

Springfield Healthcare (The Grange) Limited

Seacroft Grange Care Village

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an unannounced inspection carried out on 20 and 22 June 2017. At the last inspection in March 2016 we found four breaches of the legal requirements relating to the safe management of medicines, staff supervision, staff training and understanding of the Mental Capacity Act 2005 and insufficient controls in place to ensure potential evidence of abuse was properly investigated and reported as required. At this inspection we found on-going concerns with the safe management of medicines and that governance arrangements were not robust enough.

Seacroft Grange Care Village is a purpose built facility which provides residential, rehabilitation and nursing care for up to 95 people. The accommodation is set over three floors across two buildings, with a central facility which contains a coffee shop, spa, hair salon, therapy room and cinema. It is situated in a residential area of Leeds with good access to local facilities.

The manager had been in post nine days on the first day of our inspection. They were not registered with the Care Quality Commission but said they intended to submit an application for registration. 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 and associated Regulations about how the service is run.

Medicines were not managed safely. We found there were continuing shortfalls in managing medicines. The shortfalls included those identified at previous inspections and some new concerns which placed people's health at risk of harm.

People who used the service, their relatives and staff told us the service had improved since the new management team were in place. Staff said they found the managers supportive and approachable. We saw information was gathered which included; incidents, falls and complaints but the provider did not have fully effective systems in place to identify trends, patterns or how they could learn lessons and prevent repeat events. A range of checks and audits were undertaken to ensure people's care and the environment of the home were safe and effective. However, these checks had failed to identify the issues we noted around the management of medicines.

People and relatives we spoke with told us they felt the service was safe. Risks to people using the service were assessed and plans put in place to minimise and manage any identified risks. Overall we found there were enough staff to make sure people received appropriate care and support. We have made a recommendation that the provider keeps staffing levels under review to ensure there are sufficient staff to meet people's needs.

Safe recruitment systems were in place to ensure staff were suitable to work in a care setting with vulnerable people. Staff knew how to keep people safe from the risk of harm and abuse; they had received relevant

safeguarding training and knew how to report issues of concern. There were effective procedures in place to make sure any concerns about the safety of people who used the service were appropriately reported.

We found people's health care needs were met and relevant referrals to health professionals were made when needed. People's nutrition and hydration needs were met. Nutritional risk was assessed and people's weight was monitored. There was a choice of food and drink available to suit people's individual needs.

When people were assessed as lacking capacity, staff acted within the principles of the Mental Capacity Act (MCA) 2005 and ensured important decisions were made within best interest decision making processes. We saw appropriate Deprivation of Liberty Safeguards (DoLS) authorisations or applications had been made for people the service had identified were or likely to have their liberty deprived.

Staff had completed training to ensure the care and support provided to people was safe and effective. People told us they were treated with kindness and staff were caring. Staff received effective supervision and appraisal to discuss their roles and responsibilities.

People's needs were assessed prior to admission and this was kept under review and updated when there was any significant change. Overall, people had person centred care plans which provided staff with guidance on how to look after them.

A wide range of activities were offered for people to participate in and people told us they enjoyed these. People were encouraged to maintain relationships that were important to them. Activity was provided to ensure people received stimulation and activity that met their individual needs.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not safe.

People's medicines were not managed safely.

Overall, there were sufficient numbers of staff to meet people's needs. We have made a recommendation that the provider keeps staffing levels under review.

People and their relatives felt the home was safe and we found staff were aware of their responsibilities to safeguard people.

Is the service effective?

Good 

The service was effective.

There were induction and training opportunities for staff and staff told us they were supported by the new management team.

A range of suitable food and refreshments were available throughout the day and people were supported to maintain a balanced and varied diet of their choice.

Staff had an understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

Is the service caring?

Good 

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

People were kept informed and actively involved in decisions about their care.

Is the service responsive?

Good 

The service was responsive.

Care plans were, in the main, personalised and focused on individual needs and preferences.

People were supported to choose how they spent their time and to lead an active lifestyle of their choice and preference.

There was a process in place to deal with any complaints or concerns.

Is the service well-led?

The service was not consistently well- led.

The new management team were described as supportive and approachable. The manager of the home was not yet registered with the CQC.

