The Grange Care Centre (Cheltenham) Limited

The Grange Care Centre (Cheltenham)

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced. The service was inspected on three occasions in 2014, initially (February 2014) because there was serious concerns and we took enforcement action against the provider. We visited again in May 2014 to check that improvements had been made and again in September 2014 to ensure that the improvements had been sustained.

The Grange Care Centre (Cheltenham) is registered to accommodate up to 60 older people who have general nursing care needs and, or, are living with dementia. The facilities for people are spread over two floors and the home has level access in from the car parking area and lift access to the upper floor. On each floor there is one 10 and one 20 bedded unit. The third floor contains offices

Summary of findings

and the service delivery facilities. All of the bedrooms have an en-suite including a toilet and level access shower facilities. At the time of our inspection there were 56 people in residence.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We brought this planned inspection forward because we had concerns raised with us about a number of issues: the management of medicines, dignity issues, a member of staff working without appropriate pre-employment checks in place and care documentation being out of date.

Staff lacked understanding of the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. DoLS applications had been submitted to the local authority for a number of people however the registered manager had not considered this for others. When people were assessed as not having the capacity to make a decision, best interest decisions were made and involved others who knew the person well but the appropriate records were not always completed correctly.

Care planning documentation and other care records were not up to date and accurate. Care plan reviews were on the whole not meaningful and often only recorded 'no change'. However where changes to a person's care needs had been identified in the review, the care plan had not been amended accordingly.

The registered manager and staff team were knowledgeable about safeguarding issues, took the appropriate actions when concerns were raised and reported promptly to the relevant authorities. All staff received safeguarding adults training. The appropriate steps were in place to protect people from being harmed.

Risks were assessed and appropriate management plans were in place. The premises were well maintained and all maintenance checks were completed. Staff recruitment procedures were safe and ensured that unsuitable staff were not employed. Medicines were administered to people safely although some very minor improvements were pointed out to practice.

Staff were provided with basic mandatory training to enable them to carry out their roles and responsibilities. New staff completed an induction training programme and there was a programme of refresher training for the rest of the staff. Care staff were encouraged to complete nationally recognised qualifications in health and social care.

People were provided with sufficient food and drink and those people who were identified at risk of malnutrition or dehydration were monitored. There were measures in place to reduce or eliminate that risk. Arrangements were made for people to see their GP and other healthcare professionals when they needed to.

The staff team had good working relationships with the people they were looking after. Relatives told us the staff were kind, hard working, friendly and always made them welcome when they visited. Staff paid attention to ensure that people's privacy and dignity was maintained at all times.

People were able to participate in a range of different activities. External entertainers visited the home and there were opportunities for people to go out from the home and use local facilities and community based social functions.

People were encouraged to have a say about their daily living activities. There were regular resident and relative meetings and there was an opportunity for people to comment on issues as satisfaction surveys were sent out. People and their relatives felt able to raise any concerns they may have and felt they would be listened to.

There was a good management structure in place. Staff were well supported and staff meetings were held on a regular basis. There was a regular programme of audits in place which ensured that the quality of the service was checked.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from being harmed, and staff took the appropriate action to safeguard them. Risks to people's health and welfare were well managed.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective for all.

There was limited understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation. Where assessments of a person's capacity to give consent had been recorded, these had not always been fully completed.

People were looked after by staff who had the necessary knowledge and skills to meet their needs. They were provided with food and drink that met their individual requirements.

People were supported to see their GP and other healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them.

The care staff had good relationships with people and talked respectfully about the people they looked after.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care planning documentation was not accurate or complete which meant that people may not receive the care and support they need. Other care records were not accurately maintained.

There was a varied programme of activities, including activities appropriate for people living with dementia.

Those who acted on behalf of people living in the home were encouraged to make comments and have a say about how their relative was looked after.

Summary of findings

Is the service well-led?

Good

The service was well-led.

People (indirectly), relatives and staff were positive about how the service was managed. There was a range of measures in place to capture feedback from people, their relatives and the staff team. The registered manager responded and said what action was taken

There was a programme of regular audits to monitor the quality and safety of the service. Any accidents, incidents or complaints were analysed to see if there was any lessons to be learnt.

