Care Quality Commission

Gracewell Healthcare Limited

Gracewell of Fareham

Inspection report

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Date of inspection visit: 25-26 November 2015
Date of publication: 07/03/2016

Ratings

Overall rating for this service	Inadequate
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?	Inadequate

Overall summary

This inspection took place on 25 and 26 November 2015 and was unannounced.

Gracewell of Fareham had recently changed its name from Parker Meadows Care Home. The service is registered to provide accommodation, nursing and personal care services for up to 89 older people and people who may be living with dementia or a physical disability. At the time of our inspection there were 75 people living at the home. They were accommodated in a purpose built building consisting of three floors and six bungalows for people with greater independence. The ground floor accommodation was intended for people with less complex needs, people living with dementia were supported on the first floor and the second floor accommodated people with other, more complex nursing needs. Each floor was managed by a unit manager (although one post was vacant) and divided into two named wings. Each wing had a shared sitting and dining area and each floor had a larger, central shared area. The ground floor had a hair dressing salon and cafeteria area.

The service had been without a registered manager since January 2015. 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.

Summary of findings

When we inspected the service in September 2014, we found that records and record keeping did not meet the minimum standards required by the Regulations. At this inspection we found continuing problems with records.

There had been a period of staff instability with a number of experienced management, care and nursing staff leaving. This had led to reliance on agency staff. The provider had recognised the service in some areas had fallen below the minimum standards expected. They had appointment a new home manager and developed a "Community Development Plan" to improve the service. The home manager was supported in this by the director of operations, and management and specialist staff from other homes and elsewhere in the organisation. Their plans included actions to address most of the areas of concern we identified.

The provider had processes and procedures in place to protect people from avoidable harm and to manage risks to their safety and welfare. However these were not always followed and effective. This meant people were at risk of abuse, avoidable harm and inappropriate care and treatment. The provider did not always make sure there were always sufficient staff deployed who were able to support people according to their needs and preferences. Processes were in place to store, manage and administer medicines safely, but these were not always followed where people were prescribed creams and ointments to be applied "as required".

The provider had processes and procedures in place to make sure people who lacked capacity to make decisions were protected. However these were not always followed and people were at risk of receiving care which was not in their best interests. The provider supported most people to eat and drink enough and to have a balanced diet. However some people's specialised dietary needs had not been incorporated in their care plans. The environment was decorated and maintained well, although some of the furniture and crockery was not suitable for people with limited mobility and movement. People were supported to maintain good health by access to other healthcare services when they needed them. The provider had a training programme to keep staff members' skills and knowledge up to date.

Most staff developed caring relationships with people, took steps to involve them in their care and support, and helped them to maintain their dignity and privacy. However we saw some examples of staff behaviour which was not caring or respectful of people as individuals.

While some people's care and support met their needs and reflected their preferences, other people did not have the same experience. Staff did not always follow people's care plans, and care plans did not always reflect people's needs, particularly when their needs changed.

There was a variety of activities and entertainments for people to enjoy. The provider made people aware of their complaints process, and complaints were followed up and logged.

The service had not been well led in recent months and staff had become demoralised. The provider had recognised problems with the service and identified actions to resolve them. There was a new, experienced, home manager in place but they had not had time to bring about significant changes to the quality of service provided.

The overall rating for this service is Inadequate and the service is therefore in "special measures".

We keep services in special measures under review. If we have not taken immediate action to cancel the provider's registration of this service, we will inspect them again within six months.

We expect that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If the provider has not made enough improvement in this timeframe so that there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures to begin the process to prevent the provider from operating this service. This will lead to cancelling their registration or to changing the terms of their registration within six months if they do not improve.

We will continue to keep this service under review and, if needed, will take urgent enforcement action. Where necessary, we will conduct another inspection within a further six months, and if there is not enough improvement so there is still a rating of inadequate for

Summary of findings

any key question, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to changing the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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.

People were not always protected against the risk of avoidable harm because safeguarding procedures were not always followed.

People were not always protected against other risks to their safety and welfare because risks were not always identified, assessed and managed effectively.

People were not always supported by sufficient staff with the right skills and experience.

Most medicines were managed and administered safely, but records of creams and ointments applied “as needed” were not kept up to date.

Is the service effective?

Requires improvement

The service was not always effective.

People who lacked capacity to make decisions were at risk of receiving care that was not in their best interests and of being deprived of their liberty without legal safeguards.

