one new bathroom could not be used because there was not a suitable hoist to use with the bath. Although there had been no accidents in these bathrooms, there was a potential for people to slip or fall as there were no suitable aids to support them keep their balance.

There was very little signage to help people find their way around to ensure they did not become disorientated. Bedroom doors were not personalised to help people know which room was theirs. Toilets and bathrooms were not clearly signposted to help people recognise these rooms.

There were large communal areas and hallways through to different parts of the service which were free from clutter and obstacles that might cause people to trip. The lounge areas were set out so people could sit and talk to each other and there were quiet areas where people could sit and read rather than watch television if they wanted to.

We recommend that the provider seeks guidance and advice about best practice in ensuring the environment supports people living with dementia.

Requires improvement

Is the service caring?

Our findings

People were complimentary about the caring nature of the staff. People told us, "They pamper me here". "The staff have always got a cheerful smile and that makes such a difference" and “The staff treat me well and are friendly”.

Relatives told us they felt involved and fully informed about the care their family members received. One relative said, “Everyone helps and it is lovely here”. Another relative told us how, ‘staff had gone out of their way’ to arrange a party. They said, “Nothing was too much trouble for staff”.

There was variable information in care plans about people’s life histories, likes, dislikes and to what extent people had been involved in making decisions about their care. Staff, however, demonstrated that they had a good understanding of people’s preferences, likes and dislikes. Relatives told us that they were involved and consulted about the care of their family member and people told us that staff supported them in the way they preferred.

Staff values were discussed at team meetings to reinforce staff behaviours so staff were aware that people were the focus of the service and the care they received should be central to their needs and not task orientated. Staff told us they tried to spend as much time as they could with people, although sometimes staffing levels meant that they could not always do this.

People were given choices about where they spent their day. Some people preferred to spend their time in their rooms and told us that they could choose to do this. One person said, “My room is comfortable and I like spending time in there”. Some people preferred to spend their time in the main lounge area, and when people wanted to go to a quieter lounge they were supported to do this, as staff listened to what people asked. People told us that when they asked for help staff listened to them.

Staff communicated with people in a way they understood. Some people could not hear very well and staff spoke slowly and raised their voices to help the person hear them, but they did not shout loudly at people. Staff offered comfort if anyone was upset. Although staff were busy they sat and chatted with people when they had the opportunity. Observations showed there was ‘cheerful banter’ between people. Staff were laughing and joking with people and talking about different things that interested them. One person was interested in cricket and a member of staff had a conversation about the latest cricket scores. Staff were considerate and people responded well when staff spoke with them.

Relatives thought staff treated people with dignity and respect. One relative told us, “When they help with washing and dressing it is done with dignity. We are asked to leave the room so they can have privacy” and another relative said, “Staff are very respectful and very polite”. Staff told us how they promoted people’s dignity and explained that they always made sure people’s doors were closed when giving personal care. Observations showed that staff respected people’s privacy and when they asked people if they wanted to help to go to the toilet, this was done quietly so they were not overheard by other people. People were asked if they preferred male or female staff to support them and people told us that this was always respected.

People were supported to maintain friendships, and to keep in touch with family and friends. People told us they had made friends with other people at the service. One person said, “I like to sit and chat and I have plenty of people to talk to”. Relatives told us they ‘turned up unannounced’ and were made welcome when they visited. One relative said, “We can come at whatever time we want”. Another relative said, “If we want to take Mum out, the staff always make sure we have everything we need”.

Some people were being supported with ‘end of life’ care. This is when a care pathway has been discussed and agreed by the person, where possible, families and health professionals involved in people’s care. People’s care plans for end of life care included how to support people with their personal care, mouth care, management of pressure areas to prevent people from suffering from sore skin and management of pain. People were supported to make choices about how they wanted their care to be delivered and families told us they were involved. Some people had ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) decisions in place. These had either been made in people’s best interests by a doctor and had been discussed with the person or their relative or by the person themselves. The registered manager made sure these were reviewed at regular intervals so they were always up to date. The registered manager stated that they were committed to

Requires improvement

Is the service caring?

supporting people to stay at the service and worked with health professionals to enable this to happen to prevent people having to move to unfamiliar surroundings in their last days.