Systems to assess and monitor the service were in place but these were not sufficiently robust. These checks had failed to fully identify the issues we noted around the management of medicines. Auditing processes were not always robust enough to effectively make and sustain improvements.

Overall, people and their relatives felt the home was well organised. Staff understood their roles and worked well as a team with the new management support arrangements that were in place.

Requires Improvement 

Seacroft Grange Care Village

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 20 and 22 June 2017 and was unannounced on both days.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications sent to us by the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted health and social care professionals involved with the service.

Before the inspection providers are asked to complete a Provider Information Return (PIR). 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. This was returned when we requested it.

The inspection was carried out on day one by four adult social care inspectors, a medicine's inspector, a specialist advisor in governance and an expert-by-experience who had experience of older people's services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, two adult social care inspectors attended to complete the inspection.

On the first day of our inspection there were 70 people using the service and 71 people on the second day. During our visit we spoke with 11 people who used the service, six relatives of people who used the service, one volunteer, 19 members of staff which included the manager, the deputy manager, the head of operations, the activity co-ordinator, the catering manager and the administrator. We spent time with and

observed how people were being cared for, and looked around areas of the home which included some people's bedrooms and communal rooms. We looked at documents and records that related to people's care and the management of the home. We looked at 15 people's care records and 17 people's medication records.

Is the service safe?

Our findings

At our last inspection in March 2016 we found people were not safe because medicines were not managed safely and there were insufficient controls in place to ensure potential allegations of abuse were properly investigated and reported as required. At this inspection we found the provider had made the required improvements to ensure any allegations of abuse were properly reported and investigated. However, they had not met the legal requirements to manage medicines safely.

We saw medicines rounds took a long time and people were given their lunch time medicines only an hour and a half after the morning medicines round finished. This meant people were at risk of having their medicines doses too close together or at irregular time intervals. Staff administering medicines did not record the time they gave people medicines, therefore they could not ensure people were given their medicines properly and safely.

Medicines were not always given according to the prescribers directions. One person was given half their prescribed dose of medication but no reason was recorded to explain why the prescriber's direction had not been followed. Another person was given their strong pain relief patch 24 hours later than was prescribed which meant they may have experienced pain during that time. One person was given medication that was almost two weeks out of date. This placed their health at risk because out of date medication may not work properly. Medicines were not obtained safely. We saw that six people could not have one or more of their medicines because they had run out, placing their health at risk of harm.

People were not always given all their medicines as prescribed because they were asleep, or because they had refused to take the medication even though they had been assessed as needing their medication to be given to them covertly; hidden in their food or drink. This included medication for diabetes and medicines usually prescribed for seizures. When people needed their medicines to be given covertly there was no information recorded that a pharmacist had been consulted to check how to do this safely. There was also no verbal information passed on to nurses to explain how their medicines should be disguised. This meant that people missed having doses of medication or that the medicines were not given safely.

Some people were prescribed medicines to be given 'when required'. We found some guidance for these medicines was in place but did not contain enough personal information to enable these medicines to be given safely and consistently. Some medicines were prescribed with a choice of dose; there was no guidance available to help staff select the most appropriate dose. This meant there was a risk people would not be given the best dose for their condition. The records about the dose of medicine given when there was a choice of dose did not show exactly how much medicine people had been given.

Records about medicines were not always clear or accurate. Staff administering medicines left gaps on the Medicines Administration Records which meant it was not possible to tell if medication had been given. We did some stock checks and found on some occasions medicines had been given but not signed for and at other times medicines had not been given. The quantity of medication held in the home for people was not always accurate. Records about creams were inconsistent and did not always show that creams had been

applied properly.

No records were made about the use of prescribed thickeners used to thicken people's fluids to prevent them from choking. Staff who made drinks told us they had no written guidance to refer to when making thickened drinks which placed people at risk of not having their drinks thickened appropriately.

Most medicines were stored safely. However, we saw that fridge temperatures were not recorded daily and the minimum recorded temperatures showed that medicines were sometimes stored at lower than recommended temperatures. Waste medication was not stored safely in accordance with national NICE guidance which means there was a risk that it could be misused.

We concluded there was a continued breach of Regulation 12 (Safe care and treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding incidents were collated monitored and managed through the homes quality assurance systems. The log was reviewed on a monthly basis for completeness of investigation. Evidence seen from March 2017 onwards demonstrated the system was thorough and managed closely by the management team to ensure any safeguarding issues or concerns were reported and investigated as required. Any issues arising from safeguarding investigations were fed back to staff through meetings, briefings and staff drop-in sessions.

