Care Quality Commission

Counticare Limited

Grosvenor Court

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 7 & 8 August 2018 and was unannounced.

Grosvenor Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Grosvenor Court provides accommodation and personal care for up to 17 people who have a learning disability, autistic spectrum disorder and some physical disabilities. With the exception of the accommodation on the top floor, the service is accessible to people in wheelchairs. At the time of our inspection there were eight people living at the service. Staff provided for people's day to day basic care needs, however many shortfalls highlighted where some needs were not being met.

The service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. However, the values that underpin the guidance such as offering choice, promotion of independence and inclusion were evident in the support people received from staff so that they can live as ordinary a life as any citizen.

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

At the last inspection on 8 August 2017 the service was overall rated as requires improvement. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective and well led to at least good which was not provided. Since then the service had experienced a period of unsettled management. The provider had placed an interim manager in post until a permanent manager could be found and the interim manager had registered with the Commission and was present for part of the inspection. They had provided some stability for the staff team and enabled work to commence on addressing previous shortfalls. A new permanent manager has now been appointed who told us that they would be applying to the Commission to be registered; they were also present on both days of inspection.

We observed people in the communal areas spending time with staff and receiving support. We also observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported.

We found that whilst improvements had been made to meet a previous breach regarding staff training, other breaches in respect of maintenance and equipment and quality assurance had not been fully met. We have rated the service as Requires Improvement overall, this is the fourth consecutive time the service has

been rated Requires Improvement.

At this inspection we found further breaches of regulation that could impact on people's safety. Medicines were administered and recorded appropriately. However, there were issues with their safe storage and ordering as this did not ensure that people always had their medicines available when they needed them or that they were stored in accordance with best practice guidance and manufacturers storage instructions. Staff were aware of their safeguarding responsibilities to protect people from abuse; they were confident they would act if they witnessed or suspected abuse and knew how to escalate concerns. However, the procedure for the reporting of incidents and accidents although in place was not always followed; there was a potential risk that not all incidents were reported to the registered manager and considered as requiring a safeguarding alert. These omissions could place people at risk of incidents being overlooked. Accident and incident analysis needed improvement to inform assessment and mitigation of future risk.

Epilepsy guidance needed development and review to keep people safe and ensure support was provided in a timely manner. Fluid monitoring of people assessed as at risk of dehydration did not provide evidence people were receiving enough to drink.

Staff supervision and appraisal was infrequent. It did not provide staff with the opportunity to discuss training and development or provide management oversight of team strengths and weaknesses. Appraisals of staff work performance were not completed in line with the providers' policy or regulatory expectations.

Staff had not received the appropriate training to undertake safe evacuation using evacuation equipment in the event of a fire. Some fire escapes were not alarmed so there was a risk people could leave the building unobserved by staff and place themselves at risk of harm.

The system for the recruitment and selection of staff was not effectively used. Some checks on staff suitability were not completed until after staff were in post.

Staff deployment and staff numbers needed review. Although staff attended to the needs of people our observations showed that they were not always able to flexibly spend time with people to give them the attention they wanted and needed for their emotional wellbeing. Although people were calm and relaxed and comfortable with staff, people sought staff attention and became restless and bored when this was not provided. Our observations also showed that staff carried out their duties respectfully and kindly, respecting people's privacy and dignity and carrying out personal care tasks discreetly.
People were provided with activities but staff recognised these were not always suitable for some people's needs and were working in partnership with occupational therapists to develop a more appropriate range of activities and stimulation for people.

Staff said they felt supported and that there was good communication and team work. They found the present registered manager approachable and they were encouraged to express their views, they felt listened to and regular staff meetings were held to keep them informed and updated. Senior management acknowledged the good work staff did and the quality of support they provided. Staff received appropriate induction and training to ensure they had the right skills and knowledge for their role and to support people safely. Staff had been trained in infection control and the service was clean, odour free and staff used protective clothing appropriately.

Individual risks were assessed and measures implemented to reduce these. Guidance was in place for staff to follow about the action they needed to take to protect people from harm. Care plans were person centred and reflected people's individual needs and how they preferred to be supported; people and their relatives

were consulted about these and they were kept under review. People were supported to retain their independence and to do as much for themselves as they could with staff on hand to help them. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People were provided with meals that suited their specific dietary requirements and preferences. Staff monitored people's health and supported them to access healthcare as and when needed. Staff understood people's end of life choices and advanced decisions and would act accordingly when these needed to be implemented. The service was adapted to meet people's physical care needs and provide accessibility to all communal and bedroom areas on the ground and first floor. A second floor was currently not in use but would suit people with good mobility who could use stairs.

