Gracewell Healthcare Limited

Gracewell of Weymouth

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visits took place on 3, 4 and 7 November 2016. Gracewell of Weymouth is a purpose built home, over three floors, registered to provide care for up to 70 people in a residential area of Weymouth. At the start of our inspection there were 52 people living in the home. People living on the top floor of the home had predominantly nursing care needs. People living on the middle floor had needs associated with the impact of their dementia. The service specialised in some aspects of dementia care such as supporting people who were disoriented and those that needed assistance with continence care. They did not specialise in supporting people who were resistive to care to the extent that they would need staff to physically intervene to support them when they were resistive. People living on the ground floor needed less staff support.

The service did not have a registered manager at the time of our inspection. The last registered manager had left the service in February 2015. The current manager had taken up their post in October 2016 and planned to apply to become the registered manager. They had an agreed period of absence of one month which was being covered during our inspection by another manager from within Gracewell Healthcare Ltd, the provider organisation.

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

Gracewell of Weymouth had been through a sustained period of management change when we inspected. We found a number of areas that required improvement during our inspection. The management and staff team of Gracewell of Weymouth was aware of some of these issues and had started work on plans to make improvements.

Staff were committed to providing a high quality of care for people living in the home and supported each other to achieve this. However, systems to ensure the quality of care were not always embedded and a lack of consistent oversight meant that monitoring was not adequate to review care practice effectively.

People were not always protected from harm because staff did not fully understand the risks they faced. Care plans were not always followed and records were not always accurate. This increased the risk that people could receive inappropriate care.

Where people needed to live in the home to be cared for safely and they did not have the mental capacity to consent to this Deprivation of Liberty Safeguards (DoLs) had been applied for. Staff did not know who had a DoLS in place and this put people at risk of receiving inappropriate care.

The home looked and smelled clean. We observed that some practice did not reflect current guidance for

good practice in infection control. This put people at risk of catching health care related infections.

Statutory notifications had not been made to CQC. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had not received information to support their monitoring of the service.

Health professionals were not always confident that people received support for their health related needs in a timely and appropriate manner. A GP had noted an improvement in this and people felt confident they saw health professionals when necessary.

People had the support they needed to eat and drink in ways that met their needs and preferences. People told us the food was good and we saw that there were robust systems in place to ensure that the food was of a high quality and appropriate for individuals. We observed that meal times were an opportunity for choice and socialising.

Staff were safely recruited, felt supported and knew how to identify and respond to abuse. People were at a reduced risk because staff knew how to report potential abuse appropriately.

We heard some mixed opinions from relatives as to whether there were always enough staff available and we observed times when staff were not deployed in ways that met people's identified needs. The staffing had been reviewed and increased since the manager came into post and remained under review. Changes to deployment were made immediately following our inspection.

People were engaged with a wide range of activities that reflected individual preferences, including individual and group activities.

People and their relatives were positive about the care they received from the home and told us the staff were compassionate, kind and attentive. Staff treated people, relatives, other staff and visitors with respect and kindness throughout our inspection. Relatives told us they felt able to raise concerns.

We have made a recommendation asking the provider to review signage and environmental cues available in the home for people with dementia.

There were breaches of regulation relating to the management of risk, how consent to care and treatment was sought and the oversight of the service. You can see the action we asked the provider to take at the back of the full 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. People were supported by staff who understood most of the risks they faced but did not provide consistent support in response to these risks.

People received their medicines as prescribed but records relating to the application of creams and covert medicines were not appropriate to ensure people were receiving these appropriately.

Some people living in the home could become agitated and anxious. Staff had not received appropriate training to keep themselves or others safe if this resulted in violence.

The home was kept clean but staff did not always follow good infection control practice. This meant people were at risk of infection.

People were protected by staff who understood their role in keeping them safe.

Is the service effective?

Requires Improvement

The service was mostly effective. People had access to healthcare but some health professionals identified difficulties in partnership working that had led to people not being supported according to guidance.