There were effective procedures in place to make sure any concerns about the safety of people who used the service were appropriately reported. Staff had received training in the safeguarding of vulnerable adults and could describe what constituted abuse and how they would report poor practice or concerns.

People who used the service said they felt safe at the home. Comments we received included; "Yes love, I feel safe here, I like it", "Staff nice" and "Yes love, I feel safe here, no one bothers me." Overall relatives of people said they were happy that their family members were safe. A relative said, "Yes, I think my [family member] is safe but wouldn't quite give it a 10." Another relative said, "The care staff are so good with her, I definitely feel she is safe." A volunteer we spoke with told us, "I have never seen anything I am not happy with here. People are safe; everything is risk assessed."

Overall people who used the service and their relatives said there were enough staff to meet needs but staff were very busy. People commented on the high use of agency staff and how this affected their care delivery. Comments we received included; "There are definitely not enough staff here, they are lovely but the girls are run off their feet but they do their best, they really need more permanent staff and less agency staff", "There is never enough staff here, there are too many agency staff, there should be a regular team of staff, I have personal care needs and some of them that come don't know how to manage me and I have to tell them what to do, I don't like that it's embarrassing", "We went through an awful patch of having all agency staff, but it seems much better now. Since Christmas they seem to be trying harder." Other people who used the service said there were enough staff and they were responsive to their requests for assistance and answered call bells in a timely manner. One person said, "I have a buzzer in my room and on my wheelchair and the staff come in three minutes." Another person said, "I get support when I need it. Staff come promptly." A relative told us, "Plenty of staff; never had a problem and we are here most days."

Some staff told us they had seen improvements with staffing and staff were working well as teams. Comments we received included; "It's important for people to have a familiar face", "We have a good and consistent team here", "Staffing is sufficient here" and "We are working more as a team." However, some staff told us they felt there was a lack of consistency in team members on each unit, either through high use

of agency staff or by moving staff around the units. They said care was not impacted as staff had adequate skills and training but people reacted better to staff who knew them.

The deputy manager told us staff were now placed permanently in teams in the units with a designated senior staff lead. Vacancies and absences meant staff did have to move from time to time to cover and there was some use of agency staff. Recruitment of nurses had proved challenging and the management team said recruitment was constant in this area. Agency nurses were covering over half of the nursing shifts each day. Records showed they were mainly nurses who were familiar to people who used the service. We were told agency nursing staff completed an induction checklist on their first shift but found this had not occurred for them all.

The registered provider used a dependency tool to determine staffing levels required in the home. This was completed monthly or updated in response to any changes in people's needs. Rotas we reviewed showed they worked to the numbers planned from their assessment of dependency and sickness was covered. We recommend the provider continues to keep staffing levels under review to make sure there are always sufficient staff with the right skills and knowledge available to meet people's needs.

Risks to people who used the service were appropriately assessed, managed and reviewed. Care records contained up to date and regularly reviewed risk assessments. They included continence, mobility, moving and handling, use of bedrails and skin care. Weight was monitored monthly, and where a risk was identified support plans were put in place and monitored for their effectiveness. There were up to date and detailed Personal Emergency Evacuation Plans (PEEPs) in people's care plans which gave clear and person centred instructions on how to evacuate individuals safely in the event of an emergency. PEEPs were reviewed monthly.

There were effective recruitment and selection processes in place, which included people who used the service on the interview panel. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. A system of audit had been put in place to check recruitment was carried out safely.

We completed a tour of the premises as part of our inspection. We looked at some of the communal areas, bathrooms, shower rooms and hallways. We also looked at some people's bedrooms. Each person's bedroom was homely, clean and safe with no hazards identified. All bedrooms had en-suite and shower facilities. People who used the service and their relatives all told us they thought the home was clean and well maintained. One person said, "I have a lovely room and they keep it so nice." Overall there were no malodours present. However, we noticed on one unit there was an unpleasant odour in the corridor and a badly stained chair. We also noted the lighting in one of the units was not sufficient at times. We reported this to the management team who said they would look in to it.