Relatives spoke positively about the service, staff and the care their relatives received. They told us that they were always made welcome by staff and offered refreshments. They were surveyed for their comments and on an individual basis were responded to, but they never received feedback on how their or other responses had been used to influence service development.

There was a complaints procedure, relatives said they felt able to raise concerns and thought these would be listened to and acted upon.

We have made one recommendation in relation to activities.

We found two continued breaches and eight further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

There was not a proactive approach to identifying potential risk and to reduce this to protect people.

Measures for the safe storage of medicines were not satisfactory.

The environment was clean and generally in a good state of repair but maintenance remained an area for required improvement.

The deployment of staff impacted on the ability of staff to spend time with people.

Staff suitability checks were not always in place prior to commencing work.

An accident and incident reporting system was in place but was not always used to record incidents. Staff had an awareness and understanding of safeguarding issues and how to protect people from harm but did not always follow procedure.

Is the service effective?

Requires Improvement

The service was not always effective

Health needs were supported but guidance regarding epilepsy needed improvement to keep people safe. Risks of dehydration were not sufficiently recorded and reduced by the system of fluid monitoring in place.

Systems in place to monitor and appraise staff performance and practice were infrequently used.

Staff received the induction and training required to fulfil their role safely.

Staff followed the principles of the Mental Capacity Act 2005. People were supported to make their own decisions and staff offered people choices to enable this.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were kind and respectful towards people, individual engagement and interactions were good. However, staff did not always have time to acknowledge or respond to people.

People were calm and relaxed in the presence of staff and sought their attention.

Relatives said they were made to feel welcome and staff knew them well.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

Staff were aware improvement was needed to the range and appropriateness of activities and stimulation offered to people.

Care plans were person centred and people and their relatives were involved in their development and review.

Relatives said they knew how to complain and were confident of doing so if needed. Staff knew people's methods of communication and how they expressed their concerns and would explore this with them.

People's end of life wishes and advanced decisions were recorded.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Quality monitoring systems were not effective in identifying shortfalls in the service.

Relatives spoke positively about the care their relatives received and were surveyed for their views, but not informed how this information was used.

Staff felt supported and able to express their views.

Policies and procedures were available to staff to inform their knowledge and support and inform their practice.

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Detailed findings

Background to this inspection

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

This inspection took place on 7 & 8 August 2018 and was unannounced.

We looked at three people's care and support records, associated risk assessments and medicine records. We looked at management records including three staff recruitment, training and support records and staff meeting minutes, and quality audits. We observed people spending time with staff. We spoke with the registered manager, new manager and area manager, two team leaders and four support staff. We also spoke with three visiting relatives.

The inspection team consisted of one inspector. People were unable to tell us about their care so we undertook a 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 also observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. .

Before the inspection we reviewed information about the service the provider had sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also contacted and received feedback from the local commissioning and safeguarding teams.

After the inspection we contacted professionals and relatives that have regular contact with the service and received feedback from one social care professional, a health professional and two relatives.

Inadequate

Is the service safe?

Our findings

During the inspection we observed that people were reliant on staff for engagement and stimulation, and were relaxed and comfortable in their environment. They enjoyed their interactions with staff and sought their attention which was not always available. Relatives said they were happy with the care provided and were confident in staff knowledge and understanding of their relatives.

A previously identified breach of regulation regarding maintenance and equipment had not been fully met. This was because the laundry fire door highlighted at the previous inspection could still not be shut on the first day of inspection. This was a concern because this made the laundry accessible to people where there was an open cupboard which held detergents; these could be harmful if ingested. This shortfall was immediately addressed on the first day of inspection but had not been highlighted by the service's own health and safety checks.

Both lifts when on the ground floor had their doors permanently open. People could access these when unsupervised by staff which was a potential risk that had not been identified or assessed. Lifts were serviced and in working order but there were outstanding works recommended from the last four servicing visits. This work was still awaiting approval since January 2018, with no evidence of this being resolved quickly. There was a risk that the lifts could cease to function safely if recommended maintenance work was left for too long.