There was information about advocates, and people were supported to access additional support if they needed it. Some people had a lasting power of attorney in place and the registered manager was aware of which relatives had the authority to make decisions.

People's care plans and other records were kept in an office. These records were only accessible to staff, so information was kept confidentially. Staff did not talk about people in front of other people. Handovers were carried out in the privacy of the office and when staff completed their daily notes, they sat in a quiet area so records were not visible for other people to read.

Requires improvement

Is the service responsive?

Our findings

Most people thought staff were responsive and supported them to keep their independence. People told us, “Staff will always help me if I need it, but I like to do as much as I can on my own”. “I have to have some help washing and dressing and they (the staff) are very good” and "I can get up when I like and I go to bed when I want, which is quite late and staff don’t mind at all”. One person told us they had fallen in their room during the night and couldn’t reach their call bell. They went on to say, “I was alright because staff always check on me every half hour, so they helped me”. One person told us that staff, “Did the best they could” but felt that they sometimes had to wait for support as staff were very busy.

Relatives were mainly positive about the way staff supported their loved ones and one visitor told us, “We are able to talk to staff and they are very pro-active”. Another relative, however, said “Sometimes staff are slow to respond and I don’t feel they can always answer all my questions”.

Staff were mostly responsive to people’s needs by helping people when they asked for support. One member of staff, however, told one person they would have to wait for ‘a minute’ before they helped them because they were writing up their notes. This person had to wait for a few minutes before they were helped. Other staff responded immediately when they were asked for help and people were given the help they needed when they needed it. One person was agitated and staff were concerned that this person was unwell and contacted the person’s G.P. to arrange a visit for them.

One relative said staff did not always offer people who stayed in their rooms the same choices as people who spent time in the communal areas. They told us, “People who are in the main lounge can have more fruit and get asked if they want a glass of wine with lunch. That doesn’t happen for (my relative) when I visit, because they spend all their time in their room”. We asked the registered manager what arrangements were in place for people who spent most of their time in their room. The registered manager told us that the fruit would be offered in the same way as it was offered to people who spent their time in the communal areas. They also told us that this included the arrangements for offering people wine, although some people’s needs meant that they were not able to drink. The registered manager told us that they would check the records to make sure that people were being offered the same choices at all times.

Care plans contained some information about people’s preferences, choices, likes and dislikes, which included favourite foods and what time people liked to get up and go to bed. This information was not recorded for everyone and for others, lacked detail. People living with dementia may remember and want to talk about historical events rather than more recent events so it is important to ask about and record this information. Staff demonstrated that they knew what people did and did not like and could tell us about people’s preferences which reflected what people told us and what the care plans stated. However, this information should be recorded for everyone so that all staff, including new and agency staff are aware.

People’s care needs had been assessed and documented before they moved in. This took into account people’s physical and personal care needs. A short term care plan was developed from this assessment and a more detailed care plan was written once people had lived in the service for a while. Most of the care plans contained information about people’s needs and gave staff guidance about how to support people. Some parts of the care plans lacked detail so staff were not given the information they needed to provide consistent support. For example, care plans for people’s mobility did not give staff guidance about how to use equipment to move people safely.

There was a system in place to make sure that staff were given the information they needed when they started a shift. There was a handover record which gave information in relation to each person’s key support needs such as to encourage a person to drink or to ensure people were turned at regular intervals if they were in bed. This was updated when there were changes in people’s health or support needs. Staff told us the handover was important and it kept them up to date with any changes in people’s needs.

There was one full time activities coordinator working at the service when we visited. Another member of staff had been appointed as a second coordinator and was waiting to transfer across to this role. These staff told us that this would give them the opportunity to improve and develop activities.

Requires improvement

Is the service responsive?