Decisions about people's care were not always made within the framework of the Mental Capacity Act 2005.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home. Staff did not know who had a DoLS authorised. This meant people may not be having their rights upheld and their needs met.

People enjoyed the food and were supported to eat and drink in ways that reflected their needs.

People were cared for by staff who felt supported.

Is the service caring?

Good

The service was caring. People were supported by staff who were caring in their approach. There was a commitment to promoting dignity and person centred care.

People were supported to make choices that promoted their independence.

Is the service responsive?

Requires Improvement

People received care that was responsive to their individual needs. Care plans were not all accurate and work was being undertaken to ensure they were maintained effectively.

People were able to take part in varied activities.
People and their relatives were confident they were listened to and complaints were responded to effectively.

Is the service well-led?

Requires Improvement

The service was not always well led because systems in place to monitor and improve quality were not always effective in ensuring positive change.

There was a new manager in post who was on extended leave during our inspection. The organisation had the confidence of people, staff and relatives following a period of management change.

Gracewell of Weymouth

Detailed findings

Background to this inspection

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

This inspection took place on the 3, 4 and 7 November 2016 and was unannounced. The inspection team was made up of an inspector, a specialist adviser and an expert by experience The specialist adviser had clinical expertise in the care of older people. The expert by experience had personal experience of caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. The provider had also completed a Provider Information Record (PIR). A PIR 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.

During our inspection we spoke with 14 people living in the home, some of whom did not always communicate effectively with words due to their dementia. Because people could not describe the care they received we observed care practices to help us understand the experience of people who could not talk with us. We also spoke with six visiting relatives and another regular visitor to the home. We spoke with 17 members of staff, the area manager and the temporary home manager. We also looked at records relating to seven people's care, and reviewed records relating to the running of the service such as staff records, meeting minutes, incident and accident records and quality monitoring audits. Following the inspection visits we spoke with the provider organisation's dementia lead by telephone.

We also spoke with two social care professionals and five healthcare professionals who had worked with the home or had visited people living at the home.

Requires Improvement

Is the service safe?

Our findings

Some risks people faced were managed effectively but there were also examples of risk management that was not sufficiently robust to protect people. Staff described some of the risks people faced consistently but had differing understanding of other risks and were not always aware of assessed risk or the plans in place to mitigate these risks.

One person had a care plan in place that said they should have regular supervision by an allocated member of staff to protect them from potentially abusive behaviour. This care plan was not followed throughout our inspection. We spoke with staff about the risks facing this person and two staff were aware of a historical issue but did not feel it was a current risk. Other staff did not know about the assessed risk. We asked the interim manager and area manger to ascertain if this care plan was still relevant on the second day of our inspection. They told us that it had been reviewed and we saw that a review completed before our third visit indicated that it was still required to protect the person from the risk of abuse. On the third day staff members continued to be unaware of the risk and did not follow the care plan. There had been no incidents reported, however person was at risk of harm because an assessed risk was not being mitigated because the relevant care plan was not being followed.

We reviewed the records related to three other people who had regular supervision identified in their care plans to monitor their wellbeing in light of risks such as not being able to move independently and falls. Records indicated that they received this supervision.

Incidents were not reported in line with the provider's incident reporting system. For example, during the month prior to our inspection we identified three of incidents of physical aggression had not been reported using the incident reporting system. This meant that the risks faced by people could not be appropriately reviewed to ensure action to reduce the likelihood of reoccurrence. During our inspection staff were not aware that a person had been physically aggressive the day before. This was identified as a new concern in the daily record the day before but had not been recorded as an incident or handed over to the nurse in charge the following day. Where incidents had been reported it was not always clear what action had been taken as a result to keep people safe.