Some people with specific dietary needs did not receive appropriate support to eat and drink enough. However most people had access to a healthy diet with menu choices.

People could see their GP and other specialist healthcare providers when they needed to.

People were supported by staff who kept their knowledge and skills up to date.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always supported by staff who behaved in a way that showed they were caring and respected people’s dignity.

People were not always encouraged to take part in decisions about their care and support.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive care and support that met their needs and reflected their preferences.

People had access to entertainments and activities according to their choices.

Summary of findings

People were able to make complaints if they needed to, and the provider recorded and followed up any complaints.

Is the service well-led?

Inadequate

The service was not well led.

The new home manager had not had time to make significant improvements following a period of poor leadership which had led to low staff morale and examples where the provider's processes had not been followed.

The provider had systems in place to monitor the quality of service provided. There was a service improvement plan in place but it had not yet delivered the necessary improvements to meet the minimum standards required by the regulations.

Gracewell of Fareham

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 26 November 2015 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. 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.

We spoke with 19 people who lived at Gracewell of Fareham and three visitors. We observed the care and support people received in the shared areas of the home, including part of a medicines round.

We spoke with the provider's director of operations, the home manager and other members of staff. These included a unit manager, an interim deputy manager, five nurses, seven care workers, an activities coordinator, a chef and members of the catering, housekeeping and maintenance teams.

We looked at the care plans and associated records of 12 people. We reviewed other records, including policies and procedures, internal checks and audits, quality assurance survey results, training and supervision records, meeting minutes, newsletters and other information provided to staff including the staff handbook. We looked at the recruitment records for four staff members, nurse diaries, staff rotas and records of staff handovers.

We saw records associated with the provider's "Community Development Plan", and the home manager and director of operations sent us updated information about this improvement plan in the weeks following our inspection.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and staff treated them with respect. One person said they felt "quite safe" and another said, "It is the best it can be for a communal living place". The service had procedures and policies in place to protect people and manage risks to their safety and welfare, but we found they were not always followed.

Staff told us they were aware of the provider's policies and procedures on safeguarding adults and whistle blowing. They said they were confident any concerns raised would be followed up in a timely and effective manner. Information about safeguarding and whistle blowing was included in the staff handbook. There was a safeguarding file which contained three records of safeguarding concerns which had been followed up. One of these had been reported to the local authority safeguarding team, and found to be not substantiated. Two had been investigated internally.

However we found records in four people's files of unexplained bruising which were not included in these safeguarding records. Two of the files included photographs. One of these was described as an "old bruise" but the bruise was not mentioned in earlier records, such as when staff supported the person to have a shower. The third person's file contained the note, "Whilst assisting with personal care found bruise on hip". The fourth person's notes stated, "Bruises on arms cause unknown".

There were no records in these people's files to show that the concerns raised in their notes, and in two cases photographed, had been followed up or investigated. The provider had a log of accidents and incidents which included occurrences of pressure injuries, unplanned weight loss, and injuries and falls. However none of the four examples of unexplained bruising had been raised as an incident or accident in this file. We found no evidence these incidents had been identified and reported as safeguarding concerns.

We discussed this with the home manager and director of operations. They were not aware of the individual examples of unexplained bruising we had discovered. They added wound management procedures to their care planning improvement plan.

Failure to operate effective processes to prevent abuse and investigate allegations or evidence of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had processes and procedures in place to manage risks to people's personal safety and welfare. Personal emergency evacuation plans were in place which identified people's needs in the event of an evacuation. There were thorough records of checks and maintenance to fire safety equipment, kitchen and laundry gas appliances, hoists and lifts. Processes were in place to manage risks associated with water temperature and legionella. Rooms were checked for safety issues regularly and a maintenance book was maintained on each floor to record minor works and repairs.

Processes were in place to protect people against individual risks associated with their care needs and conditions, however these were not always effective. People's risks of poor nutrition and of acquiring pressure injuries were assessed and reviewed monthly using standard tools. These risks informed their nutrition and skin integrity care plan. Where people were at risk of falls there were moving and handling risk assessments and falls prevention action plans. Where people were protected against the risk of falling from bed by the use of bed rails or by positioning their bed against a wall, there were assessments of the associated risks, and action plans in place, for instance to check the person once an hour.