The Grange Care Centre (Cheltenham)

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, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two adult social care inspectors.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not requested that the Provider Information Record (PIR) be submitted because the inspection was planned to take place later in the year. We would have used the key information in the PIR to plan our inspection, taking account of what they told us the service did well and the improvements they planned to make.

We contacted two health and social care professionals as part of the pre-inspection planning process. During the inspection we spoke with one GP.

During the inspection we spoke with 19 people who lived at The Grange, seven visitors, 16 staff including the registered manager, the clinical lead nurse and three nurses, care staff and ancillary staff. Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework for Inspection session (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

We looked at eight care records to check that people's care needs had been assessed and they were provided with the care and support they needed, seven staff recruitment files and training records, staff duty rotas and other records relating to the management of the home.

Good

Is the service safe?

Our findings

Not every person we spoke with during the inspection was able to tell us whether they felt safe. Comments that we did receive included, "They are very gentle with me", "I am extremely well looked after and have no worries", "Everyone is very kind to me" and "I am completely safe here". Relatives and visitors were complimentary about the service and said people were safe. They said, "I chose this home because of the safety aspect. My husband wanders a lot and here he cannot get outside on his own", "The staff are always very loving and kind", "I have watched the staff using the hoists to move people and they are very competent" and "I have no concerns about my mum's safety when I am not here. They look after her very well and nothing is too much trouble".

People were protected from cross infection. All areas of the home were kept clean and tidy and care staff were provided with personal protective clothes (gloves and aprons) and guidance was displayed in respect of good hand washing techniques. However, on two occasions at the very start of the inspection, two members of care staff were seen holding used bed linen or towels next to their uniforms. We brought this to the attention of the registered manager as this requires improvement**.** After the inspection the registered manager advised us that a staff meeting had been held and they had been reminded of the importance of good infection control measures at all times.

Staff had good awareness of safeguarding issues and were able to tell us what abuse was and how they might recognise if a person was being harmed. They told us they would report any concerns they had about a person's safety to the nurse in charge, the clinical lead nurse or the registered manager. Staff were less aware they could report any concerns they had directly to Gloucestershire County Council safeguarding team or the Care Quality Commission. One staff member said "I would speak to a nurse immediately" and a nurse told us they had previously informed the lead nurse when a person was noticed to have bruising.

Safeguarding training was included in the induction training programme all new staff had to complete and the mandatory training programme. A number of staff had recently attended a training session about safeguarding, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Two further sessions were already booked for June and July 2015. One nurse told us they had not had a recent safeguarding update.

Where staff had previously had concerns about the safety of people in their care they had raised safeguarding alerts appropriately with the local authority and also notified the Care Quality Commission. The registered manager had worked well with the local authority and provided management plans where people's behaviours had affected upon others, in order to reduce or eliminate the risk.

Risks assessments were completed for each person in respect of the likelihood of developing pressure ulcers, falls, continence, risks of malnutrition and moving and handling tasks. Where a person needed the staff to support or assist them with moving or transferring from one place to another a safe system for moving and handling activities was devised. These set out the equipment required and the number of care staff to undertake any task.

Personalised risk assessments had been completed where appropriate. For example the risk of choking or a person's behaviours that may impact upon others. Bed rail assessments were completed to determine whether they were safe to be used when the person was in bed. In some cases the bed rails were considered to pose a greater risk and were not used. In this event the bed was kept at its lowest level with a soft mat by the side of the bed. Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed the level of support the person would require in the event of a fire and red/amber/green coding was used on bedroom doors to inform staff and the fire service.

The maintenance person had a programme of checks to complete on a regular weekly or monthly basis. Records were kept of all checks and actions taken where remedial work was required. These included the fire alarm system, fire fighting equipment, fire doors and hot and cold water temperatures. The maintenance person also checked the safety of the windows, the beds, the bed rails and the wheelchairs. All specialist hoisting equipment, the baths, passenger lift and the call bell system were serviced regularly and maintained in good working order. The kitchen staff recorded fridge and freezer temperatures, hot food temperatures, food storage and kitchen cleaning schedules.

