Care Quality Commission

Brancaster Care Homes Limited

Cartmel Grange

Inspection report

Allithwaite Road
Grange over Sands
Cumbria
LA117EL
Tel: 01539 533563
Website: cartmelgrange@brancastercare.co.uk

Date of inspection visit: 6-7 October 2014
Date of publication: 09/02/2015

Ratings

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

Overall summary

This unannounced inspection took place over two days on 6 and 7 October 2014. We last inspected Cartmel Grange Nursing Home in August 2013. At that inspection we found the service was meeting the essential standards that we assessed.

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

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

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living in this home. However, we found that an incident of possible abuse had occurred had not been referred to social services for investigation under locally agreed safeguarding vulnerable adults procedures. Nor had the registered manager notified to CQC of possible abuse in line with accepted procedures. This meant that people could not be confident that appropriate action would be taken to identify possible abuse and safeguard them from risk.

Some people who lived at the home were not able to make important decisions about their care or lives due to living with dementia or mental health needs. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we saw that some people's care records did not make clear how their ability to make a decision about treatment options, care and support had been assessed. For example it was not always made clear in care plans who held any Power of Attorney (PoA). Powers of Attorney confirm who has legal authority to make decisions on a person's behalf when they cannot do so for themselves. These may be in place for financial affairs and/or also care and welfare needs. It is important that staff have this knowledge to make sure only those with the right authority make decisions on people's behalf.

Some care plans we looked at had conflicting information about nutritional needs so staff might not have the right information regarding some aspects of a person's care. People were not being protected against the risk that their needs may not be fully met because care planning information was unclear and planned actions had not always been followed.

We saw that where people had some complex health care needs, appropriate specialist health care services were included in planning and providing their care.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. This meant the quality monitoring processes were not effective as they had not ensured that people received safe care that met their needs.

We spoke with people in their own rooms and those who were sitting in the communal areas. People told us they were happy with the care and support they received and felt they were well cared for. We saw that people were treated with kindness and respect by the nursing and care staff. People we spoke with told us, "They (staff) are very good to me" and "They (staff) are nice, kind people here. They have helped me settle in". The staff on duty knew the people they were supporting and their preferences.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff when they visited. We could see that people made day to day choices about their lives in the home and were provided with a range of organised activities. We saw people participating in a range of activities during the day and staff provided one to one time with people as well.

The home had effective systems when new staff were recruited and all staff had appropriate security checks before starting work. We found that there were enough staff to provide the support people needed, at the time they required it. Staff were trained and competent to provide the support individuals required. We found that training and staff support was given a high profile in the home and was well established and organised.

The home had received accreditation for the of Gold Standard Framework (GSF). The aim of this was was to promote high quality care, proactive planning, working with GPs and other health professionals and more advanced care planning and reduced hospital deaths.

There were suitable hoists and moving aids in use in the home to assist with the different mobility needs of people living there. The premises and equipment were being well maintained for the people living there.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to safeguarding people from abuse, care planning information, assessing capacity and monitoring the quality of some aspects of service provision. We also found a breach of the Care Quality Commission

Summary of findings

(Registration) Regulations 2009 in relation to the notification of incidents to CQC. You can see what action we told the provider to take at the back 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?

Requires Improvement

Aspects of this service were not safe. Staff had not always followed local guidelines to refer possible abuse to the appropriate safeguarding agencies.

Staff had been recruited safely and had been given training to meet the needs of people who lived in the home. The home was clean, hygienic and well maintained with equipment and moving aids in use.

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

Is the service effective?

Requires Improvement

The service was not effective. Some information in the care plans was contradictory and care and risk management planning for aspects of nutritional risk were not always effectively followed in practice to meet people's needs.

We found that there was inconsistency in the process of assessing mental capacity and on how information on Power of Attorney (PoA) to confirm who has legal authority to make decisions on a person's behalf.

Where people had complex health care needs, appropriate specialist health care services were included in planning and providing their care. People who required support to eat and drink received this is a patient and kind way.

Is the service caring?

Good

This service was caring. Staff showed good knowledge of the people they supported, for example detailed information on their backgrounds, their likes, dislikes and preferred activities.

People told us that they felt well cared for and we saw that the staff were polite and caring and people were treated in a kind and compassionate way. People were treated with respect and their independence, privacy and dignity were protected and promoted.

The staff took time to speak with people and gave them the time to express themselves. We saw that staff engaged positively with people. This supported people's wellbeing.