A quarterly health and safety walk around of the service environment was undertaken although we were informed that more frequent checks were to be implemented soon. There were several potential risks to people not highlighted by internal checks of the environment undertaken by staff. For example, a window restrictor was missing from a first-floor bedroom window enabling the window to be opened to its widest extent; this posed a safety risk to people if they could access the window. Two other window restrictors in bedrooms on the first floor were in a poor state and needed replacement to make the window safe. The wooden frame to another window on the first floor was rotten and in need of repair. A cupboard on the first floor was left unlocked. It contained a range of household equipment and other items that could pose a risk to people if they gained access. No clear system was in place for checking that repairs and work recommended by external contractors resulting from servicing and safety checks had been seen by the head office maintenance department. This included repairs to the service's electrical system that had been recommended by the electrical engineer that carried out the last electrical safety test, and some new parts required for powered beds and hoists used in the service for lifting people.

Cold water temperatures were not maintained at levels recommended to reduce the risk of Legionella and staff were not following the procedure in place for regular flushing of the system.

People who use the service and others were not protected against the risks associated with unsafe or unsuitable premises because maintenance was not suitably responsive and did not keep pace with the requirements of the service. The premises and equipment used by the service was not properly maintained to ensure its safety. This is a continued breach of Regulation 15 (1) (e) of the Health and Social Care Act

(HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

Firefighting equipment, alarm and emergency lighting had been serviced and regular checks that these were in working order were undertaken. Fire drills were held. People were at risk because their personal emergency evacuation plans (PEEPs) were reliant on staff using the lifts during a fire. The fire service confirmed that this was incorrect and unsafe. The area manager reviewed all PEEPs so staff were advised to use instead of the lifts, equipment such as ski pads and evacuation chairs for which they had not been trained and which was not actually available to use. People were therefore at risk that staff may not be able to evacuate them safely in the event of a fire. We observed that two fire exits, one on the first floor and one on the ground floor, were not alarmed. These posed a risk to people living in the service who might be able to exit the building unobserved by staff thus placing themselves at risk of harm.

People were at risk because specialist equipment for evacuating people safely was not available and staff were not trained to use this. This is a breach of regulation 12 (1) (2) (a) (b) (c) (d) (e) of the HSCA 2008 (RA) Regulations 2014.

Medicines were not always well managed. Storage temperatures in the medicine storage cupboard at times exceeded the required maximum temperature of 25 degrees. When exceeded there was a risk that medicines effectiveness would be impaired. Between 26/7/2018 and 7/8/2018 there were nine occasions where the room storage temperature exceeded 25 degrees. A fan used to cool the room was ineffective in the exceptionally hot weather. The temperature recording system for the drug fridge was confusing showing two readings some of which exceeded the temperature for medicines requiring refrigeration. Staff were unable to explain what the two readings meant, or whether medicines were being stored at the appropriate temperature. At the previous inspection we had noted that a medicine had not been ordered for someone undergoing a procedure, this had led to a cancelled appointment. At this inspection we found that there were three recent occasions where three people's medicines for pain relief, epilepsy and thickener (for use with drinks where swallowing difficulties exist) had run out before the end of the medicines cycle. These were people's important daily prescribed medicines which they needed to maintain their health and wellbeing. Emergency prescriptions had been provided to ensure people received their medicines but there was a risk this may not always be the case.

Staff had been trained to administer medicines and their competency was routinely assessed. Medicines requiring more secure storage were managed appropriately. Medicine records were completed well. Medicines were disposed of appropriately. Boxed and bottled medicines were dated upon opening. An external pharmacy inspection highlighted no specific concerns but made some recommendations for improvement. These had not all been acted on.

The ordering and storage of medicines were not well managed and could place people at risk. This is a breach of Regulation 12 (1) (2) (g) of the HSCA 2008 (RA) Regulations 2014.

A system for the assessment of risks was in place but was undermined by many of the shortfalls we identified. These shortfalls did not provide assurance that those actions the provider told us they would take had been embedded, or that the provider, registered manager or staff were proactive in being able to identify the potential on-going and emerging risks in the service.