However we found examples where there were risks that had not been identified and assessed or where the risk assessments were not effective in making sure people received safe care and support. One person had a feeding tube. Records showed their tube frequently fell out. Staff had consulted with a specialist nurse at the local hospital but their advice had not resolved the problem. A review of the person's risk assessment was two weeks overdue.

Another person's records showed they behaved in ways that could be aggressive and dangerous to themself and to staff supporting them. Their care plan recorded incidences of these behaviours, but there were no instructions to staff on how to manage this, no information about what might trigger the behaviours, and no risk assessments in place. We spoke with two experienced members of staff about this person. They told us they had worked out their own strategies to support the person safely. They described the person as "difficult" but did not experience physical

aggression when supporting them. However this information had not been recorded for the benefit of other staff. Records showed the same person had been losing weight, but this had not been identified as a risk, there was no risk assessment and their care plan had not been amended.

Information in another person's care plan was out of date. They were losing weight, were reluctant to accept support with personal care and had four pressure injuries. These changes had not been identified as new risks, there were no risk assessments in their care plan to reflect these changes in their needs, and no information on how to care for them safely.

Records showed another person had suffered a fall from bed. A crash mat was in place which had prevented serious injury. A note on the incident report stated "cot sides" were "not allowed", but elsewhere in their file there was a risk assessment for bed rails which had been agreed to by a family member. These records were dated ten months before they fell from bed.

We discussed these examples with the home manager and director of operations. They were aware that care plans and risk assessments were not always up to date and fit for purpose, and had started a review of all care plans.

Failure to assess risks and take action to mitigate them was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager and director of operations told us staffing levels were based on people's needs and there were dependency assessments in people's care files. However they said the provider's usual model for defining staffing requirements tended to underestimate the staff required at this home. This was due to the large numbers of people with complex needs and the unusual layout of the home which meant it was difficult to support people who could be in one of three shared areas on each floor or in their own room. They had recognised before our inspection that the provider's standard process led to staffing levels that were not appropriate to this home, and had agreed increases in staff numbers in some areas of the home. In addition large numbers of experienced staff had left which led to a high reliance on agency staff. The provider was actively recruiting for experienced staff, but there was still a shortfall of 500 hours per week in permanent employees that had been identified.

Staff found staffing levels "tight", and considered they did not always have enough time to provide the care and support people needed without rushing. They found the large numbers of agency staff to be a problem as they needed to explain people's care to staff who were not familiar with them, and this meant handovers were longer and more complicated. They were concerned by the number of experienced colleagues who had left the service. On one floor of the home staff were concerned that their unit manager had left and not been replaced. Staff felt they would be able to provide care to a higher quality with a small increase in staffing levels. This was particularly difficult at meal times, and where there were a number of people who needed two staff members to support them when moving about the home. The home manager was aware that some members of the catering team, who were expected to support people in the dining areas at meal times, were in fact working in the kitchen.

Staff told us there were occasions when suitable staff were not available, for instance a night shift when only male care workers were on shift to support people who had expressed a preference for female care workers.

During our observations we saw some examples of care and support that were delivered in a calm, unhurried and professional manner. At other times staff were rushed and did not have time to interact meaningfully with people they were supporting. On two occasions we saw people living with dementia who were left without staff support in shared areas of the home. At other times the only staff available were agency staff who did not show an understanding or awareness of people's individual needs.

The provider was taking action to reduce their dependency on agency staff and rebalance the skills and experience of staff. However at the time of the inspection failure to deploy sufficient numbers of suitably skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Procedures were in place to store and administer medicines safely and according to the manufacturer's recommendations. Accurate and complete records were in place for tablets and other medicines administered by nurses during the regular medicines rounds. These medicines were administered in a caring manner with nurses using people's preferred names, explaining to people what the medicines were for, and making sure the

Inadequate

Is the service safe?

person took them before they moved on to the next person. Records showed staff received training in administering medicines and competency checks before they started to manage peoples' medicines. We noted that one person was responsible for their own medicines, but there was no risk assessment in place for this.

Records of prescribed creams and ointments, particularly those for creams prescribed "as required" were not kept to the same standard as the records for medicines administered as tablets and capsules. One person was prescribed a cream to be applied twice a day. In the four weeks before our inspection there were seven days when no applications were recorded and three days when only one application was recorded.

Where creams were prescribed "as required" the instructions for staff were to prompt the person every day and record that this was done. In four cases there were between four and seven days in the previous four weeks when these records had not been completed.