Is the service responsive?

Good

The service was responsive. People's needs were assessed prior to their admission to the home. The service worked with other agencies and services in a co-ordinated way to access to the support people needed.

People made choices about their lives in the home and were provided with a

Summary of findings

range of organised activities. We saw people participating in a range of activities during the day.

People were supported to maintain relationships with friends and relatives. Family members spoken with confirmed they could visit whenever they wished and staff made them welcome in the home

Is the service well-led?

Requires Improvement

The service was not well-led. The systems to assess the

quality of the service provided in the home were not always being applied effectively in practice. As a result safeguarding systems, complaints procedures and incident analysis had not been consistently monitored.

We found that some notifications that should have been submitted to the Care Quality Commission (CQC) had not been made. This meant we were not able to check that the provider had taken appropriate action

There was a registered manager employed in the home who was relatively new in post. Staff told us they were well supported by the registered manager and had team meetings and supervision. People who lived in the home and their relatives were asked for their opinions of the service and they told us that their comments were acted on.

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People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff when they visited. We could see that people made day to day choices about their lives in the home and were provided with a range of organised activities. We saw people participating in a range of activities during the day and staff provided one to one time with people as well.

The home had effective systems when new staff were recruited and all staff had appropriate security checks before starting work. We found that there were enough staff to provide the support people needed, at the time they required it. Staff were trained and competent to provide the support individuals required. We found that training and staff support was given a high profile in the home and was well established and organised.

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Requires Improvement

Is the service safe?

Our findings

We looked at records of the accidents and incidents that had occurred on the three units in the home. We found that the registered manager had not always taken appropriate action when there had been incidents that had affected the safety and wellbeing of people who lived there. We had received information from other agencies, before our inspection, including about a safeguarding incident that was not reported by nursing staff to the manager for two days. This meant that people could still be at risk if incidents were not reported to the right agencies quickly.

There had been an incident of aggression between two people in the home and we also saw records of three people with bruising of unknown origin. We found that possible abuse had not been referred to the local authority safeguarding team for investigation in line with accepted local procedures and the services procedures. We asked the registered manager to make sure incidents were followed up correctly to protect people.

We also found that staff had reported a safeguarding incident, as per procedure, to a senior member of staff who had not taken action to refer the matter in line with the service's policies. People had been put at risk because swift action had not been taken to refer the incident to the local authority safeguarding team for their consideration of the incident and investigation, if needed. We saw that adverse incidents had not been followed up formally by the management to monitor and take action to reduce such accidents and injuries happening again.

We found that that the registered manager had taken some internal action to manage the risk to the two people involved at the time. However referral to the local authority team of any suspected abuse is required under the local multi-agency safeguarding of vulnerable adults procedures. An investigation by a safeguarding team allows all evidence to be assessed and to put agreed protection plans in place to protect vulnerable people. It is important to follow the guidance to make sure the right action has been taken to uphold a person's rights and safety.

Nursing and care staff we spoke with told us they had received training on safeguarding vulnerable people. Staff told us if they witnessed poor care or ill treatment of people in the home they would challenge poor practice and report any allegations or suspicions of abuse to their manager. Ancillary staff we spoke with confirmed they had received training on safeguarding and whistle blowing. One staff member told us "Doing the safeguarding training really made me more aware and I know what to do. I would have no problem reporting anything I see that is not right".

Some nursing and care staff we spoke with were not clear about what should happen after they reported and that suspected abuse needed to be referred to social services safeguarding team not just their manager. This indicated to us that staff understanding of safeguarding procedures was not consistent and could result in safeguarding incidents not being referred quickly to keep people safe. This lack of action by senior staff, in line with agreed local procedures, to respond appropriately to any allegation of abuse demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records indicated that the mobility equipment in use had been serviced and maintained under contract agreements and that people had been assessed for its safe use. There were records of monthly maintenance checks on fire alarms, fire extinguishers and emergency lighting and records indicated that fire drills and training took place.

We found that the home was clean and tidy and was being well maintained. Everyone we spoke with who lived in the home told us that they felt safe living at Cartmel Grange. One person who lived there said, "It's very nice here, it's not home, but it's comfortable and I feel safer knowing there is always someone about". Another person who had recently come to live there told us, "Most days I think I have made the right decision to come here, I am settling in and everyone has made me feel at home and secure".