There were five incidents/accidents recorded between June and July 2018. Some were linked to people's self-harm behaviours or towards each other. In discussion staff demonstrated a detailed knowledge of people's characters and behaviours. Staff understood some of the observed triggers to the behaviours and knew the agreed strategies used to de-escalate these. We observed that a bruise on one person had been

recorded on a body chart, but neither the registered manager nor area manager had been alerted to this. Staff had not followed procedure by reporting this through the incident reporting system. The person was prone to bouts of self-injurious behaviour and there was a risk that this could be viewed as routine behaviour and similar injuries could therefore be unreported, over looked and not discussed either with senior management or the local authority safeguarding team. Analysis of accidents was not routinely carried out; the last analysis was carried out in April 2018. There was no record of actions taken or whether there was learning from this through a change in staff practice or monitoring.

People could be placed at risk from risks not being appropriately managed or identified and incidents not being recorded with appropriate actions taken, to reduce overall risks of harm. This is a breach of Regulation 12 (1) (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014.

Staff had received training in safeguarding. In conversation they demonstrated a clear understanding of the different forms abuse could take. They were confident of reporting concerns about possible abuse they witnessed or had suspicion of to their senior management team or escalating this to external agencies where needed. However, our observation of the unreported bruise suggests that their understanding of their reporting responsibilities needs to be reiterated to ensure they follow the correct reporting process.

People's personal effects were inventoried on admission to the service and this was amended as items got replaced. Safe systems were in place for the management of people's personal finances, and these were audited to ensure procedures were followed.

Recruitment files did not contain all the necessary information. For example, gaps in a staff members employment history had not been completed until months after they had already commenced work. These checks inform decisions about staff suitability and recruitment and demonstrate that a robust process was in place.

There was a failure to maintain a robust recruitment process. This is a breach of Regulation 19 (1) (2) (3) (a) of the of the HSCA 2008 (RA) Regulations 2014.

There were not enough staff to support people safely. Staff were not always available to support people with their assessed needs. On each shift one member of staff is tasked with all aspects of meal preparation, and cooking. In between kitchen responsibilities they were to help with care support work. This was not practical given the full time responsibilities of the support worker for cooking, cleaning and maintaining kitchen records. Three people each required support from two staff when mobilising and for personal care. Everyone required staff support or supervision around personal care tasks, going into the community and some people needed assistance with eating their meals. At the time of the inspection two staff were out with people the community. This left two staff on duty who at one point needed to provide two to one support to a person which left three people in the lounge unattended and unsupervised for more than 40 minutes. One of these people had a history of seizures. The cook was observed to pop in once to visually check people were okay before other staff came back, during this time there was no interaction between the cook and people in the lounge. During the same period another person, confined to bed and requiring half hourly checks, was not checked for 47 minutes. Staff agreed that the current staffing arrangement was not providing the support people needed. Night staffing levels of two waking night staff were insufficient to be able to adequately support people in the event of an emergency as all the people required staff assistance.

People were at risk because there were not enough staff to provide the appropriate level of care and support they needed. This is a breach of regulation 18 (1) of the of the HSCA 2008 (RA) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Relatives said they thought the health needs of their relatives were well understood and supported by staff.

One person had epilepsy and could experience seizures day or night. There was an epilepsy plan in place to inform staff what seizures looked like or other possible triggers. However, when we spoke with staff they only had an understanding of one possible trigger and were not aware of any other triggers. Action to reduce the likelihood of this one occurring had been put in place, but staff's lack of knowledge about other key triggers meant the person was at increased risk of not receiving effective care when they needed it . Emergency medicine was prescribed in the event of a seizure, the plan for its administration required that it be administered within two minutes of a seizure. Staff would be unable to access and administer the medicines within this timescale as it was locked away and not easily accessible within the timeframe. No consideration had been given to ensuring the medicine was accessible: this placed the person at significant risk of not receiving the treatment they needed.

Measures in place to reduce risks to people with epilepsy were not satisfactory, People with epilepsy could be at risk of not receiving the support and care they needed. This is a breach of Regulation 12 (1) (2) (a) (b) of the HSCA (RA) Regulations 2018.

In all other respects staff were observant and proactive in attending to people's health needs. Staff knew people well and during the inspection had appropriately called a GP to one person who was unwell. People were supported to attend health appointments and received routine dental, hearing, optical and chiropody checks in addition to health checks from the GP. Records of contacts showed that people received input from a range of medical professionals from the community to guide and inform the support and care staff provided.