We saw maintenance records which showed a range of checks and services were carried out, for example, gas safety, passenger lift, fire safety equipment and electrical installation. This meant the premises and equipment was safe.

Is the service effective?

Our findings

At our last inspection in March 2016 we found staff who worked with people who may lack capacity had not received training in the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS). We also found staff had not had regular opportunities to discuss their performance in supervision meetings. At this inspection we found the provider had made the required improvements.

The 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.

Staff told us they had received training in MCA and DoLS and the records we looked at confirmed this. Staff we spoke with showed knowledge around how to support people who did not have capacity to make some decisions. Staff understood these should always be in the person's best interest. One staff member said, "We always presume capacity. I have done a best interests meeting regarding someone's weight and health." Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. One staff member said, "[Name of person] can often refuse to do things with personal care, the best thing to do is to do as she says and just keep coming back."

Care records we looked at contained evidence the service had identified whether a person could consent to their care. Assessments were appropriate and there was evidence best interest decisions were made with the involvement of professionals or relatives of people who used the service. We saw the service checked the most effective way people could communicate their wishes before determining they did not have mental capacity. For example, one person's records included what time of day was best to communicate with the person. We saw people were able to express their views and make decisions about their care and support. People were given time and support to express themselves.

Assessments had been carried out to see if people required the protection of a DoLS. These recorded that they had been discussed with the person and/or their relative. Where an assessment indicated the person would benefit from a DoLS then an application had been made to the relevant authorities. An overview of these applications was maintained to ensure any renewals were re-applied for in a timely way.

All staff received supervision every eight to ten weeks. This was managed through a monitoring system overseen by the administrator of the home. Daily huddle meetings showed us staff supervisions were identified and checked on a daily basis to ensure they were assigned to the correct member of the senior or management team. An overview record of supervisions was in place and showed this was up to date. Staff

told us they received good support and supervision to enable them to discuss their roles and responsibilities. One staff member said, "I'm supervised by a care practitioner." There was a system of annual appraisal in place; with a plan to identify which staff required an appraisal and when it was due.

Overall, people and their relatives told us they thought staff were well trained. One relative said, "I think they are all well trained; from the manager to the cleaners, all of them." Another relative told us they did not think all staff were trained in the use of a piece of equipment their family member used. We checked this and saw there were plans in place to ensure all staff were trained to use the equipment. A volunteer said, "Staff always seem very knowledgeable and helpful."

There was a rolling programme of induction and training available which included; medication awareness, moving and handling, infection control, food safety, basic first aid, fire awareness, MCA and safeguarding. Training records showed the majority of staff were up to date with their training and the management team were aware of who needed updates and refreshers to ensure practice remained up to date. Staff told us they received the training they needed to meet people's needs and fulfil their job role. Comments we received included; "I had some training with [name of council]. I'm a dementia champion and had advanced dementia training", "I have had two days shadowing in [name of unit]. Also had a full weeks training" and "I think this company give really good training. I'm a dementia champion. Have a meeting each month. I'm supported by management."

We observed the lunchtime meal on two of the units in the home. The environments were pleasantly presented. Tables were laid out in restaurant style with clean tablecloths, flowers, menus and there was soft music playing. Staff offered refreshments throughout the service. Staff wore personal protective equipment and people were given an opportunity to wash their hands before the meal. Mealtimes at the service were 'protected', which meant visitors and guests could not interrupt the mealtime. This was to ensure the proper monitoring of food and fluid intake.

There were two main meal options and where people required pureed or fork-mashable food this was presented well. Staff knew each person's dietary requirements and preferences. Food was visually appealing and one person who used the service said their particular meal was "Delicious". Most people were complimentary about the food. People's comments included; "I can't fault the food here I love it, I can have as much as I want", "I like the food" and "The food is quite good we get enough, tea, coffee and juice." One person was not as complimentary, they said, "Oh the food, well it's not like home cooking. I'm not keen, the sandwiches are not very appetizing the bread is too thick and too much filling in them, they serve chips with everything and the food is left in the oven for too long." People's relatives were positive about food and nutritional needs being met. One relative said, "Mum eats very well, has what she wants, plenty of choice and drinks, she says she likes the food." Another relative said, "The food is nice and she is eating now where she didn't before."

