Care Quality Commission

Gracewell Healthcare Limited

Gracewell of Basingstoke

Inspection report

Pemberley House
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21 June 2016
23 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection of Gracewell of Basingstoke took place on 20, 21 and 23 June 2016. The home is registered to provide accommodation with personal and nursing care for up to 72 people. At the time of our inspection there were 69 older people living at the home, some of whom were living with dementia.

Accommodation at the home is provided over three floors, which can be accessed using the stairs or passenger lifts. There are five different areas within the home, referred to as communities. Two communities are located on each of the first two floors, with a single community situated on the top floor. There is a large enclosed garden and patio area which provides a secure private leisure area for people living at the home. The home also has a boutique café with internet and computer facilities for people to meet and keep in touch with family and friends. The home contains a purpose built salon to provide hairdressing, manicures and other therapeutic services.

The home did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The home has not had a registered manager since 31 July 2015, during which time the home has had four interim managers. At the time of our inspection there was a home manager who had been appointed in January 2016, who was in the process of making an application to become the registered manager with the CQC.

The lack of consistent leadership and management had left people, their relatives and staff feeling concerned about the quality of care provided in the home. Staff told us the perpetual change of management had been demoralising and left them feeling as if they were not valued.

The quality of the service had not been consistently monitored by the series of interim managers. The monitoring systems had not identified that care plans did not contain sufficient up to date information to provide people with safe consistent care, that was focussed on meeting their individual needs. The provider had failed to ensure records were completed in a timely manner or to keep records up to date to ensure people received safe care.

There were not enough staff with the appropriate experience and knowledge to meet people's needs safely. Without exception people, their relatives, friends and staff told us there were far too many agency staff who did not know the people they were supporting. The home's high dependency on agency staff often meant they did not know people or their needs and people did not recognise staff supporting them.

The home manager had not completed annual appraisals or two monthly supervisions with staff, in accordance with the provider's policy. Staff had not been enabled to deliver care and treatment to people safely through the provision of effective supervision and appraisals.

Identified risks to people's health were not always managed by staff to reduce the risk of harm. Although people received the care they required to manage risks to them, some people's records did not contain all of the required written guidance for staff unfamiliar with people's risk management requirements to ensure their safety. This increased the risk of people experiencing unsafe or inappropriate care when agency staff were supporting them.

During the inspection several safeguarding concerns were brought to our attention by the provider's Director of Operations. The provider took the correct action to ensure people were safe whilst the allegations were investigated.

Staff had completed the provider's required safeguarding training and were able to recognise the different types and signs of abuse. Staff understood their role and responsibility and knew how to report abuse and protect people from harm.

Staff had undergone robust pre- employment checks as part of their recruitment, to ensure their suitability to support vulnerable people.

Records demonstrated staff administering people's medicines had completed relevant training and had their competency assessed. We observed staff administer people's medicines safely, in the way people preferred, in accordance with their medicines management plans.

New staff had completed the provider's induction programme which was linked to the Care Certificate, and the provider's mandatory training was up to date. This ensured staff maintained the skills and knowledge to meet people's needs effectively.

Staff supported people to make as many decisions as possible. We observed staff constantly seeking people's consent about their daily care and allowing them time to consider their decisions, in accordance with their support plans.

Records showed that staff had undertaken training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a clear understanding of the legal requirements to protect people's human rights when they lacked capacity to consent to their care. Staff were able to demonstrate that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare when necessary.

People were protected from the risks of malnutrition and dehydration. Where people had been identified to be at risk of choking staff supported them discreetly to minimise such risks.

People's records demonstrated they were referred promptly to healthcare professionals when required, which we observed in practice.

Positive caring relationships were not consistently developed by all staff with people living at the home. People had mixed views with regard to how caring agency staff were.

Staff were careful to ensure that peoples' privacy and dignity were respected and listened to what people wanted. People were supported by staff to make day to day decisions that reflected their preferences and recognised their individuality.

People's care records were not consistently person centred, which means they were not always focussed on

the individual, their needs and wishes. Regular staff were able to tell us about people's life histories and things that were important to them. However, this person centred information was not always known by the agency staff.

Most people and relatives told us there was not enough stimulation for those who were less mobile and requested more one to one support and staff being able to just "stop and chat". People were not consistently supported to follow their interests or to take part in activities of their choice, to ensure they received regular stimulation and social engagement to enhance their wellbeing.

People and their relatives told us they knew how to make a complaint and felt comfortable to do so if required.

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

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

The service was not always safe.

The provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people. Without exception people, their relatives , friends and staff told us there were far too many agency staff who did not know the people they were supporting.

Identified risks to people's health were not always managed by staff safely to reduce the risk of harm to people.

During the inspection several safeguarding concerns were brought to our attention by the provider's Director of Operations. They took the correct action to ensure people were safe whilst the allegations were investigated.