There had been regular incidents of violence against staff and between people reported. For example in separate incidents: a person had used a knife from the dining table during an incident when they were physically aggressive towards a member of staff; a staff member's arms were bruised during an incident; a member of staff had their wrists grabbed; a member of staff was head butted and a member of staff was kicked in their abdomen. Incidents between people involved grabbing, pushing and hitting. We spoke with staff about how they managed behaviour when people were distressed and anxious and this resulted in physical aggression. They told us they removed themselves from the situation when they could and used distraction to reduce people's agitation levels. They told us they also shared any techniques that worked with each other informally. For example one member of staff described verbal indicators that one person was becoming agitated and explained distraction techniques they had found to be useful to help this person calm down. Another staff member described different methods of distraction and explained that staff have

to be told to be "very careful" as this person's mood could change very suddenly. We looked at the person's care plan and saw that it described how the person's behaviour could escalate and what staff should do. It did not contain the details described by the staff members. There was a risk that some staff were using techniques that were not as effective as those used by other staff when trying to help the person calm down. This put the person and staff at risk of avoidable harm.
This care plan also indicated that guidance should be sought from the mental health team if the person's behaviour became unstable and escalated to violence. We saw that 10 days elapsed between a marked escalation in aggression and contact being made with the mental health team. This meant that the person did not have access in a timely manner to other professionals to ensure care was planned to ensure health, safety and welfare of the person and others.

Incidents had not been reviewed and analysed to ensure staff had the training necessary to keep themselves and people living in the home safe if an incident escalated and involved violence. We spoke to the management team about this and they told us that there was a policy of no restraint and for this reason staff were trained in distraction techniques but not any techniques that involved physical intervention or safe ways to break away if they were being held and hurt. We discussed when physical intervention would be deemed necessary and they acknowledged that this could include separating people when one was being aggressive towards the other. Incidents reported in the home identified that these were situations that arose. Staff were not receiving training in how to safely respond to an identifiable risk and this put people and staff at risk of harm.

People were given their medicines as prescribed during two observed medicine rounds during our inspection and medicine storage and administration was safe. However, creams were not consistently signed as having been administered by staff. We looked at two people's records related to the application of creams and found frequent gaps. It was not possible to ascertain if creams had been applied as prescribed. The administration of covert medicine was also not clearly recorded. One care plan detailed that a person took their tablets without any difficulty when in fact they were given their tablets covertly. There was a letter available from the doctor to acknowledge the necessity of this but no care plan detailing how the medicines should be administered. We looked at another two people who were receiving their medicines covertly and found that they did not have care plans in place. It is important to be clear about how covert medicines should be administered because some medicines will not be effective if given with some foods. Prior to our inspection health professionals had identified that one person was not receiving their covert medicines in an effective way. We spoke with a nurse about this and they started to add relevant information to care plans.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Plans designed to reduce the risks associated with being supported to move by staff and protecting skin from developing sores were followed appropriately. We reviewed care plans related to three people's care and found that care plans designed to reduce the risk of people developing sores on their skin were followed appropriately. We also reviewed plans describing how staff should use equipment to help people move and found that these had been reviewed regularly and were mostly clear about the support needed. One person's plan suggested either two or three staff should assist the person to move and it was not clear how this decision should be made.

The home smelled and looked clean. People and relatives told us that this was always the case. We spoke with the staff with responsibility for housekeeping and they explained the systems in place to ensure the home was kept clean and tidy and good infection control procedures were followed. We saw that staff

usually followed good infection control practice and people told us this was the case. One relative said: "The staff always wear aprons and gloves when they do personal care." However we observed that hand hygiene did not always reflect good practice guidance. For example we saw that a nurse didn't decontaminate their hands between administering medicines to people and two nurses were wearing nail varnish.

Staff were deployed in a way that met people's needs. Most staff, relatives and people told us that there were enough staff and that they knew and liked the staff who helped them. Some people and relatives said it could be difficult to find staff due to the layout of the building and that they felt more staff were needed to ensure people didn't wait for personal care. During our visits people did not have to wait for support and staff were available when people needed assistance. We discussed staffing levels with the manager and they described changes that had been made to reflect the current dependency needs of people living in the home. This had included an additional member of staff on the middle floor to ensure that the communal area could be supervised and an increase in staffing levels at night following feedback from night staff. Staff told us that with these changes in place there were enough staff to meet people's needs. They told us that staffing levels remained under review. Staff were recruited in a way that protected people from the risks of being cared for by staff who were not suitable to work with vulnerable people.