A person assessed as at risk of dehydration or poor nutrition was monitored for their food and fluid intake. Measures were put in place to support good nutrition and hydration. However, records of fluid intake were poor and did not record a minimum amount of fluid the person should have each day. We were unable to assure ourselves that the person was in fact receiving an adequate amount of fluid each day. Staff said the person was often asleep but this was not our observation. There were significant gaps in entries of when drinks were provided. For example, on 29/7/2018 drinks were recorded as given at 8.45 am, 13.30 pm and 15.30 pm, nothing more was recorded until the following day 30/7/2018 when six drinks were recorded as given between 7.30 am and 17.30 pm. This meant the person may experience periods of up to 16 hours without having a drink. On the first day of inspection the person's first drink of the day was recorded as being given at 10:45 am. The drink was only provided when prompted by our concerns.

The system in place to ensure people received enough to drink to reduce the risks of dehydration was not effective. This is a breach of Regulation 12 (1) (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014

In all other respects staff worked closely with dieticians and the Speech and Language therapy team to ensure that people's specific nutritional requirements were met. The support worker deployed to provide

cooking had additional qualifications to inform their cooking and food hygiene practice; they had a detailed understanding of everyone's specific dietary needs and catered for these. Two people received their meals and medication through a percutaneous enteral gastro tube (PEG). The tube is passed into the stomach and allows nutrition and medicines to be administered where these cannot be taken orally. Staff showed themselves to be confident and adept at managing the PEG routine for people. Other people needed their food pureed or ate a diabetic diet. A menu was devised on a weekly basis, staff understood peoples likes and dislikes and their observed preferences for some types of meals. The support worker deployed to undertake cooking was innovative in adapting dishes to suit individual dietary needs, for example hash browns providing the base for a quiche for someone who could not eat pastry. Observations of staff assisting people with their meals showed them to be patient and kind in supporting people, and providing person centred attention throughout the task.

Staff were in receipt of formal supervision. Staff told us that they felt well supported, that there was good teamwork and communication between staff. Staff records however showed that the frequency of their supervisions were inconsistent with gaps of between three and five months between meetings. This was not in line with the providers supervision policy of six annually. The Provider Information Return (PIR) informed us that only three staff had received an annual appraisal in the last 12 months, contrary to the providers' policy. For example, a staff member who commenced employment in the service in 2013 had never received an appraisal. Supervision and appraisal are a chance for staff and their registered manager to identify areas for further training and development. They provide the registered manager with an overview of the team's strengths and weaknesses, and provide an opportunity to assess competency and understanding.

The provider had not ensured that staff employed for the provision of a regulated activity had received an appropriate level of supervision and appraisal. This is a breach of Regulation 18 (1) (2) (a) of the HSCA 2008 (RA) Regulations 2014

At the previous inspection we had identified that staff had not received the training they required to fulfil their role. At this inspection we looked at the induction process for new staff and their ongoing training. All new staff were expected to complete essential training within six months and attended induction training prior to taking on their role as a full team member. Two staff were currently completing 'skills for care' care certificate training standards. This is a nationally recognised training course for staff new to care. These standards are achieved through assessment and training so that staff can gain the skills, they need to work safely with people. As a team, staff had made progress to address the previous shortfalls in their training; those spoken with told us that they had completed most of what they were required to do including specialist training to support their knowledge such as communication, positive behaviour support, mental capacity and Deprivation of Liberty Safeguards (DoLS). Staff were encouraged to take further formal care qualifications and 10 staff had achieved a national vocational care qualification at level two or above. Based on our findings at this inspection we consider the provider has taken appropriate action to develop and address the training needs of staff.

Capacity assessments for people were in place for everyday decisions in respect of personal care, medicines and finances. Staff sought consent and permission from people when offering them support. The Mental Capacity Act (MCA) 2005 provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of their responsibilities regarding DoLS and eight DoLS applications had been made for people but only one had been authorised to date. This was to support the assessments that people needed help in making decisions around their everyday care. There was evidence of best interest's meetings with relatives or health professionals when decisions needed to be made about continuing with a treatment or having a medical procedure. These best interest decisions were recorded in people's files.