Good

Is the service safe?

The registered manager said the numbers of staff per shift were based upon the number of people in residence. Staffing numbers had been increased as the home had admitted more people and were based on one member of staff to five people (day) and one to 10 at night. We were told that staffing numbers would be increased when people were unwell or when the behaviours of a person living with dementia required there to be more staff available. The service does not have a formulae in order to calculate safe staffing levels and take in to account the collective needs of all people. All care and nursing staff were allocated to work within specific units per shift but could be moved to other units if needed. During the day there were five care staff and one nurse allocated for each floor and overnight, five care staff and one nurse for the whole home. The registered manager said there were plans to introduce an extra 7am – 2pm shift for each floor. Staff felt that on the whole the staffing numbers were alright but that at peak times of the day it was busy. One person said "They (the staff) come quickly if I press the bell".

The service had been relying upon agency staff because of a number of staff vacancies, however a number of new nurses and care staff had recently been recruited. At the time of the inspection there were still vacancies for day and night nurses and care staff. One agency nurse was used on a regular basis therefore there was some consistency as they had got used to the people being looked after. The registered manager said they were currently waiting for pre-recruitment checks to be completed for a number of care staff and they would have an on-going recruitment plan in place to ensure the service is staffed with their own staff.

The staff team for the service also consisted of a care coordinator, housekeeping and laundry staff, catering staff, an administrator, two activities organisers and the maintenance person. The staff team were led by the registered manager and the clinical lead nurse.

The service had a safe recruitment procedure and followed this at all times. All pre-employment checks had been completed and these included at least two written references and a Disclosure and Barring Service (DBS) check (formerly called a CRB- Criminal Record Bureau check). The DBS helps employers to make safer recruitment decisions by providing information about a worker's criminal record and whether they were previously barred from working with adults. Nursing & Midwifery Council checks had been completed for all nurses. Information received prior to the inspection was a nurse working at the home did not have a DBS check in place. The registered manager told us that this nurse had been recruited through an agency but the agency had not done the correct checks. The nurse had been unable to provide appropriate written references and had therefore been dismissed on 6 May 2015.

People were administered their medicines by nurses at the prescribed times. The night staff only administered time specific medicines in the morning (for example Parkinson's medicines or analgesia). All medicines were stored in locked medicine trollies or within locked cupboards within a secured area. Medicines were stored at the correct temperatures and suitable arrangements were in place for storing those medicines that need additional security. Records showed that these medicines had been looked after safely.

One of the nurses had delegated responsibility for the management of medicines. They were re-ordered four weekly to ensure people's medicines were always in stock. When new supplies were delivered they were checked against the medicines administration record (MAR chart) and the prescriptions to ensure they were correct. The nurse signed in how many medicines were received. Where handwritten entries had been made on the MAR charts, these had not been countersigned by another member of staff to ensure their accuracy. This requires improvement. Charts would be handwritten if new medicines had been prescribed during the four week period, changes had been made to the prescription by the GP, or the person had been newly admitted to the home.

The supplying pharmacy provided printed four weekly MAR charts for staff to complete when people had taken their medicines. We looked through the MAR charts on the upper floor and found that there were some omissions in signing. We checked this out with the clinical lead nurse who had already found this, had checked that the medicines had been dispensed from the blister pack and was to discuss with the nurse who had failed to sign the MAR chart.

Information we were given prior to our inspection was that nurses were not following safe working practices when dispensing medicines. We were told they were 'secondary dispensing' or 'potting up' of a number of people's medicines at the same time and then delivering them on a tray to people in the lounge of their bedrooms. Despite

Good

Is the service safe?

questioning care staff, nurses, some people and relatives, we were unable to confirm whether this practice was being used and we have asked the registered manager to monitor this.