Many of the people living in the home were living with dementia and did not use words effectively to communicate their emotions and could not tell us whether they felt safe. We saw that they were relaxed with staff; smiling and engaged when staff were with them. People who could speak told us they felt safe. One person said: " I feel safe here. The security is very good." The majority of relatives we spoke with shared a confidence that their relative was safe. One relative told us, "I feel sure (person's name) is safe. The staff are very attentive." Another relative described how staff used mobility equipment to keep their loved one safe. Staff were able to describe how they protected people from the risks of abuse by describing the signs they needed to be aware of and knowing where they would need to report any concerns they had.

Requires Improvement

Is the service effective?

Our findings

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.

The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately, however we were not given accurate information about who had DoLS authorised. The interim manager explained that they did not know who had DoLS authorised and advised we speak with the nurses regarding DoLS as they did not know this detail about people in the home. This meant staff in the home did not know who they were depriving of their liberty. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely. They also detail any conditions of the DoLS that must be met for the person to be deprived of their liberty at that location. It was not possible for the nurses and interim manager to ensure that any conditions were met because they did not know who had a current DoLS authorised. We saw that one person had a condition attached to their DoLS that they should have time with staff every day separate from task based support to chat and reminisce. This condition was not reflected in their care plan and staff were not aware of it and had not been asked to ensure that this happened. Whilst we observed that the person did get staff spending time with them when they were sat in communal areas it was not possible to determine if their DoLS condition was being met and there was a risk it would not be as staff were not aware that it was a requirement.

We saw that some care plans reflected the principles of the MCA and were clear about how decisions about care should be made. For example one care plan identified that a relative had the legal right to make decisions about their relatives health and welfare and that they should be contacted about any care and treatment decisions. We saw that they had provided consent to the care plan. However, we also found examples where decisions about care and treatment had not been made within the framework of the MCA. For example one person was described as having capacity to make decisions and yet there was a description about how decisions were to be made in their best interests. Another person had power of attorneys who could make decisions about their health and welfare but their consent and capacity care plan referred to best interest decisions being made by another person and staff on their behalf. Restrictive care practices were in place for this person including covert medication and close supervision. There was no record that the people with legal authority to make these decisions had been asked to agree these care and

treatment decisions. We spoke with staff about this person's care and they told us they discussed care decisions with the person detailed in the care plan.

There was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe how they supported choice and the approaches they took when people refused care. We saw that people were encouraged to make choices and that their wishes were valued about day to day decisions.

People and relatives told us that they were supported to maintain their health. One person told us "I see the doctor on a Friday if I need to." Another person told us they had felt unwell and called staff who attended to them quickly. Feedback from health professionals identified that improvements were necessary to ensure that their guidance was followed and sought appropriately. We spoke with two mental health professionals who had worked with the home. Both had experienced difficulties in ensuring guidance was followed around recording behaviour and the administration of medicines. This had resulted in a safeguarding investigation. A GP with regular contact in the home told us they had worked with the management and seen an improvement in the confidence of staff to make clinical decisions and this had led to a decrease in appropriate doctor and ambulance call outs. They also commented that the home was always well organised when they visited. We saw from records that people had been seen by a wide range of health care professionals such as dentist, opticians and specialist nurses.

The environment at Gracewell of Weymouth was spacious and well maintained with good lighting throughout. During our inspection, however, we were asked by people to help them find the toilets on a number of occasions. We also saw people went into other people's bedrooms. We noted that signage within the home was low impact and reflected the luxury hotel style of the accommodation. This made it more difficult for people with dementia to find their way around the environment and could have contributed to the difficulties we observed. Consideration had been given to other aspects of the environment for example the ends of corridors that can be difficult for people with dementia who are driven to walk a lot were made interesting with examples of period furniture and artefacts to aid memory.

We recommend you review signage and environmental cues in the home using best practice guidance about dementia friendly environments.