No new people had been admitted since the last inspection. An assessment process was in place. The pre-admission assessment considered the person's care and support needs, the person's ability to make decisions about their support and their personal preferences. Information was gathered from the person or family members, and some professionals where appropriate, to inform the decision to admit. People's protected characteristics under the Equality Act 2010, such as their race, religion or sexual orientation, were recorded during the assessment, and this was then transferred into the care plan. There were equality and diversity policies in place for staff to follow, and staff received training in this subject as part of their induction to inform their support of people.

The service had been adapted to the needs of people with complex physical needs but it did not meet Registering the Right Support guidance which promotes smaller units of no more than six. The building was accessible through use of ramps and lifts. Equipment for moving and handling and specialist bathing facilities were also provided to enable staff to support people appropriately and safely.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that they thought their relatives were well cared for and many had been living in the service for years without any concerns arising. Relatives said, "They call us straight away if anything happens" and "We don't have to go searching for staff when we visit, they're around." People themselves did not interact particularly with each other but were comfortable in the presence of their peers and staff. They sought staff attention and responded to this with smiles, gestures and vocalisations.

Staff were not always able to give people the attention they needed. We observed staff interactions with people were patient and kind. However, staff were entirely focused on the person they were supporting and speaking with them and offering encouragement to the exclusion of other people in the immediate and surrounding area.

We spent time in the communal lounge undertaking a focused observation of four people and how they were cared for by staff. One person in the lounge was unwell, the two staff present devoted all their time and attention to caring for this person and talking to each other about the person's needs. There was no acknowledgement of the other three people in the room. Staff were observed to discuss whether the TV programme was appropriate for the needs of the other people in the room, but as this was a favourite of the person who was unwell, it was left on even when they were taken out for personal care to be attended to.

The three people left in the lounge were left unsupervised, and without stimulation suited to their preferences. Consequently, they became increasingly, restless and vocal. The cook looked in briefly to check people were okay but again left without acknowledging anyone. When staff returned with the person they had provided personal care to, they did not acknowledge the people still in in the lounge, they talked amongst themselves and about the person they were attending. The cook took two of the people into the kitchen so they could sit and watch lunch preparation. This was not a scheduled activity but alleviated the need for staff to divert their attention from the person who was unwell. Insufficient staffing levels meant that there was a risk people did not receive the support they needed. This was an area for improvement.

Staff took care to maintain people's privacy and dignity at all times, providing personal care discreetly and utilising screens when providing nutrition or medicine through a PEG. People's bedroom doors were closed if they preferred this. Staff addressed people by their first name, to provide a degree of familiarity and comfort. Due to people's physical care needs their physical independence was limited but they were supported to maintain a level of independence in their choices and decisions to enable them to live as ordinary a life as possible.

People had been supported by relatives and staff to personalise their bedrooms to include things that interested and stimulated them. We spoke with the new manager and relatives about providing additional stimulation to someone confined to bed and the new manager had agreed to take this forward.

Relatives said that they were made welcome by staff, and we observed drinks being offered to guests. Relatives said they felt that they were kept informed and consulted about their relatives care and found staff

attitudes helpful and kind. Only one resident meeting had been held since 2016 and the format did not meet the needs of most people in the service currently. People did meet individually with their key workers (a keyworker is a named person who has specific responsibilities to assist the person in meeting their individual needs and wishes). The key workers understood people's needs well and knew what people were interested in to inform their activity planners.

Staff maintained good confidentiality and records were kept securely locked away. Computers were password protected and each staff member had their own personal password. Staff were receiving training in the new General Data Protection Regulation (GDPR) and how this differed from existing data protection regulation and impacted on their role.

Requires Improvement

Is the service responsive?

Our findings

A relative told us if they had any concerns they would raise issues with staff, "They know me, if I got upset over anything they would try to sort it out." Relatives told us that they were consulted about their relative's care, "We are absolutely kept well informed about (name)'s needs." Relatives said they thought people were given the activities that they liked to do.