Failure to maintain accurate and timely records of care and treatment provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

People were satisfied they were supported by staff who had the right skills and experience. People were happy with the choice and quality of food offered. People described the meals as "good" or "very good", and were aware that a new menu had recently been introduced.

Staff were happy the training they received prepared them to meet their day to day responsibilities. One experienced member of staff described the training as "some of the best, in depth, relevant and practical". The same training was available to all staff, including housekeeping and catering staff. Some staff members who supported people whose behaviours might cause harm to themselves or others told us they would like more training in this area, and a nurse had identified areas of clinical care where more training was needed.

The home manager was aware training needs had been identified in certain clinical specialisms. They also planned to introduce additional specialist training in supporting people living with dementia and end of life care. Training records showed 91% compliance with the provider's mandatory training programme. This had been 96% before a new course had been introduced which staff were working through. Courses included moving and handling, health and safety, food hygiene, dementia awareness, and pressure injury care. Training was a combination of e-learning, practical sessions and workshops. All training was delivered in-house. Staff were able to work towards a relevant external qualification if they wanted to.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider's policies and procedures in this area were based on relevant government guidance. Staff were aware of the need to obtain people's consent to their care and treatment, and of the principles underlying the Mental Capacity Act. Staff used a toolkit provided by the local authority which guided them to follow the two stage process required by the Act.

Most of the records of capacity assessments we reviewed showed that staff followed processes which complied with the legal requirements. Assessments were specific to a single decision, for instance whether to live at the home for care and support, whether to go to hospital for a non-urgent operation, and whether to have medicines disguised in food. If the first stage of the assessment showed there was no impairment of the mind or brain, then the person was assessed as having capacity and the process did not move on to the second stage. Where the assessment concluded that the person lacked capacity, records showed how the decision was made in their best interests, for instance by engaging an independent mental capacity advocate.

However we found some examples where the principles of the Mental Capacity Act had not been applied consistently. One person's file contained a "do not attempt to resuscitate" form which stated the person "does not have mental capacity". There were no records of capacity assessments for this person, and their consent form stated "cannot physically sign". It was therefore not clear whether the person had been involved in the decision not to resuscitate.

Another person's consent and capacity care plan stated, "I am no longer able to consent to decisions and therefore need them to be made for me in my best interests." There were no records of decision specific capacity assessments in their file. However an entry in their notes stated "permission given by son [Name] for flu vaccination". The correct process to make sure decisions were made in people's best interests had not been followed. The provider had made an application under the Deprivation of Liberty Safeguards (DoLS) for this person. However the records for this had been filed in an office and were not reflected in their care plan.

Requires improvement

Is the service effective?

The DoLS file contained 15 applications. Information at one of the nurse stations stated nine people had DoLS in place. The home manager told us they would have expected more than half the people living at the home to have DoLS applications in place based on their observations since joining the service. It was not clear that the provider had always followed the DoLS process when required and people were at risk of being deprived of their liberty without the legal safeguards in place.

Failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meal times were made a special event with carefully set tables and quiet music playing in the background. Arrangements were in place to keep food warm in the dining areas, and the meals appeared appetising and well presented. Care workers showed people exactly what each meal looked like, and allowed them to specify what size portion they wanted of which menu choice, and their choice of vegetables. In this way people were able to exercise choice over their meals.

Where people needed assistance to eat this was provided, either by equipment such as plate guards, or by staff helping by cutting people's food for them. This was done discreetly. Staff encouraged people to drink enough both during and between meals. Staff told us the food was normally of a high standard and reflected people's health needs if necessary.

Kitchen staff were aware of most people's need for particular diets such as pureed or vegetarian meals, and of their likes and dislikes. However we found examples where people's changing nutrition needs had not been accommodated in updated nutrition care plans. One person had lost weight and was recommended a high protein diet which was not reflected in their care plans. Another person was recommended finger food by a speech and language therapist. Again this information was not used to inform their care plans. Where people had particular needs we could not be certain they were supported appropriately to eat and drink enough and to enjoy a balanced diet.

People were supported to maintain good health through access to other healthcare services. Records were in place which showed people had visits from or appointments with a range of healthcare providers including their GP, specialist nurses, psychiatric nurses, speech and language therapists, chiropodists and dentists.