People enjoyed the food and had enough to eat and drink. People, relatives and staff all told us that the food was good. It smelled and looked appetising during each day we visited. One person told us," The food is fantastic." A relative told us that their relation liked the food and described the choices available: "The food is always a choice of two meals and if they don't like it they will always make an omelette." Tables were set with clothes and condiments and people had a choice of drinks available. When people needed their food and drink prepared in a certain way to ensure they could consume it safely this was done consistently. The chef received updates from the nurses and people which informed a visual record of people's needs and their likes and dislikes. Gracewell Healthcare Ltd provided nutritionally balanced menus to the kitchen staff which were informed by people's likes and dislikes. There were systems in place to review people's nutritional needs and weights were recorded regularly and plans reflected any changes in weight.

Staff told us they felt supported to do their jobs. They described access to regular online training and practical training and told us that they were supported to learn by their colleagues. There was a system in place monitoring staff training and ensuring that staff undertook the training and refresher training identified by the organisation as necessary for their role. The Care Certificate had been introduced by the

provider. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. A six module course to enhance staff understanding of dementia had just become mandatory for staff. An accredited award in understanding and managing distressed behaviour in dementia had also become mandatory. Staff supervision had not been kept up to date due to management changes in the home. However senior staff were aware of this and a drive to ensure all staff had appropriate and effective supervision had started.

Good

Is the service caring?

Our findings

Most people and relatives described the service as caring. One relative told us, "The staff are kind and caring." Another relative told us "They are extremely nice." Relatives told us that this caring approach extended to them too. We were told: "They are very supportive of me too – very caring." We also heard from two relatives who felt that decisions about their loved ones care had not been caring. We spoke with the interim manager about these situations, they explained they were in discussions with these relatives to address their concerns.

Staff described a strong commitment to promoting person centred care and dignity. This was in evidence in all the interactions we saw during our inspection and reflected in the comments made by people and relatives. One relative said: "They treat everyone with dignity."

Staff were skilled at communicating and took time with people throughout our inspection; offering reassurance whenever necessary. We saw staff taking time to talk with people and to make a connection as they went about their tasks. This person centred approach had a visibly calming and mood enhancing effect on people. These interactions were informed by knowledge of the person and valuing them. People with dementia were spoken with in ways that were meaningful to them and did not unnecessarily challenge their view of the world at any time. They were reassured that they would achieve what they stated they were trying to do and told they would get any help they needed; where the person was trying to achieve something that was not possible staff offered considered distraction and reassurance. For example a nurse encouraged a person who was unsettled and uneasy not to set off on a long walk to find their parent on an empty belly and made sure they had a meal that they enjoyed made specifically for them.

People were supported to make choices that promoted their independence throughout our inspection. Where people were no longer able to make complex decisions due to their dementia they remained encouraged to make choices such as what they wore, where they sat, what they ate and whether they joined in activities. One person told us: "I get up when I want." Where people did not use words to communicate due to their dementia staff reflected on their demeanour and behaviour and respected these as expressive communication when possible. For example, people were checked regularly before being supported to get up and this was done when they were awake and responsive to staff. A relative reflected on this saying: "The staff know them. They know what they want." People's care plans described their abilities to make decisions and provided staff with information about how the person communicated.

There was a community feeling in the home which was enhanced by events for people and their friends and families and a welcoming approach to visitors. For example during our inspection firework night and Children in Need were reflected in activities such as baking and fundraising. Whilst people were encouraged to feel part of a community their personal information was protected by staff who kept people's personal details and records confidential and discussed care needs in a discrete manner.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed and recorded alongside plans to meet these needs in their records. This included information about people's histories and preferences. Most of the care plans we reviewed had been updated and reflected people's current needs. However we found examples of important information being missing. For example one person could be resistive to personal care and staff needed to take a certain approach to help the person accept this care. The person's care plan did not reflect that the person could resist care or how staff should support the person in these instances. Another person had been assessed as needing substantially altered support from staff. This had not resulted in a change to their care plan. We spoke with a nurse who added this information to these care plans immediately.