The current activities coordinator supported people with one-to-one time, carried out personal shopping for people and accompanied people to hospital appointments. In the mornings they spent time with individual people. Some people spent all of their time in their rooms for reasons of choice or ill-health and their care plans identified that staff should spend some 'one-to-one' time with people to prevent isolation or loneliness. Staff told us that this happened 'as often as possible'. We visited some people who stayed in their rooms and observed that staff checked on these people. Staff interacted well and spent time talking to them. We also observed the activities coordinator spending time with people in their rooms reading and chatting to people.

There was a mixture of activities to take part in including arts and crafts, drawing, a knitting circle and a range of board games. Regular outside entertainment was provided with different entertainers visiting the service providing music and exercise sessions.

People had opportunities to access local community resources. Some people attended a day centre on a regular basis. A visitor told us that their relative had been, 'keen to keep visiting their day centre' and staff had supported them to do this. Some people liked to go out shopping and staff arranged for this to happen. Various trips out had been arranged including visits to local historical towns, garden centres and a countryside public house.

People told us they could join in activities when they wanted. Some people preferred to sit in a quiet lounge and read books or newspapers. Other people liked to join in the arts and crafts. Most people told us they were happy with the activities, although one person felt that was, "Never anything to do". The person's care plan stated that they liked to watch television but did not identify any other activities they enjoyed, so staff had not explored what else they could offer the person to give them a variety of activities to be involved in.

The management of complaints was inconsistent even though there was a complaints policy and procedure in place. The complaints procedure was on display so people knew who they could make a complaint to, although it was only available in one format that some people may find difficult to read due to the size of the print.

People and their relatives told us they were happy to raise any concerns or complaints should they feel they needed to. Some relatives thought any concerns were handled quickly and staff resolved any issues. However, not all relatives thought complaints were handled properly. One relative told us, "I have made complaints on numerous occasions, sometimes verbal and sometimes in writing". They went on to tell us, "I am confident that they will do something and I think we have got things sorted out, but then before long it's forgotten about and we are back where we started".

Requires improvement

Is the service well-led?

Our findings

People and relatives told us that the registered manager was approachable and polite. Most relatives felt that manager responded quickly to any queries they had and addressed any issues and told us, "The manager is very good and very helpful" and "I can always speak to her when I need to know anything". Some relatives, however, felt that although the manager acted on any concerns they had, they felt any improvements or changes that were made were not always maintained.

Quality assurance systems are about improving standards and ensuring that the service is delivered consistently and safely. Although there were regular audits carried out to check areas such as infection control, medicines and accident and incidents, the most recent audits did not highlight some of the shortfalls identified at the inspection. For example, the infection control audit had found the laundry to be 'satisfactory', but when we inspected there were no proper systems for keeping clean and dirty laundry separate and areas of the laundry were dirty. The medicines audit had not identified that there were not any protocols in place for 'as and when required' medicines. A monthly audit of accidents recorded the number of accidents, but did not identify who had been involved or how the accident had occurred. This information was important to help recognise trends and patterns to reduce the likelihood of reoccurrence. Following our visit the provider reviewed how audits were carried out and told us that monthly audits would be taking place and the outcomes would be reviewed to ensure actions were taken to address any shortfalls.

Complaints were not used as part of the quality assurance process to look at where improvements could be made. Written complaints were logged and acknowledged and responded to fully within the timescales set out in the policy. No record had been maintained of any verbal complaints which meant that the manager did not have complete oversight of all of the complaints and what they related to in order to prevent the likelihood of any problems reoccurring. Resolutions to problems that had caused complaints were not always sustained leading to further complaints. The provider assured us that the complaints procedure would be reviewed to ensure that verbal complaints were recorded.

The registered manager told us that they were responsible for staff training. Although there was a training plan for the year, this had not taken into account or prioritised key areas of specific training related to people's specific needs or conditions. Staff felt they lacked some skills and told us they were not always sure how to support a person when they became aggressive towards staff or how to use equipment safely. Staff did not have the knowledge they needed to support people in accordance with their needs. Following our inspection the provider has sent us assurances that the training programme has been reviewed to prioritise the training needs of staff.