People were supported in an environment which was maintained and decorated to a high standard, although staff told us they thought the decoration could be more interesting and the home manager had plans to make it more colourful. There were examples of adaptations to meet the needs of people living with dementia. These included appropriate signs with words and pictures, reminiscence prompts such as photographs, household objects such as a sewing machine and typewriter, and memory boxes outside some people's rooms. The shared areas of the home had information about the date, season and weather, although this was not always kept up to date. The home manager was aware that some of the chairs in the shared areas, although comfortable, were not suitable for people with limited mobility. They were seeking financial approval to replace some of this furniture. A visitor pointed out to us that the cups in the shared cafeteria on the ground floor had small handles which could be difficult to grip for people with limited hand movement.

Requires improvement

Is the service caring?

Our findings

Many people told us they were supported by staff who were caring, knew about their needs and preferences, and involved them in their care and support. One person told us, "I am quite satisfied. They are really nice girls. They know what they are doing. They ask me what time I want to get up. I sleep well. The food is good. I like to come to the dining room for meals, to be with friendly staff and residents. I would not change anything." Another person said, "It is as good as you can get, here. The accommodation is very attractive. You have your privacy. I can remain independent. I would give it a good write-up!"

Other comments included, "The ladies [staff] here are wonderful. They do so much for you, your hair, your nails. I feel I've got a lot of people to talk to," and, "You ask a question and they tell you, straight away."

A visiting family member said, "The staff are lovely. The whole atmosphere is one of friendliness. Mum is quite happy here – they all get together and have a giggle!" They also told us they had a thorough review of their mother's care "roughly every three months, which is fine for me – I think that's about right".

We saw examples of positive care and support where staff took time to understand the person, communicated clearly and gave the person time to understand what was happening. One member of staff patiently supported a person living with dementia whose behaviour risked compromising their dignity and safety. They made eye contact with the person, got down on the floor with them, spoke clearly, showed they understood the person's behaviour and redirected them safely to their room. Some staff supported people to enjoy organised activities and entertainments by helping them move to a different area of the home, and by joining in and encouraging people to participate actively.

However we also saw examples of less positive care where staff did not engage with the person they supported. We saw staff talking with each other about their previous jobs while they supported people, discussing people's care in front of other people, calling across the room to ask a person's name, raising their voice when supporting a person, walking away while a person was still talking, and laughing at a person's mistake while they were still in earshot. One member of staff knocked on a person's door and asked permission to go in. They spoke to the person politely and kindly. While they were in the room, another member of staff went into the room without asking. They were carrying another person's meal and went on to discuss the other person's care with their colleague.

Staff used people's preferred names when they were aware of them and respected their preferences and wishes. However staff were not always aware of people's names. On one occasion we observed a staff member call people by the wrong name according to the preferences in their care plan. On another occasion two staff members who had been asking colleagues about people's names were left on their own to support five people about whom they did not know this basic information.

Failure to treat people consistently with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who were familiar with people they supported told us how they developed relationships with people, and learned about their background from their care plans. They were aware of the need to engage with people and build up trust. One said they treated people as they would want their own family members to be treated and tried to see things through their eyes.

People told us they were involved in decisions about their care, and records showed when family members and other advocates had been consulted about a person's care. There were policies in place for equality, diversity and dignity, and staff were aware of them. There were few examples where people's needs arose from their religious or cultural background. One person had information in their care plan about their culture's traditions of death and mourning.

Requires improvement

Is the service responsive?

Our findings

People we spoke with and their visitors told us how they received care and support that were adapted to their needs. One person described how they had difficulty getting used to having their main meal at lunchtime. Staff had made adaptations "as much as they could", and the person was served sandwiches and fruit at 6:30pm instead of 5pm. They said, "It does help." Another person's relation told us how the person had had a number of emergency hospital admissions due to acute attacks of breathlessness. The person was living with a long term lung condition, but staff analysed the circumstances which led to their hospital admissions and found there was another cause. The other cause had been treated and the person had not needed to go to hospital since.

Another person's records showed their care and support had been adapted because they had a developing pressure injury. This had been successful and the record showed the pressure injury had "cleared up nicely".

However we found other examples where people's care and support did not meet their needs and reflect their preferences. In one case, a district nurse had recommended creams for a person's soreness. These had not been obtained and the person told us their soreness had got worse in the eight days since the nurse's visit. They were planning to go out with a family member to buy a suitable cream. Staff we spoke with were surprised the recommended creams were not available. They were also aware of suggested changes to the person's personal care which had not been recorded in the person's care plan.