The interim manager explained that they were aware that care plans needed reviewing and that discussions with the nurses had identified the need for time allocated to this task. This had been agreed but had not yet been implemented. Nurses and care staff explained that whilst care plans were being updated that the handover was providing a robust framework to ensure staff understood people's needs and that they discussed people's care in a person centred way each day. This process was largely effective. Staff were able to talk about what mattered to people, how to distract them if they were upset, however we came across examples of staff having different understandings of how risks were managed.

Records indicated that relatives had been involved in the assessments of their loved ones needs and the development of their care plans. One relative described how they share information about their loved one with the staff and management.

Gracewell of Weymouth is described in its literature as being "experienced and expert in providing dementia care". The provider had a clear stance on the nature of support that they could provide and their policies and procedures reflected this. We spoke with the member of staff who assisted people to make decisions about moving into Gracewell of Weymouth and they told us that they made the scope of the care provided in the home clear before people moved in. A detailed assessment of need was carried out prior to people moving into Gracewell of Weymouth and additional advice could be sort from the provider's dementia lead. We spoke with the dementia lead who told us that this detailed assessment enabled them to determine if they could safely provide care and treatment to individuals prior to admission. They also stated that if a person became regularly aggressive or resistive of personal care to a point where they needed staff to use physical intervention strategies they would serve notice on the person as they would not be able to meet their needs safely. One person had recently left the home because their dementia had developed in a way that meant they required physical intervention.

There was a dedicated and committed activities team who arranged individual and group activities within the home. The program across the week and year was varied and afforded people the opportunity to take part in a range of activities such as: baking, exercise, discussion about current events, reminiscence activities and events linked to calendar events such as the Queen's birthday, Burns night and Remembrance Sunday. There was a gentleman's club catering to the specific leisure needs of some of the men living in the home. This was appreciated by those who attended and we were told with a smile that it "… may sometimes

involve some beer". The activities co-ordinator described plans to develop activities for people with advanced dementia. This included the development of rummage boxes for individuals. The activities team were supported by the provider; the activities coordinator described how they had recently had an opportunity to share knowledge and ideas with other activity coordinators from other homes within the organisation.

Complaints were addressed by senior management and we saw records that indicated that they were taken seriously and used as an opportunity to improve practice. For example staff were asked to provide information and practice was reflected upon as part of the process. Correspondence was either recorded or referenced outlining the outcome of any complaint with the person who had raised it.. People and relatives told us they would be comfortable to raise any concerns they had with the managers. One person told us about a time their relative had complained on their behalf and they had felt listened to. Another person told us they felt all the managers were approachable.

Requires Improvement

Is the service well-led?

Our findings

Gracewell of Weymouth had been through a period of unstable management. Relatives and staff referred to this during discussions but identified that they felt confident in the current permanent manager and manager who was covering for their leave. One member of staff told us: "They (interim manager) get things done." The last registered manager had left in February 2015 and the current manager was in the process of applying to take on this function.

Providers have a statutory duty to inform CQC of certain events relating to the running of the service and the care of people living there. We found that notifications had not been submitted relating to the development of a pressure sore, the outcome of DoLS applications, the involvement of the police and an allegation of neglect. There were systems in place to ensure that notifications were made but these had not been followed during this time period where that had been changes in management. We spoke with the management team in place during our inspection about the allegation of neglect and they had not identified the concerns raised by health professionals and discussed at a recent meeting as an allegation of abuse. This meant that CQC was not aware of information about the safe running of the service.

There was a breach of regulation 18 of the Health and Social Care act 2008 (Registration) Regulations 2009.

People recognised the interim manager and were comfortable with them and we observed residents, staff and relatives talking with them throughout our inspection.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. For example there were audits and reviews undertaken by senior staff and meetings scheduled to ensure consistency and shared understanding. Staff were encouraged to express their views and there was an annual survey of these. Where audits had taken place they were effective in ensuring change. For example, an audit of medicines had highlighted problems with getting medicines in a timely manner and this was being addressed by the provider organisation.