Staff had undergone robust pre- employment checks as part of their recruitment, to ensure their suitability to support people in the home.

Staff administered people's medicines safely, in the way people preferred, in accordance with their medicines management plans. Records demonstrated all staff administering medicines had completed relevant training and had their competency to do so assessed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not been enabled to deliver care and treatment to people safely through the provision of effective supervision and appraisals.

Staff supported people to make as many decisions as possible.

People were protected from the risks of malnutrition and dehydration. People told us they enjoyed the food and drink prepared. Staff provided appropriate support to enable people to eat and drink at their own pace.

People's records demonstrated they had seen a variety of healthcare professionals as needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Positive caring relationships were not consistently developed by all staff with people living at the home.

People were supported by staff to make day to day decisions that reflected their preferences and recognised their individuality.

Staff were able to explain how they upheld and respected people's privacy and dignity in the provision of their personal care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records were not consistently person centred, focussed on the individual, their needs and wishes,

People were not consistently supported to follow their interests or take part in activities of their choice.

Complaints had not always been resolved to the satisfaction of the complainant.

Is the service well-led?

Inadequate

The service was not well led.

There had been a lack of sufficient permanent clinical leadership to support and supplement the work of the home manager.

The lack of consistent leadership and management had left people, relatives and staff feeling concerned about the quality of care provided in the home.

The quality of the service had not been monitored by the series of interim managers.

Care Quality Commission

Gracewell of Basingstoke

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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. A service provider is the legal organisation responsible for carrying on the adult social care services we regulate.

This unannounced inspection of Gracewell of Basingstoke took place on 20, 21 and 23 June 2016. The inspection was completed by two adult social care inspectors.

Before the inspection we reviewed all of the notifications received about the home. Providers have to tell us about important and significant events relating to the service they provide using a notification. We reviewed the Provider Information Return (PIR) about the home. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the provider's website to identify their published values and details of the care and services they provided.

During our inspection we spoke with 17 people living at the home who were able to tell us about their experience. We spoke with six relatives visiting their family members, two friends and two visiting GP's.

We used a range of different methods to help us understand the experiences of people using the service who were not always able to tell us personally. These included observations and pathway tracking. Pathway tracking is a process which enables us to look in detail at the care received by an individual in the home. We pathway tracked the care of two people living at Gracewell of Basingstoke. Throughout the inspection we observed how staff interacted and cared for people across the course of the day, including mealtimes, during activities and when medicines were administered.

We spoke with the staff including the home manager, the deputy manager, the clinical support manager, four regular Gracewell nurses, five agency nurses, three senior care staff, 12 Gracewell care staff, two agency care staff, two activities coordinators, the head housekeeper, a housekeeper, two administrators, two maintenance officers, and the driver. We also spoke with, the Director of Operations, the homes' admissions

advisor, and a national training manager.

We reviewed 20 people's care records, which included their daily notes, care plans and medicine administration records (MARs). We looked at 20 staff recruitment, supervision and training files. We spoke with a registered nurse who had just completed a selection interview for a post as a nurse at the home. We looked at the individual supervision records, appraisals and training certificates within the staff files.

We also looked at the provider's policies and procedures and other records relating to the management of the service, health and safety audits, medicine management audits, infection control audits, emergency contingency plans and minutes of staff meetings. We also reviewed staff rotas during between 1 May and 24 July 2016. We considered how people's, relatives' and staff comments were used to drive improvements in the service.

Following the visit we spoke with, two health and social care professionals who provided their feedback. These health and social care professionals were involved in the support of people living at the home.

The home was last inspected on 28 August 2014, where no concerns were identified.

Is the service safe?

Our findings

There were not enough staff with the appropriate experience and knowledge to meet people's needs safely. Without exception people, their relatives, friends and staff told us there were far too many agency staff who did not know the people they were supporting. People and relatives told us that the regular staff were "Wonderful" but often did not have the time to stop and chat because they were always rushed.

People and their relatives told us they frequently had to wait far too long for support to use the toilet. This often caused them great distress as they took great pride in remaining continent. One person told us at night agency staff did not listen to them, and were often kept waiting for over twenty minutes before staff came to see them. "They go their own sweet way". This person told us they had recently been left on the toilet for over 40 minutes unsupported.

People and their relatives told us there were not enough staff, which adversely impacted on the quality of care. One person said, "It's gone downhill since (previous manager) left over a year ago.There's never enough staff and those that are here don't know you." Another person said, "The staff do their best but there's just not enough of them." We observed a number of occasions when people had waited in excess of five minutes for staff assistance after they had rung their call bell, which was confirmed by the provider's alarm bell response audit. On the first two days of our inspection the provider's call bell response audit identified 68 calls took longer than five minutes for staff to respond, with four taking over 45 minutes. This meant there was an increased risk that people would not receive care and treatment when they needed it to keep them safe.