The ten visitors we spoke with told us they felt the home was a safe place for their relatives to live and that they were kept informed about anything that might affect their relative. We were told that they had no concerns about their loved ones' safety at the home. One visitor told us, "They are really well looked after, I would say its excellent". Another relative told us, "It's excellent care, we have no worries or fears" and "When we leave we know we are leaving them in safe hands".

As part of this inspection we looked at medicines records, supplies and care plans relating to the use of medicines. We looked at care plans for five people with complex healthcare needs and saw that these had been regularly

Requires Improvement

Is the service safe?

reviewed so that people continued to receive appropriate care. We saw guidance in place for 'when required' medicines so that people received safe and effective treatment when they needed it.

We observed staff handling medicines and spoke with nursing staff about medicines procedures and practice on Ingleborough and Arnside units. We saw nursing staff giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines.

We looked at how medicines were stored and found that they were stored safely and records were kept of medicines received and disposed of. We looked at the handling of medicines liable to misuse, called controlled drugs. These were stored, administered and recorded correctly. Medicines storage was neat and tidy which made it easy to find people's medicines. Clinical room and refrigerator temperatures were monitored the records showed that medicines were stored within the recommended temperature ranges.

Staff we spoke with told us that there were usually sufficient staff on duty to make sure people were safe and that their needs met. Staff said that if they needed additional help they were able to get it, either by moving staff, working extra shifts or using bank staff. On the day we visited a member of staff had called in sick but a bank carer had been come in to maintain the staff level.

The numbers of staff on each of the units was as stated on the rotas and there was a registered nurse on each of the three units 24 hours a day. The registered manager and clinical lead nurse were also available during the day and there was an on call system out of normal hours. There were sufficient domestic staff to keep the home clean and tidy.

People's care plans included risk assessments for pressure care, falls, moving and handling and mobility and nutrition. We found people had been assessed to determine whether they were at risk of malnutrition. All the care plans we looked at had a nutritional risk assessment to help make sure people remained well nourished.

We looked at staff recruitment records to see that checks were used to help ensure nursing and care staff were only employed if they were suitable to work in a care environment. Since our last inspection in August 2013 there had been 19 new staff employed. We saw that references had been obtained and recruitment files showed that a Disclosure and Barring Service (DBS) check had also been completed before people had started working in the home.

Requires Improvement

Is the service effective?

Our findings

The evidence we found demonstrated to us that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that health care needs were not always clearly stated so staff could not be sure they were always meeting people's assessed healthcare risks and needs. Records for one person showed that their nutritional assessment required that their oral intake be recorded daily. The care records indicated their oral intake had not been recorded since March 2014 and this had not been addressed following an audit. Therefore the plan for this person was not being put into effect as planned or updated if a change had occurred.

Some information in care records was conflicting and the correct actions for all staff to refer to was not always being made clear. For example, one person's nutritional assessment stated they needed to have "Easy to chew foods" because of assessed problems with swallowing. The care plan in place stated instead that "Normal foods" were required. This meant that in this area staff had contradictory information to work from. The information needed to be clear as following the wrong information could affect the person's welfare and increase their risk of choking.

The nutritional assessments we looked at for people stated that weight loss was to be acted upon but this had not always happened. Records for one person showed a weight loss of two kilograms but no action had been taken as required in their care plan. One person had not had their weight monitored for four months to make sure they were not at risk from weight loss.

We looked at the care plan for one person who had been assessed as being at 'minimal risk of malnutrition'. Their weight record indicated that over a three month period this person had lost over six kilograms. There was no record of how this had been followed with the dietician for assessment or advice as their risk assessment suggested. There was no care record of a discussion at the GP visits on what action was to be taken to manage this risk. We saw that formal action being taken was not always recorded for continuity and monitoring and this could mean that people's nutritional needs, and their associated risks, may not always be effectively met.

We also looked at records of positional changes for people at risk of skin damage. We saw on the charts being used that for some people there had been long periods between repositioning. On the day we visited we saw for one person this was over five hours and that could increase their risk of skin damage.

We saw evidence that indicated that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people who lived at the home were not able to make important decisions about their care due to living with dementia or mental health needs. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated an awareness of the code of practice and confirmed they had received training in these areas.

At our previous inspection in August 2013 the registered manager had confirmed to us that all those people living there with treatment and end of life decisions on resuscitation were having the processes reviewed. This was to make sure their involvement and the best interest process, had been properly incorporated into the decision making and the records. This review had taken place and the home had worked with local GP's to make sure these records were in place.