Staff asked people what they wanted to eat by plating up both options and showing them to each person, encouraging them to make their own choices. This reflected some of the care plans we reviewed which said that although an individual may lack the capacity to make complex choices or retain information, they were able to make simple choices themselves and should be encouraged to do so. Where people refused food, alternatives were offered.

Some people who used the service required one-to-one support to eat. In one such instance, we saw a staff member sat at eye level with them and continually reassured them and asked if they liked the food. For another person, we saw a staff member was standing up while assisting and did not engage the person. Another staff member recognised this, brought a chair and encouraged them to sit at eye level which they

did. We raised this with the deputy manager who assured us the staff member would attend further training on person centred mealtimes. Overall we saw people were given dignified support with their meals. We saw some people had to wait to be served their meal as they needed one to one support and staff were not free to help them. This led to people's meals going cold at times.

We spoke to the head of hospitality who had oversight of the catering department. They said their supplier was flexible and consistent in quality; furthermore they were able to supply Halal, Kosher and also food of Afro-Caribbean origin if required. The service used feedback forms at the end of mealtimes for staff to note what people liked and didn't like, and this was used to inform the supplier not to provide those items again. A staff member said, "I think the food is wonderful, but if people don't like it then we report it."

Care plans contained nutritional assessments and people were weighed regularly. Where people required support with nutrition and hydration this was built into people's care plan and monitored by staff. We saw appropriate referrals had been made to professionals where needed.

Records showed arrangements were in place that made sure people's health needs were met. People who used the service or their relatives spoke highly of the health support they or their family member received and said staff were prompt in seeking medical assistance for them. People's comments included; "They are prompt to respond to any ill health and keep us well informed. I have every confidence in them", "The staff here know how to do my bloods very well, I've not really felt unwell for a while", "Mum can see the doctor whenever she needs to and one pops in all the time" and "I have my own chiropodist where I go, the doctor comes here to see me."

We spoke with a visiting health professional who told us they found staff were competent and took direction from professionals. They spoke positively about the service and said they would be happy for a loved one to live at the home.

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home and staff were kind and caring. Comments we received included; "I'm very well looked after", "The nurses are nice they take care of me" and "Oh I can do what I want, they know me in here, I wouldn't go anywhere else." However, one person said, "The quality of care varies between very good and not so good. I'm trying to find out why the best carers have been moved." They also said they sometimes felt rushed by staff but overall described the care they received as "excellent."

Relatives said they found the staff caring, kind, patient and thoughtful. People's comments included: "The staff do treat mum with dignity and respect", "Staff are very kind and gentle; always explain things well" and "The staff are understanding, caring and tolerant." A volunteer told us; "I am very impressed with staff. They are good at letting people be, respecting their wishes and so on."

We were told a relative of a person who used the service gave a talk to staff during induction on how it felt to have a relative staying in the home. The relative told us they liked to make sure staff could see things from their perspective and understand the situation they were in. The relative told us they found most staff to be open to listening to this. They said, "There is some amazing care here and staff are good at making sure people keep their independence." The relative also told us they had been able to tell staff how the impact of some negative behaviours from staff in the past had made them feel. They said they felt this was taken notice of and improved staff's approach.

People looked well cared for, clean and tidy which is achieved through good care standards. People were dressed with thought for their individuality; they had their hair styled to their preferences and wore jewellery and make up if they wished. Staff were encouraging and supportive in their communication with people. People enjoyed the relaxed, friendly communication from staff. In the PIR the provider stated, 'Residents choices, for example, as to their time of rising and wishing to have breakfast are explored as part of their care planning ensuring that the daily routines on the communities run around the residents and not organisational or staff objectives.'

During the inspection people showed us their bedrooms. They were highly personalised and people had items of their own furniture and ornaments; plus photos of family in their rooms. We saw people had free movement around the units they lived in and could choose where to sit and spend their recreational time. The service was spacious and allowed people to spend time on their own if they wanted to. Comfortable seating was provided in all communal areas. This included some of the corridors where people could stop and rest as they moved around the service. Some signage was in place to assist people to independently find their way around.

Staff were polite, courteous and warm towards people; involving them in choices and encouraging conversation. We saw many positive interactions throughout our inspection. Any care interventions such as moving and handling were carried out gently with explanations, sensitivity and discretion. We observed staff knocking before entering people's rooms which showed they were respectful of people's privacy. In the PIR

the provider told us,' Resident's wishes in respect to privacy and dignity are fully reflected in their care plan which is regularly reviewed as part of the Resident of the Day process ensuring that it is reflective of their needs, choices and preferences.'