Staff said that morale was low. Staff told us that they did not feel they could always approach the manager and that they felt unsupported. Staff said, "Sometimes we feel we are being talked down to" and "I feel like I am treading on eggshells sometimes". Other staff commented that they felt the management support was "inconsistent" and said, "Sometimes we just don't get any help so we won't ask". Some people had noticed that staff were unhappy and told us, "Staff morale is low" and "They (the staff) are afraid for their job which is why they don't say anything".

Some staff felt they were not always supported to meet the challenges they faced. For example, one member of staff said, "I am expected to do a lot of different things during my shift, but sometimes I just don't have the time and I don't like to say anything because it is what I am expected to do". Another member of staff said, "I was given some set responsibilities, but I haven't been given the proper training to carry this role out".

We asked the registered manager what they did to ensure that staff were supported. The registered manager said that staff meetings were arranged on a regular basis. The minutes of the meetings showed that these were used to share information with staff including informing staff about new legislation and regulations. Staff had been told about the new Care Quality Commission (CQC) inspection process, so they knew what to expect when an inspection took place. At these meetings staff were invited to contribute and have a say about how the service was run. For example, discussions had been held about a new way of managing meals so that people could have a choice of having their meals when they wanted. Staff had also completed a survey, and the feedback from these had been

Requires improvement

Is the service well-led?

positive. So although there were opportunities for staff to have a say at meetings, they did not feel as supported on a daily basis and did not feel they could speak out at group meetings.

The provider did not have systems in place that operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and act on feedback from relevant people. This was a breach of Regulation 17 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff had told us that they did not always feel supported, all the staff we spoke with were confident that if they raised any concerns about the care provided or about staff values, that these would be addressed. One member of staff told us, "I have reported something and I know it is being dealt with". Staff also told us that senior management were available and visited the service regularly.

Staff felt they worked well together as a team and said they 'supported each other' to provide care to people. Staff said, "Teamwork is really good here and we share information". Staff said communication was good and that they knew what was expected from them when they were at work. They told us they were given the information they needed to support people through handover records and updates from senior members of staff. Observations showed that staff knew what support each person needed.

The culture of the service was to prioritise people and make them the focus of the service and ensure that everyone received individual care suitable to their needs. This had been discussed in staff meetings. Staff told us that they always put people first and spent as much time as they could with individual people, but felt that due to previous shortfalls in staffing levels they had not always been able to achieve this. Staff went on to say, "It is all about people who live here. They deserve the best we can do" and "We will spend as much time as possible with people, we are here to take care of them".

Relatives had been invited to meetings and were told about changes that were happening and had an opportunity to give their opinions of the service. A relative told us "We attended a relative's meeting recently to discuss all the new maintenance and were asked for our opinion". Some relatives said they were unsure about the planned changes to how the meals would be managed, and this was being looked at to ensure that any changes would be suitable for people. Relatives had asked for staff to be given identity badges and this had been implemented.

The minutes of meetings showed that one of the biggest challenges faced by the service was staffing levels. Staff had been concerned about the amount of staff on duty and actions had been taken to address this, so people were more likely to be given the support they needed when they needed it.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC checks that appropriate action had been taken. The registered manager understood her responsibilities with regard to her registration and any untoward incidents or events at the service were reported in an appropriate and timely manner in line with CQC guidelines.

Staff and the registered manager worked closely with local organisations to promote people's continued involvement in the community. Close links were set up with the district nurses and GP surgeries so people had access to the health care support they needed.

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 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have proper procedures in place to obtain consent from the relevant person for care and treatment.** **Regulation 11 (1) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were not protected from being deprived of their liberty because recommendations from DoLS authorisations were not being followed.** **Regulation 13 (5).**

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 ensured that staff were recruited safely.** **Regulation 19 (1) (a) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not assessed the risks to people and failed to mitigate any such risks.**

This section is primarily information for the provider

Action we have told the provider to take

	The lack of safe systems did not ensure that people's medicines were always managed safely and that people were protected from the risk of infection. Regulation 12 (2) (a) (b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems in place that operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and act on feedback from relevant people. Regulation 17(1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18** Staff were not supported to gain the skills and knowledge they needed through appropriate support, training, professional development and supervision as necessary to enable them to carry out the duties they were employed to perform. Regulation 18(2) (a)