Another person's records showed their GP had recommended a diabetic diet following the discovery of high levels of sugar in their urine. A nurse was aware of this diagnosis but understood the person's family preferred them to have a "normal" diet. There were no records to show the person's capacity or lack of capacity to make this decision, or that a best interests process had been followed. There had been no change or update to their nutrition care plan following the GP's advice. Catering staff told us they provided diabetic meals for other people, but there had been no request for this person.

A third person received inconsistent care on the two days of our visit. They were supported to eat their meal on one day, although their care plan did not state this was required or desired. On the second day, we saw them eating independently. We also saw staff supporting a person to move about in ways that were not consistent with their care plan, for instance by using a hoist when it was not clear this was necessary from their care plan.

People's care plans contained forms for information about their life history, preferences and interests. Forms were available to describe people's care in up to 17 areas such as; communication, personal care, continence, pain control, medication, advance care decisions, mental health and orientation. These forms were not always completed to the same standard, although staff told us they found them useful. One person's care plan stated they did not always use the call bell system because of short term memory problems, but there was no guidance for staff about how this affected the person's care, or what they should do to reduce the risk.

Records were in place to the effect that care plans and risk assessments were checked every month, but people's plans were not updated to reflect their changing needs. For instance, some people's records showed they were losing weight but there was no change to their nutrition care plans. Other people had developed pressure injuries or were showing changed behaviours without these being reflected in their care plans. A review of all care plans and risk assessments was included in the home manager's "Community development plan".

Failure to make sure people's care was appropriate, met their needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to participate in a wide range of activities and entertainments. These included organised group activities such as exercise, quizzes and musical performances and individual card and board games. There was a "spa" area on the ground floor. Volunteers assisted staff to support people with arts and craft activities. Activities organisers kept records of the activities people enjoyed and carried out risk assessments for activities where these were needed. They also made sure people who were supported in their own rooms were included and benefited from social interaction. Care staff assisted with activities and told us they found this was a useful way to get to know people better and to make sure they had regular interaction with them.

Requires improvement

Is the service responsive?

There was a “resident of the day” programme through which one person living on each floor had special attention for the day. This included activities they particularly enjoyed and a check that their room was arranged according to their preferences. There were regular events, such as a book club and visits from a local church group. There were books, card and board games and magazines available at various locations. The magazines included a newsletter written by the provider for people living at the home. Other magazines covered a range of topics of interest to both men and women.

The provider had a complaints policy and procedure in place. Information about this was available on all three floors of the home. The complaints procedure was included in a “Welcome” folder which contained information for people coming to live at the home. The home manager told us this information was being brought up to date with the help of a person who had offered to use their skills and expertise in this area. We noted, for instance, that the file still used the home’s old name.

There was a file containing records of seven complaints raised in the previous year. Most of these had been investigated and resolved. One had been raised in December 2014 and not resolved until September 2015. The home manager told us this had been due to changes in the management of the home, but the complainant was now satisfied.

Inadequate

Is the service well-led?

Our findings

When we inspected Gracewell of Fareham, the provider had identified concerns over the management and leadership of the home. They had started actions to improve these, but we found they were yet to meet the minimum standards people should expect. There had been no registered manager at the home since January 2015. The home manager appointed in January 2015 had not registered with us. A new home manager had been in post for six weeks at the time of our inspection. They were the sixth manager of the home in three years. They were an experienced manager who had been the registered manager at their previous home. They told us they intended to apply to be registered as the manager at Gracewell of Fareham. Shortly after our visit we received their application.

A temporary management structure was in place at the time of our inspection with assistance provided by management and specialist staff from other homes in the provider's portfolio and elsewhere in the organisation. This was intended to support the home manager in bringing about the necessary changes to address the concerns identified by the provider. The management structure showed each of the three floors should have a unit manager. One unit manager had left shortly before our inspection, and another was on sick leave. This meant the remaining unit manager and other members of the management team were having to cover their floors.

The provider had recently renamed and rebranded the home, but these changes had not been consolidated. Signs outside the home and records inside the home still carried the old name. Changes, for instance to the format of records used in people's care plans, had not been carried through to completion. Staff were not clear about the ownership, brand or values of the home. Their morale had been affected by the failure of the provider to provide consistent management and leadership. One member of staff pointed out that each new manager had brought their own way of doing things and their own paperwork. They said that, just as they got used to one manager, they left and they had to get used to a new way of doing things. A large number of experienced staff had left.