Most people were allocated some additional support and social hours over and above the basic care hours allocated, this enabled them to have extra support to meet their specific needs. We observed this happening in practice with people being taken out to the main shopping area, or staff spending time with people in a craft activity. Other activities noted were massage, story and memory book sessions, and a pamper session. One or two people also attended the Martello day centre once per week. We were concerned that on occasion people were moved around for the convenience of staffing. For example, we observed that two people were taken into the kitchen to sit and observe the cook whilst she prepared lunch. We were told this was to enable them to have a good sensory experience of tastes and smells. However, as the cook's time was taken up with meal preparation it was unclear how meaningful or safe this experience was. On another occasion we found one person had been taken into another person's room. When we asked staff if this was a regular occurrence and whether a relationship existed between the two parties they were unable to answer and removed the person. A review of records found no reference to a friendship existing between both people and therefore no reason for them to have been moved there.

Activities for people needed improvement, and staff acknowledged this. Each person had an activity planner tailored to their specific needs. Activities included spending time in the sensory room. However, the room identified for this purpose contained very little in the way of sensory equipment and was used as a small lounge. During the two days of inspection we never saw this room utilised as a sensory room although people were allocated time on their activity planners for this during our inspection. The activity planner for one person showed that they were allocated three sensory room sessions each week but the lack of equipment in the room limited how meaningful and sensory the experience would be. In one person's daily reports no activities were listed as having taken place between 31 July and 8 August. A relative said that they thought activities for their relative were improving because a new driver had been recruited, and they would be taken out more. Staff had sought input from the community learning disability team and occupational therapists to help develop more meaningful activities for people.

We recommend that the provider seek out and act upon appropriate expert advice for the development and resourcing of appropriate and meaningful activities.

Since the previous inspection the Accessible Information Standard (AIS) had been implemented. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Most people in the service used a mix of vocalisations, body language, facial expression and some limited vocabulary to make their needs known. Communication passports had been developed to enable staff to be fully aware of how people expressed themselves and what vocalisations and body language usually meant. This guided staff in providing the support the person

needed and wanted. Staff used a variety of prompts with people such as familiar objects of reference and pictorial prompts which enabled and helped people to have an active input into making choices and decisions for themselves.

People received care that was personalised to their needs. People had varying amounts of one to one funding for activities or tasks that staff needed to undertake for them. For example, several hours were set aside for the one to one attention that people who were on PEG feeds required for this to be undertaken. Staff were not clear about how much time individual people had as one to one hours and how this was to be used. We asked for a breakdown of this but it was not provided, although use of one to one hours was recorded on daily report sheets.

Care plans were called 'About me', they were person centred and provided a holistic description of people's needs and how they preferred to be supported. People and their relatives were involved in the planning of their care, and people received support that was responsive to their needs. Care plans included information such as how people communicated their needs, what and who was important to them, information about their medical and life history and what support they needed for their emotional needs. Individualised guidance was provided for staff regarding day time and evening personal care routines including any wishes and preferences people had in relation to these areas. This information guided staff to deliver the care the person needed in the way they felt most comfortable with. Care plans were reviewed on a regular basis to ensure the information was up to date and continued to inform staff how to meet people's needs. Relatives were consulted and kept informed about any changes. Relatives told us they felt assured that people were at the centre of everything they needed care and support with.

There was a complaints procedure displayed in a text and easy read format. Staff recorded negative escalations from those people unable to vocalise their concerns of feeling unwell or unhappy. Staff knew people well enough to have a good understanding of their communication methods and what their body language, vocalisations and expressions meant. This gave staff an insight into what may be causing the upset and enable them to give the comfort and support needed to resolve this. Relatives told us that they would feel quite happy raising concerns with staff. One relative said they had raised issues previously and these had been resolved to their satisfaction. No complaints had been recorded in the 12 months preceding the inspection. The complaints and compliments book contained a number of very positive compliments from relatives and professional visitors of their experience of the service and how welcome they had been made to feel by staff.

Peoples last wishes were recorded where this information had been made available to staff. The PIR told us that all eight-people had advanced decisions which detailed what actions staff needed to take in the event the person became seriously unwell or in the event of their death. A few people also had 'Do Not Attempt Resuscitation (DNACPR) authorisations in place; these authorise staff and medical professionals not to provide resuscitation in the event of a cardiac arrest. These were completed by a medical professional and had been appropriately discussed with people's relatives. One person was currently receiving palliative care. Staff provided the person with the level of care and support they required.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in June 2017, we highlighted that the provider's quality assurance systems had failed to highlight shortfalls and effectively improve quality and safety in the service to reduce risks. We checked to see what improvements made had been sustained.