On the first day of our inspection there were no regular nurses on the night shift. We spoke with the two agency nurses covering the night shift, who had been supplied by different agencies. They told us they had received a verbal handover from the day nurses, and had been provided with a brief resume of the people they were supporting. Both nurses told us they did not know the people they were supporting or their needs, but could refer to their individual care plans if required.

One agency night nurse covering the middle floor where most people with higher dependency lived, told us they were supported by four care staff, all of whom had been provided by an agency, which daily allocation sheets and rotas confirmed.

On the first morning of our inspection an agency care staff had not arrived to work in one of the communities. This meant staff from the adjacent community had to continually leave their community to support colleagues where two staff were required to support people, for example; when moving and transferring them. The replacement agency staff did not arrive until lunchtime. Staff told us, "This happens quite a lot and the agency nurses have to come from so far away."

We spoke with a regular nurse during our inspection who had worked between 7.45 am and 8.00 pm, without a break. They were upset because only one agency nurse had been arranged to provide cover during the night. The nurse had to wait for another agency nurse to be arranged to attend to relieve them.

When the agency nurse arrived they were provided with an induction by the day nurse, who eventually finished work at 00.30 am. This meant they had been working for 16.5 hours and were very tired. This meant that people were at risk of receiving unsafe care from staff who were over tired. The agency nurse who attended to relieve the day nurse was from an agency not previously used by the provider and had never worked at the home before. This meant they had never met or been introduced to people living in the home and did not know their needs. The regular nurse who provided the induction was able to impart necessary clinical information about people and their needs but was unable to introduce them as most people were asleep.

Staff we spoke with said they were always under pressure and rushing from one task to another. One staff member described their working day as being, "Always running to catch up". All of the staff we spoke with said that there was not enough staff to safely support everyone and provide high quality of care. They said that people often had to wait for long periods of time when they called for help. One care assistant said, "We're always rushed off our feet so there's no time stop and provide the care for people they deserve."

Nurses told us that more staff were required due to the number of people who required the support of two staff to meet their needs. The home manager told us that they completed a staffing needs analysis weekly but was unable to provide written evidence of this. The home manager told us they needed to recruit staff to cover 462 hours care provision per week and urgently needed to recruit at least two nurses, which rotas confirmed.

Rotas highlighted the high dependence on the provision of agency nursing staff to provide support for people. Permanent staff voiced concerns that whilst agency nurses and care assistants had been provided they often did not know people's needs and people did not recognise the staff supporting them. Regular staff told us it was 'exhausting' having to continually answer questions by or supervise agency staff who sometimes did not appear to know what they were doing.

One person who required two people to support them to move and with personal care told us they were worried that some of the agency staff did not know their needs and could not speak English. They told us that the week before our inspection there was an incident where agency staff could not understand the regular staff member who was providing guidance about how to support them to move. They also told us that an agency nurse could not understand them when they explained they were trying to apply the wrong type of continence support. This was confirmed by care staff we spoke with who had observed the incident. The person told us, "It can be upsetting with agency staff when they don't understand your needs."

We spoke with one person who was upset because they wished to take part in the afternoon entertainment, together with two friends who had come to visit. The person and their friends told us there were no staff available to support them to transfer into their electric wheelchair and were disappointed to miss about 30 minutes of the show. The person told us they regularly had to wait for staff to support them to transfer into their wheelchair, which caused them to become frustrated and anxious. This was corroborated by the experience of the person's friends during their visits.

The home provides care to people on three different floors. On night shifts there were only two nurses rostered on duty which meant the top floor did not have continuous cover by a nurse. On the second morning of our inspection we spoke with a regular care staff who told us there were never enough staff on the top floor. They told us this created a problem whenever people required to turned by two staff. The staff member told us that they had on occasions turned one very small person alone when other staff were unavailable. This obviously placed the person at risk of potential harm, for example; from falling. The provider's national training officer told us this contravened the provider's moving and positioning training.

The clinical support manager who had completed an unannounced night visit in the early hours of that morning had immediately begun to implement measures to ensure this practice ceased forthwith by speaking with all staff at shift handovers.

The provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Identified risks to people's health were not always managed by staff to reduce the risk of harm to them. Although people received the care they required to manage risks to them, some people's records did not contain all of the required written guidance for staff unfamiliar with people's risk management requirements to ensure their safety. Where care plans identified people to be at risk of falls, choking and malnutrition, management plans were not always readily accessible to address these risks. Permanent staff were aware of these risk assessments and the relevant support required, whilst agency staff were not. This increased the risk of people experiencing unsafe or inappropriate care when agency staff were supporting them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection several safeguarding concerns were brought to our attention by the provider's Director of Operations. The Director of Operations took the correct action to ensure people were safe whilst the allegations were investigated.