Two people said they thought some of the agency staff employed did not engage with them to discuss their care needs. Other people also said they felt permanent staff knew them and their needs well but this was not always the case with agency staff. One person said, "The staff treat me very well and I have a laugh and a joke with them, some of them know what I like and I don't like, just all the agency ones don't." Another person said, "Some staff sit and chat for a minute or two and some don't it depends on the staff really." A person's relative said, "Yes she is treated well and some staff know her likes and dislikes."

Records showed people who used the service and their relatives had been involved in developing and reviewing their care plans. A relative told us; I feel very involved in [family member's] care plans, health matters and so on." Another relative told us they were fully involved in all aspects of their family members care planning. However, they said they weren't sure if staff had time to read them.

The manager told us some people who used the service had an independent advocate to support them with decision making. We saw information on advocacy services was available and the manager knew how to assist people to use this service.

Is the service responsive?

Our findings

Records showed people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit. Care plans and corresponding risk assessments were developed following the pre-admission assessment of people's identified needs.

Overall, care plans were person centred and detailed. Care plans had photographs of people on the front page so that anyone picking up the care plan could see who they were for. We saw interactions with people's relatives were recorded and actions generated, for example a GP referral. We saw very specific guidance on how people wanted to be cared for. For example, in one care plan we reviewed, the communications plan detailed that staff should '(because of their dementia) keep options limited to two, however they should be able to choose what they wanted to wear, and staff should give [name] plenty of time to answer.' Care plans were regularly reviewed; for example a communications care plan we saw was reviewed monthly with comments such as 'this remains good guidance for communication with [name].' In another care plan, we saw that for a person's mobility care plan staff had updated it and written '[name] enjoys walking around the unit and must be supported to do so safely.'

The service used 'this is me' booklets kept in people's rooms which held further details and life histories. There was evidence people were involved in the creation of the booklet because this was generated by asking people questions, for example 'what makes you anxious or worried?' and 'what can we do to help when you are worried?'

There were some differences in the layout of care plans as the service was moving towards a new system of indexing. Senior staff told us they felt care plan layouts changed too much. One staff member said, "When a change happens, everything changes. We are on our fifth layout but this one works." They also said "We are almost there" with regard to consistency of care records. Another staff member told us "I think plans are straightforward, they aren't hard." This showed us staff understood and were guided on people's care needs by the care records.

We also saw that where circumstances in health had changed for a person, the care plans were updated appropriately. For example, we saw where a person had multiple falls; this triggered a referral to the falls team, an update to the mobility care plan and an environmental risk assessment that led to bed rails being installed.

People who used the service were involved in a wide range of activities and told us they enjoyed these. We saw the service had a robust activities programme organised by a passionate and enthusiastic wellbeing and engagement manager and team. The wellbeing and engagement manager told us how they involved all teams in the service in providing interesting and stimulating activity for people. For example, the catering team provided fish and chips in paper nights and curry nights. They told us there were regular cinema nights and people who used the service organised these. The wellbeing and engagement team also included volunteers and students. They got involved in organising activity both in the home and the local community with people who used the service.

In the PIR, the provider stated, 'Wellbeing Engagement opportunities are tailored to the individual preferences of the residents with a combination of group and 1:1 activities taking place throughout the Village daily. We encourage residents to regain lost skills, take up old and new hobbies and for relatives to enjoy partaking in some of the events. Our Volunteers play a role in the Village to maintain and enhance community links.' A relative told us how they felt welcomed to join in activities with their family member.

On the day of the inspection the activities were 'hairstyling', 'reflexology', 'singing' and 'baking'. We observed people from all the units engage with the baking activity where they made cheesecake. People seemed relaxed and happy during the activity which was provided in a caring way. We reviewed a person's 'my journal' document which recorded some of the activities they participated in and whether they enjoyed them, for example on 18 May the log said '[Name] took part in a seaside day, they enjoyed seeing the pat dog and eating ice cream'. When we looked at the person's care plan, their previous history was noted and in the person's interests and hobbies their love of dogs was noted. This showed the service was able to record what people liked, and monitor their engagement with activities based on this. We saw people had access to the outside for fresh air, and if people wanted to, they could go to other areas and floors. This showed people were given a choice of what they wanted to do and staff facilitated their wishes.