However we saw that discussions with families and representatives had not always been recorded by the doctor involved in the clinical decision For example, 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms stated other people and professionals and had been involved in the decision process. There was no medical record on file of who had been involved and what discussion had taken place. We discussed with the manager who understood that although such decisions were not their remit they needed to make sure the records of the decisions were always completed by the medical staff involved.

We looked at individual care records that did not indicate how a person's mental capacity had been assessed in regard to forming a decision about future care and support.

Requires Improvement

Is the service effective?

We did not see in individual records where tests, set out in legislation, had been applied or referred to in order to assess the person's understanding or 'capacity' to take a decision.

We spoke with some relatives about how they had been involved in the decision making processes around resuscitation and care decisions. One relative we spoke with who held power of attorney for health and welfare for a person was not aware that their relative had a DNACPR order in place. This indicated to us that people's capacity and best interests were not always being formally assessed and placed at the centre of the process of decision making.

We saw that information regarding who held Power of Attorney for an individual were not always clearly stated in care plans for staff to see quickly should the need arise. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or also care and welfare needs. This meant that staff could not be certain if a person making a decision on someone's behalf had the legal authority to do so.

We saw that some people had 'safety gates' across the entrance to their bedroom doors. Staff told us this was because some people living there wandered into other people's rooms and the occupant did not want them to do this. We were told that they wanted to be able to leave their bedroom doors open so they could see what was going on but not have their privacy disturbed. However, there was no reference in care planning records to the decision being agreed with the person or their legal representative or if it had been made in their best interests following appropriate assessment.

A relative we spoke with told us that they had been involved in discussions about using a safety gate to make sure people could not wander into their relative's bedroom uninvited. This indicated that informal discussions were taking place around people's best interests but were not being formally recorded to provide evidence that their rights and best interests were being actively promoted.

We saw in records that people's health care needs were being met through a close working relationships with other specialist nursing and health care professionals. Local GPs held a 'surgery' at the home each week so they could act promptly to any changes or on going health problems and reduce the need for people to attend at hospital. We also saw that the registered manager had developed good links with the community mental health team (CMHT).

All the staff we spoke with told us that they were well supported to attend training and develop their skills and knowledge. There were records of the completed training and what was planned for staff. Staff said they had regular formal meetings with a senior staff member to discuss their practice and any areas for development. This helped to ensure that nursing and care staff had the appropriate skills, knowledge and qualifications to support people who used the services.

Staff who supported people with behaviours that may challenge the service told us they had received training on deescalating situations and had used that rather than restraining people. We observed how the nursing staff supported and distracted one person when that person became agitated. The staff spent time talking to and listening to the person so that the person became calmer and reassured

The home ran regular training days. These training sessions were to update staff on best practice, for example the most recent ones had been on safeguarding vulnerable adults, back to care basics, diabetes and fire training. The monthly sessions were also to raise staff awareness on health care topics, for example, a workshop was arranged with a local hospice on palliative care to keep staff up to date with best practice. There was also a workshop arranged on hand massage for nursing and care staff so they could use this in practice.

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Good

Is the service caring?

Our findings

All the people living in the home and the relatives we spoke with made positive comments about the care and support provided in the home. They told us that they made decisions about their daily lives in the home and said the staff listened to them and respected the choices they made. People told us the staff who supported them knew them well and what they preferred in regard to the care they needed. One person told us, “Life is just fine here, they (staff) are very good to me and know my ways”.

We saw that people who required support with eating received assistance from staff in a patient and respectful way. During our observations we saw that the staff offered people assistance but respected their independence. We saw that staff took the time to speak with people and took up opportunities to interact with them, engage and offer reassurance if needed. This can that help enhance people’s social wellbeing.

Relatives we spoke with told us they were “encouraged” to be involved in their relatives care and visit as often as they wished. We were told, “If I need to know anything I just ask the manager, she’s quite new, but still very accessible and open to comments”. Another relative told us, “The nursing care provided here is excellent, I have no worries at all”. What relatives told us indicated that staff understood people’s needs and were compassionate and supportive. We were told by one relative, “The care is brilliant” and that “Everyone is very caring no matter what they do from cleaner to manager” and “They are well looked after and more important they’re content”.

We spoke with health care and medical professionals who supported people who lived in the home. They told us, “It’s a good home, they work well with us” and also “There are some people with very complex needs here and they are well cared for and managed well”. They also told us that they felt the home provided “High quality end of life care”. This indicated to us that people received good health care and that links were good between health care services and the home.