Staff had completed the provider's required safeguarding training and were able to recognise the different types and signs of abuse. Staff understood their role and responsibility and knew how to report abuse and protect people from harm. The provider ensured staff had access to their safeguarding policy and local authority and government guidance about preventing abuse, recognising signs of abuse and how to report concerns in a timely manner. Staff knew the external agencies from which they could seek support when reporting and discussing safeguarding concerns.

People were protected from the risks of abuse because staff were trained and understood the actions required to keep people safe. Most people said that they felt safe and did not have any concerns about abuse or bullying from staff.

Staff had undergone robust pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective staff underwent a practical assessment and role related interview before being appointed. People were cared for regular staff whose suitability for their role had been assessed by the provider.

Records demonstrated all staff administering medicines had completed relevant training. We observed two nurses administer people's medicines safely. They wore a red tabard stating 'Do not disturb medication round 'and had washed their hands prior to commencing the medicine round. One of the nurses who had been newly appointed, was waiting for one person to finish their lunch before administering their medicine. The nurse knew the medicine they were about to administer and why it was normally prescribed. However, they did not know why it had been prescribed to the person in question without reviewing their medicines management plan. This meant they would not be able to confirm whether it was safe to administer. The nurse told us they were in the process of reviewing everyone's medicines plans so they understood what people had been prescribed and why.

Nurses ensured they completed people's medicine administration records (MAR) after they had observed people swallowing their medicines. Nurses checked with people if they required pain relief. People's records checked mostly contained guidance about pain relief; to ensure staff knew when to offer this to people. A recent audit had identified where people required to have their pain relief management plans updated, which had been actioned by the deputy manager.

Processes were in place to audit the use of medicines within the service. An audit in April 2016 identified that there were 594 gaps recording the application of people's topical creams. We reviewed documents which demonstrated that the clinical support manager and deputy manager had provided training to all nurses to ensure best practice guidance was followed in relation to the recording of people's topical medicines. People's MARs we reviewed contained a medicines body chart, which demonstrated where staff were to apply people's topical medicines.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs and require more stringent measures to manage them safely. Processes were in place to ensure the safe storage and administration of all medicines including those which were controlled.

Requires Improvement

Is the service effective?

Our findings

The home manager had not completed annual appraisals or two monthly supervisions for staff in accordance with the provider's policy. The home manager told us they had completed supervisions in February and May 2016.

Most staff files contained 'record of supervision' forms dated 5 February 2016 and 18 May 2016. These records were actually management instructions regarding staff duties, for example; staff management of sluice rooms and clinical waste and staff use of mobile phones. Staff told us the home manager had approached them and asked then to sign the document, wherever they were within the home and that no formal face to face meeting actually occurred.

There was no written evidence of staff annual appraisals for those who had been employed at the home long enough to require one. Other than the records created on 5 February and 18 May 2016 five staff had no supervisions recorded. Fourteen staff had not had a supervision since January 2015. The chef last had a supervision in June 2015.

Staff had not been enabled to deliver care and treatment to people safely through the provision of effective supervision and appraisals. This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an induction course on the commencement of their role based on nationally recognised standards and spent time working with experienced staff. During this time they shadowed experienced staff to learn people's specific care needs and how to support them. This ensured they had the appropriate knowledge and skills to support people effectively. Nurses told us that when they first arrived at the home they were provided with a nurse mentor and had an induction workbook to work through with their nominated mentor.

Staff told us they had received a thorough induction that gave them the skills and confidence to carry out their role effectively. The provider's national training manager had reviewed the induction programme to link it to the new Care Certificate. The Care Certificate sets out learning outcomes, competences and standards of care that care workers are nationally expected to achieve.

Nurses are required by their regulatory body to have their practice re-validated every three years. The home manager told us all nurses had been assessed and their revalidation dates identified. Nurses were able to demonstrate their nursing qualifications remained valid but told us they did not feel the provider effectively supported and encouraged them to revalidate and update specific training in relation to best practice. Nurses told us this had not to date had an impact on people living at the home. The provider's national training officer and the home's newly appointed clinical lead told us they were developing a competency framework to provide more support for nurses with their continued professional development.

Staff supported people to make as many decisions as possible. We observed staff constantly seeking

people's consent about their daily care and allowing them time to consider their decisions, in accordance with their support plans. We observed staff supporting people with limited verbal communication to make choices, for example; by using their knowledge of the person's facial gestures and sign language or writing questions and answers.

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

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

Records showed that staff had undertaken training on the MCA and DoLS. Staff demonstrated a clear understanding of the legal requirements to protect people's human rights when they lacked capacity to consent to their care. Staff understood how to assess if an application for a DoLS should be submitted and had correctly submitted them for people where required.