If people required their medicines to be crushed or to be given covertly this was detailed on the MAR chart. Where people were prescribed medicines to be administered as and when needed (called PRN medicine), protocols were in place. During the inspection one person had been prescribed a new PRN medicine and the nurses was in the process of putting together the protocol.

Requires Improvement

Is the service effective?

Our findings

People told us "I always get the help that I need", "Everything seems to run like clock-work", "I am really hungry today and looking forward to my lunch. We are very well fed here" and "I get all the help I need. I have to wait sometimes which is understandable, there are a lot of us here who need to be helped". Visitors told us, "My relative has done really well since moving here. They are in much better health", "Mum says the food is very good. She has put on the weight she lost when she was unwell" and "I am generally very pleased with the care my friend receives".

Not all nurses and care staff were able to tell us about the Mental Capacity Act 2005 (MCA). One nurse had some knowledge of the MCA, for example the presumption of capacity for adults, but not of the accompanying Deprivation of Liberty Safeguards (DoLS). Another nurse showed little awareness of MCA legislation and a member of care staff had not heard of the MCA at all. Other staff were able to tell us about people's ability to give consent but they were not clear about the MCA. We heard people being asked to give consent to whatever was about to happen or to make a choice.

MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to care or treatment. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised. It details arrangements for renewing and challenging the authorisation of deprivation of liberty.

We asked the registered manager who had a DoLS authorisation in place. The registered manager told us there were no current DoLS authorisations in place but applications had been made for standard authorisations for four people. We saw copies of these applications. We felt there were a number of other people who were not able to consent to where they lived and applications for DoLS authorisations had not been considered.

We saw a number of mental capacity assessments for day to day decisions in people's care files. It had been indicated that the person had capacity to make decisions for example about 'washing and showering' but the section of the form stating 'what is the exact decision you are assessing for - please give more detail' had been left blank. We saw other MCA forms that had correctly been completed to record best interest decisions about the administration of essential medicines.

There were already arrangements in place to improve the understanding of MCA and DoLS with further training sessions being planned for June and July 2015.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All new staff had an induction training programme to complete when they commenced in post. Three new members of staff who were on duty confirmed they were working their way through the training programme. However two of them, who both had previous care work experience, commented they were "left to get on with their job" and "I was shown around and then straight on to a shift". One staff member said they had been promised there would be a number of shadow shifts but this had not happened. Care staff had a common induction standards work book to complete, have an appraisal after 12 weeks and again at six months.

All staff had to complete a programme of mandatory training and then completed refresher training on an on-going basis. They were provided with the training they needed to support them in their roles. Since our last inspection a care coordinator had been appointed whose role was to oversee the staff training plan and arrange training sessions. The previous directors had provided funding for mandatory training only and limited the number of training sessions that could be scheduled. Staff told us that training was offered and they were expected to attend. Some staff had completed dementia awareness training. There had been recent fire safety training, fire warden training and two staff had attended moving and handling 'train the trainer' training. Nurses were supported to access specific training, for example venepuncture (taking blood samples), male catheterisation, tissue viability and pressure ulcer management.

Twenty-six care staff had been signed up to complete a level two health and social care qualification (formerly a national vocational qualification (NVQ)) and six were signed up to do level three. A number of staff had already achieved their qualifications at level two, three and five.

Requires Improvement

Is the service effective?

A range of different staff meetings were held regularly. These included housekeeping meeting, catering meetings, unit meetings and night staff meetings. Staff also had a regular supervision meeting with a senior member of staff. One member of care staff told us they had an appraisal at the end of their initial six month period working at the home and felt "well supported" to do their job. The registered manager supervised the heads of department, and senior staff, the clinical lead nurse supervised the nurses and the care coordinator supervised the care staff.

Where decisions had been made about end of life care the GP completed and signed a Do Not Resuscitate yellow sticker. These were placed at the front of the person's care records. We discussed these stickers with the GP as these forms have been replaced with formal nationally recognised Resuscitation Council forms (red edged forms). These forms allowed any consultations with relatives to be recorded along with the members of nursing staff included in the decision-making process.