We spoke with nursing and care staff and the home’s training officer, who was also the 'Gold Standards Champion’ for people at the end of their lives about the GSF. Nursing and care staff were very clear and knowledgeable about the importance of providing a holistic care at the end of a person’s life. They also confirmed what we had found in the training records that the provider made sure they had provided regular and relevant training to maintain a high standard in this area of care.

Staff had also been able to take part in 'The Six Steps' palliative care programme with a local hospice. This programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. We also spoke with a local GP who visited the home each week. They told us that they felt the home provided “Very high quality end of life care” and that staff knew people well and “Respond quickly to any changes in condition”.

We were told by one relative about how much they appreciated the support the staff provided to help meet the spiritual needs of their loved one. We were told, “She has always enjoyed her bible but is too poorly to read it now. We were so pleased to find one of the activities people reading it to her”. Relatives we spoke with also confirmed that they were able to visit at any reasonable time and were made welcome by the staff when they visited.

We saw that people who could not easily speak with us were comfortable and relaxed with the staff who were supporting them. Throughout our inspection we saw that the staff on duty treated people with respect and kindness. We saw that staff protected people's privacy by knocking on doors to private rooms before entering and providing support to people in a discreet manner. We saw that staff maintained people’s personal dignity when assisting them with mobility and in using the equipment they needed. During our visit we saw that staff approached people in an informal and supportive way using their preferred names as stated in their care plans.

Good

Is the service responsive?

Our findings

People living at Cartmel Grange said that staff respected their choices, for example one person said, "I prefer to stay in my room and they (staff) understand that. They let me know if there is anything going on if I want to join in". People who could tell us their views of the home said that there were staff available to help and support them as they needed. One person told us, "There is always someone about when I want them". Their visitor told us, "It takes two staff to move them and there are always two carers doing that and they talk to her and explain". Another relative told us "I've always found there is someone available if we want to speak with them or if he wants help".

People told us that the staff asked them about how they wanted to be supported when they assisted them and that staff did as they asked. Throughout our inspection we saw that the staff gave people the time they needed to communicate their wishes. People told us that they saw their relatives and friends where and when they wanted and went out with them if they wanted to. We were told by people, and we saw from the records, that people were able to follow their own beliefs. There were monthly multi denominational religious services and also prayer services for people to take part in if they wanted.

The service had a complaints procedure that was available in the home for people. People who lived there we spoke with told us they had not felt the need to make a complaint but would feel comfortable raising anything they were not happy about. We were told, "There is nothing bothering me" and "I have nothing to grumble about, I would just say if there was".

Relatives told us that if they wanted to know anything about their relatives care they "Just asked". They also told us, "We have found this to be a nice, open and very friendly place. We would not hesitate to raise any concerns with the staff". Other relatives told us "We have raised some matters in the past and they have always done as we asked and got back to us. They seem to keep track of things". This indicated that people felt confident in raising any issues and that their concerns had been listened to and responded to.

During the inspection people we spoke with and their relatives told us that staff listened to people's views and asked how they liked care to be provided. Relatives told us that they had the opportunity to take part in helping to develop life histories and comment on their relative's social and cultural preferences. This helped to give staff a more complete picture of the individuals they were supporting. Staff we spoke with did know about the person and their families not just their care needs.

People's care records showed that their individual needs had been assessed prior to coming to live in the home. The information gathered had been used to develop care plans. We saw information had been added to plans of care as they were developed and as the persons preferences and wishes became known. Records indicated that reviews had been carried out on people's assessed needs and associated risks. People we spoke with confirmed to us that they knew there was a plan about them and they could see it if they wanted to. No one we spoke with said they wanted to look at it. One person told us, "I trust them to take care of doctors and my pills and I think they know me well enough by now just to talk about anything else".

People living there also told us that they felt they had been part of deciding what they wanted to help support them and what was important to them. People told us about the many organised activities in the home they could attend if they wanted, including exercise sessions, music for health, bingo and crafts as well as trips out. We saw that there was also a letter writing service for people who wanted to keep in contact by post.

All of the people we spoke to were aware of the organised activities or said that that staff told them what was happening that day. There was also a timetable of organised activities posted on the noticeboards and made available to people to refer to. During our visit there was a 'zoo lab' in progress where people had the chance to handle small animals and insects if they wanted to. The 'zoo lab' session was well attended by people living there.