Some systems available to staff to ensure the safety and quality of the service was not being used effectively. For example a recent incident in the home had identified problems with the administration of covert medicines and a person was not receiving their medicines by a safe method. We found that this had not led to a review of the covert medicines administered and we found that Gracewell paperwork which detailed appropriate considerations and decision making was not being used. This meant that we found people did not have appropriate care plans related to covert medicines when we inspected. People were put at risk of inappropriate and unsafe care because lessons learned were not applied effectively.

After our inspection visits we spoke with the provider organisation's dementia lead. We were concerned about provider oversight of incidents of violence within the home and asked how this information was escalated through the organisation. They told us that all incidents of aggression are entered onto a behaviour tracker which would make dementia specialist staff aware of difficulties people and staff were facing. They were unable to tell us if any incidents had been logged by staff at Gracewell of Weymouth. They

later sent us an email explaining that this system would be used at Gracewell of Weymouth from now. The policy containing the behaviour tracker had been implemented in April 2016. A system designed to ensure people and staff received appropriate specialist support had not been available to the home as the system had not been embedded. This meant the provider had not maintained effective oversight of issues impacting on the safety of people and staff.

An audit had been carried out to review how the service measured against the CQC inspection methodology in September 2016. Some of the issues identified at this audit such as outstanding supervisions had been actioned. This audit had identified covert medicines procedures were not being identified prior to the incident. It also identified that CQC notifications were not always available. People remained at risk because processes for improving quality were not implemented.

At our last inspection in August 2015 we identified issues such as record keeping and how the MCA was used to support people. At this inspection whilst some improvements were found; for example staff understanding of the MCA was improved we found that concerns had not been fully addressed and remained areas that required improvement to ensure people received safe and appropriate care and treatment.

The provider monitored key indicators across the whole organisation such as weight loss, DoLS outcomes, notifications to CQC and falls. We found omissions in reporting to CQC, we did not find staff had knowledge of DoLS outcomes and there were gaps in the recording of incidents and accidents identified during our inspection. There was a risk that due to these gaps in reporting the information received by the provider was not a reflection of the service provided at Gracewell of Weymouth.

There was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had discussed challenges facing the service with the interim and area managers. They told us that the biggest challenges related to the inconsistency of management experienced within the home. This was reflected in the views of staff and relatives. One relative said: "There have been a lot of managers." The interim management team and staff expressed confidence and showed evidence that improvements were being made by the current staff team and newly appointed permanent manager. They referred to the importance of the "stability of management and the stability of corporate policies" in ensuring staff were able to embed the processes and systems of a high quality service.

The management team and staff were responsive and proactive in seeking to continually improve the quality of their work with other professionals. A GP described how improvements had been seen and a visiting professional mirrored our finding that staff were friendly and open in their responses and provided information quickly. Where omissions were identified the staff were quick to address these and were committed to making improvements.

The interim and area managers told us they were well supported by the provider organisation. They also spoke highly of the staff identifying the difficulties they had faced with changes in management expectations. They told us the staff team were very supportive, hardworking and responsive. This respect was reflected in how the staff viewed the management team and how they understood their purpose. One member of staff told us "We work together and we all care."

Meeting minutes reflected the open approach the management team were aiming to promote with agendas to facilitate discussion about staffing concerns and focussed practice based discussion around care issues.

Relatives had also been included in this approach with meetings and newsletters dedicated to keeping them up to date with changes and promoting an open door policy.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission of specified events that had occurred whilst services were being provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always being provided with the consent of the relevant person. Care was not always provided within the framework of the MCA 2005 when people could not consent to their own care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm because plans to mitigate identified risks were not always followed. Risks were not appropriately assessed because reporting systems were not used effectively. The provider was not doing all that was practicable to reduce the risks people faced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated

effectively to assess and improve the quality of the service. Systems and processes were not operated effectively to mitigate risks to the health and safety of staff and people living in the home.