DoLS authorities we reviewed had been underpinned by a MCA assessment to demonstrate how the decision had been reached that the person lacked the capacity to consent to their care, and that they were subject to restrictions to a level that amounted to them being deprived of their liberty. The home manager had created a DoLS application tracker to ensure DoLS applications were authorised as soon as possible, which illustrated that the home was awaiting the authorisation of 34 current applications.

Staff were able to demonstrate that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare when necessary, for example; a decision had been made to remove sharp objects from a person's room to protect them from self-harming.

People were protected from the risks of malnutrition and dehydration. People told us they enjoyed the food and drink prepared at the home by the chef. They told us the chef was "Very good" and "Always asking if our food is good or if we would like anything added to the menu." One relative complimented the quality of food but found their loved one did not recognise some of the options offered which they had not experienced before, which limited their choice. They did confirm that other alternatives were suggested by staff.

We observed the service of lunch in two different communities and to four people who chose to eat in their room. Staff supported people gently into the positions they wished for and then checked if it suited them. People enjoyed their meals in the communal dining areas in pleasant surroundings. We spoke with a group of people who had become firm friends who told us how much they enjoyed eating together.

People had a choice of two main courses and puddings and could choose alternatives, for example people's favourite baked potato, a salad or an omelette. One person particularly enjoyed beetroot and told us the chef ensured they always had extra in their salads. We observed that where people had made choices earlier and had subsequently changed their mind staff asked if they would like something else, which the chef then prepared.

Staff had a list of food that people had previously chosen and this included reference to individual's dietary needs, for example; who had diabetes, high cholesterol, fortified food, small portions. This also identified their preferences, for example; no mustard or ketchup.

Staff provided appropriate support to enable people to eat and drink at their own pace. Where people had been identified to be at risk of choking staff supported them discreetly to minimise such risks.

Some people's care plans had incomplete dietary preferences and confusing information as to whether a choking risk assessment was required. We spoke with the chef and kitchen staff who had a whiteboard which detailed everyone who was at risk of choking and those people who had specific dietary requirements. All staff serving people demonstrated they were aware of people's dietary needs and any specific risks.

People had been weighed regularly and their Malnutrition Universal Screening Tool (MUST) score calculated monthly. MUST is a screening tool to identify people, who are at risk from either malnourishment or from being overweight. There was evidence that where staff had concerns about a person's weight they had correctly referred them to their GP.

Where people required a fluid chart to document their fluid intake these were in place. However we found that these were not always readily accessible or totalled and analysed by the clinical lead or nurse in charge, to ensure people were not at risk of being dehydrated.

People's records demonstrated they had seen a variety of healthcare professionals as needed, including GP's, tissue viability nurses, opticians, dentists, and physiotherapists. During our inspection we observed three GP's called out by staff to support people who needed to be seen that day. People were supported by staff to access healthcare services as required.

Requires Improvement

Is the service caring?

Our findings

Positive caring relationships were not consistently developed by all staff with people living in the home.

People and relatives provided mixed feedback regarding how caring staff were. Most people were complimentary about regular staff but wished they had more time to engage with them on a one to one basis. One person told us, "The girls (staff) are so kind and gentle, but they are always rushing about. I like it when they can sit and have a little chat." Another person told us, "Most of the staff are caring and some like (named members of staff) are wonderful."

People had mixed views with regard to how caring agency staff were. One person told us, "Some of the agency carers are very good but others work to rule or just stand around and don't seem to know what they are doing." Another told us, "Our own staff (Gracewell staff) do care and do their best but there just isn't enough. It's pot luck with agency, some of them can't communicate very well."

People and relatives told us it was difficult to build caring and trusting relationships with staff who were continually changing. People told us when they were not familiar with their care staff this caused them to worry. One person told us, "I worry if I don't know them. How can you really trust them if you've only just met them." Another person told us, "It's frustrating and disappointing when new agency come in, you don't know them, they don't know you and you have to tell them how to do things again." One relative told us there were a lot of changes of staff between the different communities within the home on a daily basis due to staffing issues. Another relative told us there were often more agency staff than regular staff. Both relatives told us this led to the provision of inconsistent care and a lack of meaningful interaction between staff and people.

We observed interactions between staff and people which were kind and considerate. Regular staff spoke fondly about people, whom they knew well. They told us when they had time they checked people's daily notes and handover records to ensure they had all the information they needed to support people to make decisions about their care. Agency staff were able to tell us about people's care needs from information provided at handovers, but were unable to tell us about people's life stories or their likes and dislikes.

Regular staff always spoke in an inclusive manner with people, enquiring about people's welfare and feelings. People and regular staff engaged in humorous conversations that did not just focus on the person's support needs. Some people had limited verbal communication, whilst others had sensory impairments. Regular staff clearly understood how people showed dislike, displeasure, and discomfort, and addressed identified issues in a sensitive manner. People were comfortable with the regular staff supporting them and chose to spend time in their company.