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

The registered manager had been appointed on an interim basis to stabilise the service and address some of the previously identified shortfalls both from the last inspection and from those inspections conducted by the providers own compliance team. Prior to this, the service had suffered a period of unsettled management. A new permanent manager had been appointed; they were still to be registered but were present for the inspection.

As a result of weekly and monthly quality assurance checks, annual internal compliance monitoring and monthly area manager visits, a comprehensive action plan had been developed which identified areas for improvement. However, not all areas that required improvement had been included in the plan, and therefore were not being addressed. Some identified issues, such as recommended improvements to the lift, had not been rectified in a timely manner.

The quality monitoring systems had not proved effective in addressing all the shortfalls identified at the previous inspection and bringing about change to improve the service. The provider and registered manager had failed to identify and reduce the risks we identified at this inspection. For example, inadequate evacuation procedures, fire exit doors without alarms, a missing window restrictor and a fire door that could not be closed. A medicines audit had failed to adequately address the issue of storage temperatures, or adequately investigate reasons for medicines running out. There was a lack of satisfactory and accurate guidance for staff in supporting people with epilepsy. These shortfalls directly placed people at risk of harm. Staff supervisions and appraisal were not conducted in line with the providers own policy.

Accident reporting procedures were not always being followed and there was a lack of informed analysis of incidents and accidents. Records of fluid monitoring were poorly kept and could not evidence that a person was receiving enough to drink. An audit of care plans had not resulted in the archiving of information no longer relevant to one person's current support needs.

In view of these shortfalls we do not consider that the provider has done enough to address the previous breach. This inspection highlighted further shortfalls in the service that had not been identified by monitoring systems in place. The provider had failed to effectively improve the quality and safety of the service or mitigate identified risks. This is a continued breach of Regulation 17 (1) (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014.

Staff were provided with access to policies and procedures through paper records but could also access electronic copies and had been provided with their own computer logins to maintain computer security. The provider was alert to changes in regulation and good practice guidance and had ensured staff undertook additional data protection training to take account of changes brought in because of the new GDPR. A holding policy was in place to inform staff about GDPR until a more permanent policy could be developed.

Staff had been proactive in seeking out sources of expertise to advise and guide them from health professionals in the community, but there was no specific accreditation with other agencies or bodies to develop working practices in line with current best practice.

The stable staff group helped to maintain continuity for people. The provider information return showed that turnover for staff was lower than expected from a similar size service. Staff said they felt well supported by the interim registered manager. They said they felt confident of expressing their views and felt listened to at staff meetings, these had been held regularly since September 2017. Meetings were well recorded with opportunities for discussion. We saw that some of the issues we found at this inspection had been discussed such as the quality of recording and improvement to activities and stimulation offered to people. Staff handovers between shifts highlighted any changes in people's health and care needs. This ensured staff were aware of any changes in people's health and care needs.

Relatives spoke positively about the service their relative received from staff. They informed us that they were surveyed for their views from time to time and felt able to comment openly. However, they only received feedback to any specific comment they had made and did not receive feedback about the outcome of the aggregated results from all the surveys received. This meant they were unaware if their feedback had influenced service development overall.

The registered manager understood the need to notify the Care Quality Commission should any significant events occur, in line with their legal obligations and had done so when required.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception. We could not find a website for the location or the provider but a rating for Grosvenor Court was displayed on the providers' parent company website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use the service and others were not protected against the risks associated with unsafe or unsuitable premises because maintenance was not suitably responsive and did not keep pace with the requirements of the service. The premises and equipment used by the service was not properly maintained to ensure its safety. This is a continued breach of regulation 15 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a failure to maintain a robust recruitment process. This is a breach of Regulation 19 (1) (2) (3) (a) of the of the HSCA 2008 (RA) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk because there were not enough staff to provide the appropriate level of care and support they needed. This is a breach of regulation 18 (1) of the of the HSCA 2008 (RA) Regulations 2014. The provider had not ensured that staff employed for the provision of a regulated activity had received an appropriate level of supervision and appraisal. This is a breach of Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk from not having their needs met safely and risks to their safety were not managed appropriately

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had failed to effectively improve the quality and safety of the service or mitigate identified risks. This is a continued breach of Regulation 17 (1) (2) (a) (b) of the HSCA 2008 (RA) Regulations 2014.

The enforcement action we took:

We issued a warning notice