Requires Improvement

Is the service well-led?

Our findings

We found a breach of Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2010.

We found that some notifications which should have been submitted to the Care Quality Commission (CQC) had not been. This included failing to notify CQC about a possible safeguarding incident and also when applications had been made to a 'Supervisory body' to deprive someone of their Liberty under legal safeguards. This meant CQC were not able to check that the provider had taken appropriate action at the time in response to the incidents and applications so that, if needed, action could be taken to protect the person or their rights.

We spoke with the manager about this and informed them this must be done and that we would take further action if future notifiable incidents were not reported to CQC.

There was evidence that indicated to us that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were systems to assess the quality of the service provided in the home but we found that these had not always being put into practice effectively and followed up formally. For example, actions required from a person's care plan audit in April 2014 had not been followed up to make sure improvements were made and the care plan was accurate and up to date.

We looked at the records of accidents and incidents that had occurred in the home on the three units. We did this to check if action had been taken promptly to analyse any incidents and make changes if needed. It was also to see if injuries or bruising were recorded and what had action taken to prevent any reoccurrence. We saw that some incidents had not been followed up formally by the management to monitor and take action to reduce such accidents and injuries happening again.

We saw that the last formal accident analysis undertaken in the home had been in July 2014. We found that a regular and systematic analysis of such incidents had not taken place to develop solutions and manage risk. The information was being gathered but was not of value to the people living there if the registered manager did not analyse it and act to minimise or remove a risk.

We asked about monitoring visits by the provider to check on quality issues. The registered manager told us that the Operations Manager carried out regular visits to the home to check quality systems and speak with people living, working and visiting to get their views. However no record of these visits had been kept to record and follow up any issues identified or and who had been spoken to. Therefore there was no evidence of this aspect of the quality monitoring process.

We looked at how complaints were monitored in the complaints log and by auditing. We saw that a complaint had been made about medication administration involving a staff member. This incident had not been formally logged in the compliant system for action and monitoring. There was no record that a response had been sent to the person making the complaint about what actions had been taken. However personnel records we looked at indicated that a conversation had taken place with the staff member involved although there was no formal disciplinary action taken to ensure there were improvements in practices. This indicated that the complaints system was not being monitored to make sure it was being effective in promoting quality and performance.

There were some effective audits and reviews being carried on, for example, with medicines, monitoring staff training and infection control . However the whole quality monitoring and assurance system was not consistently robust and some areas had not been subject to the same level of monitoring scrutiny.

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

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

We were told by people who lived at Cartmel Grange that there were regular meetings for them to attend if they wanted. People told they did not have to attend but could if they wished to. We saw the minutes of these meetings and noted that they had been well attended. The minutes

Requires Improvement

Is the service well-led?

showed that people had discussed various matters such as the meals and activities they wanted and suggested venues for trips out. We saw that the organised activities being made available within the home were prominently displayed along with local community news and Age UK information.

Staff employed in the home told us that they felt supported by the registered manager and registered provider. One person said, “There have been a few big changes recently and a new manager but the training has always been good and I can go to the manager at any time”.

There were formal systems for staff to receive supervision and appraisal where they could raise any concerns about the service. Staff also confirmed to us that they had their own staff meetings to discuss work issues and practices and give and receive feedback from senior staff.

Health care professionals who supported people who lived in the home told us they had good professional relationships with the registered manager and nursing staff employed there. A visiting health care professional said, “The staff are proactive and bring things to our attention in good time to deal with before they become a problem”.

At the end of our inspection we shared an overview of our findings with the registered manager and the clinical lead nurse. The registered manager of the home told us the actions they intended to take to address the areas that needed to be improved. This indicated to us that the registered manager was open to feedback to improve the service provided.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: People who used the service were not being protected from the risk of abuse because action had not been taken to identify and respond quickly and appropriately when it was suspected that abuse may have occurred. Regulation 11 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not being protected against the risk that their needs may not be fully met because care planning information was unclear and planned actions had not always been followed. Regulation 9 (1) (b) (i) (ii) (iii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider did not have a formal and verifiable arrangement in operation to assess individuals capacity to make a decision and to gain and review consent within a best interests framework for the care being provided to them. Regulation 18

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The registered provider had not effectively monitored all the systems in place to assess the quality and safety of the services provided. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: Notifications of applications to deprive someone of their liberty and also of allegations of abuse had not been made to the Care Quality Commission. Regulation 18

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.