Staff also told us that they did their own activities outside the plan. For example, one staff member said, "We take them to [name of supermarket] or the park when they want to" and "People do want to go out, we record it in the 'my journal' booklet." A relative said, "The activities are fantastic. There has been a visiting pony and the dog that comes every week. [family member] loves that." A volunteer we spoke with said, "Activity is a high priority. People can be involved as they wish. It is all based on their needs and interests. There is plenty for people to choose from; crafts, outings, games or just chatting."

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. People told us they knew how to raise concerns and, in the main, these had been dealt with to their satisfaction. One person said, "Oh yes I do know how to complain I have complained about my buzzer." Another person told us; "I know I can complain to the manager and the CQC but I don't need to complain yet."

We looked at complaints received and saw these had been investigated thoroughly and showed any actions identified had been addressed. There was a monthly summary log of complaints which were reviewed and signed off when completed by the management team. The operations director had been holding surgeries with people who used the service and relatives. Any concerns which could not be dealt with there and then were taken back to the managers and evidence was seen of responses and actions taken.

Is the service well-led?

Our findings

In the PIR, the provider stated, 'Our internal Quality Assurance Framework, Keystone, consists of daily, weekly, monthly and quarterly monitoring backed up with an audit programme which assists us in the smooth running of the Village and demonstrates where we are providing a good quality service.' There was an audit calendar in place for the year. This included a schedule for monthly audits of medication, catering and care plans, quarterly audits of falls, health and safety and infection prevention and control.

We looked at the latest infection prevention and control audit carried out in June 2017. Areas of non-compliance to the expected standard were identified. The action plan had been updated and stated all actions required were now completed. We found standards of cleanliness in the home were appropriate which indicated the audit had been effective.

Falls audits took place quarterly and the results of these were collated and presented to the Quality Governance Board. We saw a meeting took place in April 2017 and showed trends in falls had been identified. Falls were reported to be occurring more in the day time and were unwitnessed. Minutes indicated this was to be communicated to all staff to increase presence in communal areas. There was no further analysis available to show how this was communicated to staff and whether this action had led to improvements.

Accidents and incidents were recorded and monitored through the quality assurance systems in place. A standard form was completed by the senior member of staff on duty at the time of the incident and reviewed by the manager. A monthly log summarised the type of incident, the unit and the person affected. We saw this information had been more robust since March 2017 when some of the new management team had been in place. However, no trend analysis was yet available to show whether actions taken had prevented re-occurrence of accidents or incidents.

There was a system of auditing five medicines each day. We looked at an eleven day period and saw during that time it was identified there were nine discrepancies which meant that over 15% of medicines administered during that time had not been given properly. We asked the managers of the home what medication audits had been carried out in May 2017 for two of the units we looked at. They told us that no audit had been made on those units. We saw the medication audits, carried out on 24 May 2017 for the other three units which had identified some of the issues we identified during the inspection. Concerns identified through these audits included staff failing to sign MARs to show medicines and creams had been administered as prescribed, stock checks not being carried out consistently or in line with the provider's policy and no recording of how much medication was administered when prescribed as a variable dose. This demonstrated that actions taken after the audit had not been effective or ensured sustained improvements.

In the PIR, the provider stated, 'Monthly medication audits are undertaken across the Village with follow up actions recorded and completed. And, 'All accidents and incidents are collated monthly and analysed for trends and shared with identified peers and colleagues to share learning.' Records we looked at did not

show this to be the case.

The provider held monthly Quality Governance Board meetings to review audit data on a number of issues. These included complaints, incidents, pressure ulcers and falls. Notes of the meetings demonstrated discussion on actions. However, it was unclear as to whether there was any analysis of the data. The head of operations told us they had an action plan developed from the audits and monitoring of the service which was reviewed and updated weekly and discussed with the management team. We reviewed the current action plan which covered activities within the home. This included senior management team visits; managers walk arounds, falls audits, medication audits, infection control and prevention audits. Issues identified were signed off when completed. We found there was little evidence of how any learning from identified actions was shared to prevent re-occurrence of issues. The action plan frequently stated 'checked', 'to be more robust' or 'addressed'. There was no information to show how issues were addressed.