The chef had a good awareness of people's dietary requirements. Meals were generally prepared from fresh ingredients such as joints of meat, fish, fruit and vegetables. Some people required a special diet due to diabetes, there were three people who required pureed diets and "about fifteen" soft diets. Three people were having food supplements. Meals were fortified with milk or cream to increase calorie intake and drink thickeners were used where this was a speech and language therapist's (SALT) recommendation.

A Malnutrition Universal Screening Tool (MUST) was used to assess each person's nutritional needs and then reviewed on a monthly basis. An assessment of oral care and hygiene needs was also completed. People were weighed at least monthly; weekly if weight was causing concern. The nurse explained that any weight concerns were reported to the GP for advice.

The chef explained the service was trialling a change to the meals service for a six week period. A light lunch (usually sandwiches) was served at midday and the main meal was served in the evening. This was being trialled because, for some people who chose not to get up early, the interval between breakfast and lunch was not long enough. Whilst this trial was underway people were being weighed weekly in order to monitor the effectiveness of the change. Some people who wished to have still have their main meal at lunch time were provided with a cooked meal at lunch and others were provided with a cooked meal at both lunch and tea time.

In the afternoon people were served with home made cake, cubes of cheese and fruit pieces. Tea and coffee was served in a variety of different drinking vessels. We heard people being asked whether they wanted a cup or a beaker.

A relative told us their family member was "Eating very well" and others said there was plenty of food which "smells and looks good" and staff were "Very good with people who need assistance". Another relative told us, when we asked about fluid intake, "They're very good, always asking." Staff told us that they encouraged fluids and we saw that people were offered drinks at regular intervals.

We spent a period of time observing the meal time period in two of the four dining areas. The meal time experience was not the same in both dining rooms. In one of the dining areas, the television was on very loud and the care staff were serving the meals out without talking to people. There was no interaction between people sitting at the same table. All but one person was not asked what pudding they wanted and the bowls were just placed in front of them. In the other dining room, there was no television, the care staff were talking to people and offering them choice, and one staff member was sitting next to a person and assisting them to eat their meal. We noted that after the meal hot drinks were served in cups without saucers in both dining rooms.

At the time of the inspection all but one person was registered with a local GP. The GP visited the home on a weekly basis. Nurses also requested home visits whenever people were unwell. We spoke with the GP during the inspection. They told us "I think my patients are very well looked after", "The standard of care is very good and all the staff do their very best", "I am asked to see patients in a timely manner and any instructions I leave are carried out" and "I am always asked for advice if the nurses are unsure".

A range of other professionals were also involved in assessing, planning, implementing and evaluating people's care and treatment. Staff from the Care Home Support Team, speech and language therapists and mental health workers including the psychiatrist and community nurses

Requires Improvement

Is the service effective?

visited the service. The service liaised with the nurse from the Continuing Health Care Team. Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists.

Good

Is the service caring?

Our findings

People said “The staff are very kind to me, they know I am not feeling very well at the moment so they let me have a lie-in”, “I have only just moved in but everyone has been very kind to me so far”, “Every thing is OK and the staff are kind to me” and “It was my birthday a few weeks ago and my wife organised a party for me. The staff made a complete fuss of me all day”.

Relatives said “The staff are welcoming and very kind”, “Some staff are better than others. I know who I would like to help my mum”, “The staff are always very polite and considerate. They work very hard and never seem to stop” and “the staff always have a strategy” for dealing with any challenging behaviours. One relative told us they visited very regularly and had “never heard staff speaking crossly to people” and had “never seen people being treated inappropriately”.

Staff spoke about people with respect. They told us about one person who liked to wear their make-up and another who liked to wear their beads. They said they always ensured that personal care was delivered with bedroom doors shut. Each person had en-suite toilet, washbasin and shower facilities which helped to support their privacy and dignity needs. During our inspection we did see one person using the bathroom whilst the door was wide open, but staff explained this person took themselves off to the toilet.

We had been told prior to our inspection that staff changed people’s wound dressings in communal areas. We asked one lady who had dressings on her legs, where the staff provided wound care and was told this was done in the privacy of the bedroom. Relatives said they had never seen dressings being attended to in the lounge area. Nurses and care staff said that dressings were always attended to in bedrooms or bathrooms.