We observed agency staff speak with people in a kindly manner without always knowing their personal needs or histories. On our arrival we accompanied the night shift agency nurse to the nurses station on the ground floor. As we did we saw a person wandering around in their night clothes, looking lost and confused. This person said, "I'm worried and scared." The agency nurse was observed to support this person with

kindness and compassion. However, it was apparent the agency nurse did not know the person or their life history, and the person did not know the nurse. The person did not experience care and reassurance from staff they knew and trusted.

Staff treated people in a gentle supportive way and took their time whilst delivering support so people did not feel rushed. Staff were attentive and provided appropriate support with people's mobility, for example, whilst walking to the dining table and when they decided to leave. During one lunchtime we observed 11 people sat in the dining room, seven of whom had remained in their wheelchairs. The people confirmed that staff had asked them if they wished to transfer to dining room chairs and had preferred to remain in their wheelchairs.

Regular staff engaged people in conversations about things which interested them that did not just focus on the person's support needs, for example; some people enjoyed talking about their previous work experiences in public service. We observed that people were relaxed and happy in the company of staff and chose to spend time with them when possible.

Staff told us they had received training in relation to equality and diversity and treating people with dignity and respect. However they said this aspect of their care delivery had never been assessed or subject to supervision, which records confirmed.

People told us that staff listened to what they wanted, for example if they wished to go to the toilet or wished to go to bed. However some people told us that staff were sometimes so busy they thought they had been forgotten. One person told us, "Sometimes staff have emergencies to go to and it can be ages before they come back. It's not that they don't care."

People were supported by staff to make day to day decisions that reflected their preferences and recognised their individuality, for example; people were supported to make choices about their personal rooms. We observed all rooms had been personalised with people's favourite furniture and treasured items and most had memory boxes outside to support people to identify their own rooms.

We observed people's relatives and other visitors were welcomed into the home without restriction. Relatives told us they were allowed to visit at anytime without an appointment.

Staff were able to explain how they upheld and respected people's privacy and dignity in the provision of their personal care, for example; by knocking on doors and seeking permission to enter before doing so and closing doors behind them. Staff were careful to ensure that peoples' privacy and dignity were respected and listened to what people wanted, for example; whenever moving equipment was used we observed people's dignity maintained where necessary by the use of privacy screens.
When staff wished to discuss sensitive, personal matters with people they did so in private. Staff had discussed sensitive issues, for example; while supporting one person with their mental well-being. These issues were treated with strict confidentiality, whilst ensuring the person received the necessary emotional and psychological support.

The provider had processes in place to ensure people were supported to make advanced decisions, for example; in relation to resuscitation. These were recorded in people's advanced care plan and were completed with people's relatives or advocates where appropriate. Some people's advanced care plans and end of life plans had not been fully completed or were not readily accessible. Where people had been asked about their preferences and had chosen not to discuss these issues at the time this had not always been recorded. This meant the provider could not be assured that people would consistently receive care and

support in accordance with their advanced wishes.

Requires Improvement

Is the service responsive?

Our findings

People who were considering moving into the home were invited to visit the service first. This enabled people to make a decision as to whether it was the right place for them or their relative. During our inspection we spoke with two people who were considering whether the home would be suitable for their relative. They told us it was a good way for them to see the home and get a feel for the quality of care provided.

Prior to moving into the home a designated nurse visited people to complete an initial needs and risk assessment with the person and their family, where appropriate, to ensure the home could meet their needs. People and where appropriate people acting on their behalf told us they had been involved in completing their care plan before moving into the home.

People's care records were not consistently person centred, which meant they were not always focussed on the individual, their needs and wishes, for example; some people's "Who am I" records did not contain detailed explanations about people's previous life, their goals and ambitions, likes and dislikes. Regular staff were able to tell us about people's life histories and what was important to them. However this person centred information was not always known by the agency staff deployed at the home.

People had provided mixed feedback in relation to their involvement in their care planning once they had begun to live in the home. The home manager and nurses told us how they reviewed everyone's care plan once per month, or more frequently when required. Every day two different people were nominated as "The Resident of the Day". As part of this process the person should be visited by their designated nurse and keyworker to review their care plans. A key worker is a named member of staff that is responsible for ensuring people's care and support needs were met. Where possible people should be visited by all department heads, such as the chef to ensure that any improvements in their area of expertise were addressed. On the first two days of our inspection the "Resident of the Day" process was not completed. This meant the two people did not have their care plan reviewed and the person did not experience being made to feel special by the department heads.

Nurses told us people should have their weight, pulse, blood pressure and MUST scores checked monthly together with a review of their care plan. People confirmed that staff had completed their monthly health checks but some were unsure whether they had been consulted about their care plan during this process. One person we spoke with told us, "The nurses are very good, if I have any problems I talk to them and they sort it out." They also said, "I am regularly consulted about everything in my care plan and I feel I can ask the nurses anything." Another person said they did not feel they had been asked about what they thought. People did not always feel their views had been sought during care plan reviews.