We concluded there was breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. Auditing processes were not robust enough. The provider failed to show how patterns, trends, lessons learned were communicated to ensure continuous improvement and to prevent re-occurrence of issues that had put people's safety and the quality of the service at risk.

At the time of our inspection there was a manager in post. They had been in post for nine days at the start of our visit and told us they intended to apply for registration with the CQC. They were supported by a deputy manager who had been in post for eight weeks. The head of operations was also permanently on site at the service; they had been in post for the last three months prior to our inspection. The management team acknowledged there had been a number of recent changes in the management structure. They all said they received good support in their roles from the registered provider and the operation's director. The managers were all caring and compassionate and said that since the new management team has been in place systems and processes had been strengthened to change the culture in the service and to put people who used the service at the heart of it.

People who used the service and their relatives told us the management of the service was improving and they found the current management team helpful. People's comments included; "I am increasingly happier as things are improving here", "There have been four different managers in two years we are hoping this has been resolved now", "I know who the managers are; can talk to them, they are very approachable" and "It has taken me a long time to work out who to speak to if there is an issue, but I think I do know now, and would speak with the manager." Staff also told us they had seen improvements in the management approach within the home. One staff member said, "Previous managers I wouldn't speak up; they weren't approachable at all, now you can tell them straight, I have lots of confidence in that." Another staff member said, "We hope the new manager stays; hopefully they won't bring too many changes as there is a good core."

In the PIR, the provider told us, 'A high level of visibility is essential and management undertake daily walk rounds and huddles each day to ensure strong lines of communication. Our daily walk rounds by management staff ensure that areas for improvement are highlighted each day and fed back to the community teams as part of on-going quality improvement.' The daily walkabouts were recorded on a daily log, including records of people spoken with, actions arising and sign off by the relevant staff member of actions completed. Daily huddle meetings with managers and senior staff were also recorded. We saw evidence of meetings which demonstrated people were listened to. For example, asking people about their dining experience. We attended a huddle meeting during our visit and saw there was an exchange of

important information on the running of the service. This included activities for the day, updates on staff supervisions to be completed, maintenance and health and safety issues, feedback on how new people were settling in to the home and feedback from GPs on medicines reviews and changes.

The management team told us they had now identified lead staff and consistent teams of staff for each unit in the service. Rotas we looked at confirmed this. Most staff told us this was working well. However, one staff member said they had been moved to cover shifts on other units in the last month. They said, "It's not the same team every day. Last month we went to different floors. I think it should be consistent." The deputy manager confirmed they sometimes had to move staff due to sickness and absence to ensure they had the right skill mix and experience of staff on the units.

People were encouraged to contribute to the running of the service. 'Resident/relatives' meetings took place monthly. Issues identified were reported back to those present and actions signed off once completed. A person who used the service said, "I have been to a few residents meetings, they are okay." A relative told us, "I feel we are kept up to date on things through the relatives meetings." Another relative said, "They do have meetings for relatives but it was not a strong point in the past. We met the new manager at a gathering here, it is a case of wait and see now. I would like to see more input between relatives and management but I have no reason to think it is not well run at the moment."

People who used the service and their relatives were asked for their views about the care and support the service offered. In May 2017 the provider sent out questionnaires for people and their relatives. At the time of our inspection ten questionnaires had been returned. These showed a high degree of satisfaction with the service. All ten scored 4/5 for overall satisfaction with the service. Three people had said they did not know how to complain. No analysis of this information had yet taken place as the survey had not concluded.

Staff said they felt well supported in their role. We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the service. Weekly staff briefings newsletters were also distributed to staff with key information to keep them updated. These briefings gave information to staff on issues such as training, infection prevention and control and the importance of handovers.

A staff survey was undertaken in December 2016. Three key areas for improvement were identified. This included better communication systems, support for night staff and staffing levels identified as too low. In response to this we saw a staff suggestion box and daily huddle meetings had been introduced, recruitment for a night manager was underway, out of hours and night visits had taken place, staff drop-in sessions with the manager had commenced and staff were now working in consistent teams in areas they were experienced in or wanted to join.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.
Treatment of disease, disorder or injury	

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The registered provider had not ensured appropriate systems were in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
Treatment of disease, disorder or injury	

The enforcement action we took:

Warning notice.