The home manager had made a good impression on those staff that remained, but they were not confident the new manager would stay any longer than their predecessors.

One staff member said, "[Name] has been supportive. It is disheartening about the managers, but teamwork is OK." The home manager was aware of signs that morale was poor and had taken actions to try and improve it. These included refreshing a "Your voice counts" scheme intended to improve engagement with staff and providing small tokens of appreciation for staff contributions. They were concerned that due to ineffective leadership in the past, staff had looked to each other for support and concentrated on their own floor. This meant standards were not consistent across the home and the provider's methods and values were not consistently applied.

At our previous inspection on 8 September 2014, we found that records and record keeping did not meet the minimum standards required by the regulations in force at the time. At this inspection we found records did not meet the standards required by the current regulations.

Records relating to the previous managers' management system were inconsistent. The new home manager had taken some steps to improve this, but their main focus was on their "Community development plan". This was intended to improve the quality of the service and included actions to address the premises and equipment, management, staffing, safety, care and treatment, nutrition, complaints, and recruitment. With the director of operations, they were negotiating a suitable budget for the next financial year to enable them to carry out their plans to improve the service.

The "Community development plan" had identified that records of people's care and treatment and records relating to staff recruitment did not meet the provider's own standards. Actions had started to review and improve all such records. We saw evidence that where records had been addressed by the plan they had been found on average to meet 96% of the provider's standards. However we found care records that did not reflect people's care needs, had not been changed in response to people's changing needs, and did not accurately reflect the care provided. For example, one person's plan for skin care required them to be helped to change position regularly. Records of daily care were completed but did not show they were supported to change position regularly. We discussed this with staff who said they could not comply with the skin care plan because the person also had a feeding tube which meant they had to stay in the same position. This person's care plans for specific conditions or

Inadequate

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risks did not take into account other conditions or risks. In another person's care plan we found a blank record for wounds / bruising. There was an undated, unsigned note attached to the record instructing staff to complete the record, but this had not been done.

Four staff records had some missing or incomplete information relating to their recruitment. This included out of date information relating to a nurse's registration, missing information about qualifications, missing information about criminal record checks, and incomplete information about conduct in previous employment.

Failure to maintain accurate, complete and timely records relating to people's care and to staff employed was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to monitor the quality of service provided. Monthly audits of specific areas of the service were analysed by the provider. Reports showed how Gracewell of Fareham compared with other homes in the provider's portfolio. Past reports had highlighted possible problems with medicines in April 2015, with nutrition in May 2015, and with medicines and infections in June 2015.

The director of operations told us they had been regularly visiting the home in person for ten months, and it was the highest priority of the seven homes they were responsible for. They had daily conference calls with the home manager to monitor progress of the "Community development plan". There were frequent visits by operations and quality specialists to assist and monitor progress. There had been operations support visits in the weeks before our inspection on 20 October 2015, 10 November 2015 and 24 November 2015. They all showed the home was considered "red". The provider had taken steps to improve the quality of service provided but the steps had not yet resulted in sufficient improvements to meet the minimum standards people should be able to expect.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect.** Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Where service users were unable to consent because they lacked capacity to do so, the registered person did not act in accordance with the Mental Capacity Act 2005.** Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess risks to the health and safety of service users and did not do all that was reasonably practicable to mitigate such risks.** Regulation 12 (1) and (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed.** Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Service users' care and treatment was not appropriate, did not meet their needs and did not reflect their preferences.** Regulation 9 (1) (a) (b) and (c)

The enforcement action we took:
We have issued the provider with a warning notice which requires them to comply with this regulation by 23 March 2016. We will return after that date to confirm actions have been taken to achieve this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not protected from abuse and improper treatment because systems and processes to prevent abuse and to investigate any allegation or evidence of abuse were not established and operated effectively.** Regulation 13 (1) (2) and (3)

The enforcement action we took:
We have issued the provider with a warning notice which requires them to comply with this regulation by 23 March 2016. We will return after that date to confirm actions have been taken to achieve this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user. The registered person did not maintain such other records as are necessary to be kept in relation to person employed in the carrying on of the regulated activity.** Regulation 17 (1) and (2) (c) and (d) (I)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have issued the provider with a warning notice which requires them to comply with this regulation by 23 March 2016. We will return after that date to confirm actions have been taken to achieve this.