The provider had established a system to ensure all staff were informed about people's changing needs. The home manager and deputy usually completed a walk through the home in the morning and shift handover briefings took place to ensure all staff were up to date with people's needs at the start of each shift. The home manager then held an 11 am meeting with all department heads, including one of the nurses. At this

meeting staff discussed any concerns and shared information about people's health appointments, social visits and activities. Where it had been identified that people required increased monitoring due to their changing needs plans were put in place to ensure this occurred.

The home employed an activities coordinator to arrange stimulating activities for people. They were supported by other activity coordinators who worked flexible hours. The home prominently displayed a list of all arranged activities for that month at the entrance to each community. These activities included musical entertainment, Bollywood dancing, film shows, dance and motivation therapy, alternative therapies and bingo. The activity coordinator circulated a weekly magazine which recalled various famous people and events on the days of that week and contained games and quizzes. People were invited to the home café for a coffee morning where the home's newspaper Weekly Sparkle was discussed. The hairdresser and manicurist visited weekly and there was a church service on Sunday.

On the first morning of our inspection the activity coordinators visited people providing one to one company and support. The activity coordinator told us the one to one support was provided to everyone but focussed on people who could not or chose not to take part in other group activities.

We observed an entertainer who played the organ and sang requests from the audience, which included 14 people and supporting staff. People actively participated in the singing and were dancing in their chairs. We observed one person supported to stand and dance. During the entertainment people were offered refreshments including ice lollies.

We spoke with one person who was upset because they wished to take part and had been looking forward to watching the entertainment with two friends who had come to visit. The person and their friends told us there were no staff available to support them to transfer into their electric wheelchair.

People who were able to do things independently told us there was enough to do and activities to join in, while some people told us they were unable to take part in an activity package including games and jigsaws which had recently arrived.

Most people and relatives told us there was not enough stimulation for those who were less mobile and requested more one to one support and staff being able to just "Stop and chat". People told us some agency staff did not interact with them.

People told us they used to look forward to regular trips away from the home on Monday and Thursday to visit local garden centres and places of interest. People said they were disappointed because these trips had been cancelled because the driver was not available because they were currently supporting the maintenance manager. People were not consistently supported to follow their interests or take part in activities of their choice which ensured regular stimulation and social engagement to enhance their wellbeing.

The provider had a complaints policy which was displayed in prominent positions within the home. Prior to moving into the home people received a copy of the provider's complaints procedure in a format of their choice which detailed how to make a complaint. People and relatives told us they knew how to make a complaint and felt comfortable to do so if required. Since 8 August 2015 there had been 20 complaints which had been recorded, acknowledged and investigated in accordance with the provider's policy. These complaints had not always been resolved to the satisfaction of the complainant. We reviewed one letter in the complaints file written by a staff member on behalf of the staff mainly relating to low staffing levels and the impact upon staff. Eleven other complaints related to staffing levels or concerns relating to agency staff.

The provider had acknowledged the concerns and responded with their intended action to address the concerns. People told us the home manager was approachable and always listened to their concerns. However some people told us they were "fed up" complaining to the provider about staffing levels and nothing being done. One person told us, "I have now given up complaining because nothing seems to improve." The home manager told us they had taken action to improve the service in response to complaints, although people and relatives did not think action taken had been effective.

Inadequate

Is the service well-led?

Our findings

The provider did not demonstrate good management and leadership. The home did not have a registered manager. On the first day of our inspection there was a home manager in post who had been appointed in January 2016, who was supported by a deputy manager and clinical support manager, both appointed on 3 May 2016. The clinical support manager, who was on a temporary contract, had been managing the home for three weeks prior to our inspection whilst the home manager was on annual leave. The home manager was also supported by a clinical nurse manager who had been appointed on 7 June 2016 and the home administrator who was appointed on 4 April 2016. During the course of the inspection we were informed further changes had taken place in the management of the home.

Since the last registered manager resigned on 31 July 2015 the home had been managed by four different interim managers. There had been a lack of sufficient permanent clinical leadership to support and supplement the work of the home manager. The home manager told us the appointment of the clinical support manager and clinical nurse manager would provide specialist clinical advice and knowledge regarding people's nursing care needs to ensure people received good quality clinical care moving forwards. The home manager told us their main concerns and challenges were the staffing levels, high levels of contracted agency staff and reviewing and updating people's care records.

The lack of consistent leadership and management had left people, relatives and staff feeling concerned about the quality of care provided in the home. One person told us, "As soon as you think there is a manager who will sort things out they are moved on without an explanation. One minute they're here, the next they're gone." A relative told us, "The management is a shambles, there is no management visibility. There aren't enough nurses directing the care assistants and sometimes it ends up with agency carers arguing and telling our staff what to do." Staff told us the perpetual change of management had been demoralising and left them feeling as if they were not valued.

The clinical support manager told us they had been instructed to prepare weekly reports for the provider and to review the quality of the home's care plans. We reviewed the weekly report covering 9 May 2016 to 13 May 2016. The report stated 'Care plans throughout the home require improvement however one wing in particular is critical and unsafe.' The clinical support manager told us they had audited the care plans of people in two communities and had partially completed another. The audit identified that one person moved into the home on 29 March 2016 and had no care plan completed until 13 April 2016. This audit also identified 21 care plans which needed to be updated urgently. At the time of our inspection we identified that 13 of these care plans had not been amended and updated as directed by the clinical support manager. At the time of our inspection care plans for people living in the other two communities had not been reviewed. The provider had failed to ensure robust action was taken for people in response to the results of this audit.

The provider's Regional Head of Care and Nursing had completed a care records audit of five people's records on 16 June, 2016 including two which had been subject to the audit by the clinical support manager in May 2016. This audit identified that required improvements were still needed to these files and others to

ensure safe practice and consistency of records, for example; the review of fluid intake and output charts. The Regional Head of Care expressed their disappointment that these two files had not shown the required improvement identified in the previous audit in May 2016. The home manager and staff had failed to meet the provider's own targets in this audit. This audit did not identify timescales action was required to be completed by or who was responsible for doing so.

The provider had established quality assurance and clinical governance systems but respective interim home managers had failed to operate them effectively, for example; the call bell response audits completed on 23 March 2016 and 1 April 2016. Both of these audits monitored a two hour time period and indicated there were no calls responded to in a time exceeding 10 minutes. These audits therefore concluded no action was necessary. However, a review of the data provided with these audits highlighted concerns during other time periods where calls had not been answered for up to 47 minutes, for example; on 1 April 2016 between 1.45 pm and 1.47 pm three people's call bells in different communities were ringing for over 47, 44 and 30 minutes respectively. The home manager had not analysed or investigated the reason for the excessive time taken to respond to these and other similar calls.

We reviewed a monthly medication compliance audit completed in May 2016 completed by the clinical support manager and deputy manager, which used a red, amber, green system to indicate whether concerns had been identified. This audit identified the staff were failing to meet the provider's own target in relation to management of medicines. This highlighted that there were 594 recording gaps on MAR s during April 2016 in relation to topical prescribed medicines. The deputy manager told us they had addressed this issue with all Gracewell nurses. Two nurses we spoke with confirmed this.

A provider's health and safety audit was completed on 19/12/2015 which concluded that health and safety within the home had suffered due to a succession of managers. A medicines audit completed in January 2016 identified that controlled drug stocks had not been checked twice daily in accordance with the provider's controlled drugs policy. The clinical support manager told us this was due to agency nurses not adhering to the provider's policy which had been addressed with the nurses concerned.

The quality of the service had not been consistently monitored by a series of interim managers. The monitoring systems had not identified that care plans did not contain sufficient or up to date information to provide people with safe consistent care that was focussed on meeting their individual needs. The provider had failed to ensure records were completed in a timely manner or keep records up to date to ensure people received safe care. The lack of an effective system to manage risks and improve quality is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff were not actively involved in developing the service. People, their relatives and staff told us the current home manager was approachable and listened to their concerns, but these were not acted upon. People and relatives told us there had been regular 'residents and relatives' meetings. Minutes we reviewed showed the main concerns repeatedly raised at these meetings were a lack of staffing to meet people's needs and the high level of unknown agency staff. These concerns were also the main focus of complaints received about the home. Staff told us their views in relation to the high dependence on agency staff had "fallen on deaf ears." People and their relatives told us they were disillusioned with the provider's failure to act in relation to these concerns, which had been continually repeated at all meetings. One relative told us, "They (the provider) never listen, we've had numerous assurances from (the Director of Operations) but nothing changes." People, their relatives and staff did not feel the provider listened and responded to their concerns, which made them feel their views did not matter.

The provider was already aware of most of the issues found during our inspection. The provider had created

development plans to address these issues and some improvements had been made in certain areas, for example; the recruitment of a clinical nurse manager, deputy manager and clinical support manager to share the workload of the home manager. The provider was now monitoring the service more frequently to ensure that action was taken to improve the quality of 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were systems or processes established and operated effectively to ensure compliance with legal requirements. The provider had failed to assess, monitor, improve the quality and safety of services provided, mitigate the risks relating to the health, safety and welfare of service users and to maintain complete records in respect of each service user. Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that at all times there were always sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of

people.

Staff had not been enabled to deliver care and treatment to people safely through the provision effective supervision and appraisals.

Regulation 18 (1)(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.