On the whole we observed positive exchanges between staff and the people they were looking after. One person who was walking freely in the corridor was attended to promptly when it was seen that their clothing was slipping. We watched whilst one person was hoisted from their wheelchair into a armchair. The two care staff spoke with the person throughout the whole procedure and ensured they were comfortable before leaving them. We saw a member of care staff reassuring a person who was distressed. The carer asked what the matter was, listened to the person and spoke to them calmly. Throughout the two day inspection the atmosphere was relaxed and from observing people’s demeanour they appeared to be comfortable with the care staff and the nurses. In the early evening of the first day, when a number of people had started to become restless, the care staff were attentive and kind towards them.

The main GP for the service said the staff team was “Very caring”, “Always wanted the best for my patients and “Wanted people to be comfortable and not to be in pain”. The GP said they had never had reason to be concerned about the way people were looked after or been aware of any unkindness.

Requires Improvement

Is the service responsive?

Our findings

People were supported with their care and support needs when the needed assistance. One person said "I only have to ring my call bell and they come and help me". Others said, "There are busy times, so I always try and avoid these. I ask for help with toileting before it gets too busy" and "I don't need as much help as others but I do keep an eye out for them and call for help if none of the staff are around".

Each person was fully assessed before admission to the home, to ensure that the service was able to meet their needs. The assessments covered all aspects of the person's daily life, specifics about how their dementia presented and any nursing care needs.

Prior to our inspection we received information that care planning documentation was out of date and did not accurately reflect the person's care and support needs. Six of the eight care files we looked at were incomplete and much of the printed documentation was blank. A summary plan of the person's activities of daily needs had been prepared but this only provided a basic overview. There was also a day profile and a night profile but these again only provided minimal information. The clinical lead nurse was in the process of transferring all care information on to new documentation and was completing care plan reviews at the same time. The new documentation included information about the person's life, their health needs, their dementia care needs where appropriate. The clinical lead nurse confirmed that although some of the care plans had been rewritten, they had not been typed out and placed in people's care files.

The older style care plans we saw had been reviewed but these invariably only recorded the date and "no change". Where meaningful reviews had been recorded and referred to a change in the person's needs, this did not always result in a change to the care plan. For example one person's physical health plan stated their diabetes was managed with insulin but the review had recorded this was now managed with tablets. One of the staff said "We don't have time to finish and update care plans. I've raised it with the care lead that the care plans are completely blank." They added "I'm really concerned. The biggest issue is the care plans, they're blank." They also told us "It's not safe to not have a care plan."

Where people were prescribed creams or ointments, the treatment was applied by the care staff. A separate creams chart was used to record the application. These charts were kept with other daily charts and we noted there were omissions on these charts for prescribed treatments, for one person for a three day period. Positional change charts we looked were incorrectly completed. For one person the night staff had recorded 'repositioned' on several consecutive occasions. Fluid intake forms were not totalled at the end of a 24 hour period and there was no evidence the nurse in charge had been informed if fluid intake had been low.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All staff received a handover report from the nurse in charge of the previous shift and were told about significant events and any changes in people's health or welfare. One staff member "If you have had a number of days off it is important to get a good handover report. Some of the nurses are better than others at how much detail they go in to".

People were encouraged to have a say about their care and support and to speak up if they were unhappy about anything. We asked a person if they would tell staff if they were not happy about something. They replied "Oh yes, I think they're fed up of me". Another person said, "I may have a little moan about things sometimes, but on the whole everything here is fine". A relative told us if they had a concern, "I'd raise it with the nurse on duty".

Resident and relatives meetings were held on a regular basis with the last meetings being held in April 2015. One relative we spoke with had attended two meetings and said it was important to meet the managers and be able to have a say about how they found things in the home when they visited. We saw two letters that relatives had submitted to the registered manager with suggestions for the service. The registered manager had responded promptly by letter, outlining actions to be taken. A monthly newsletter was produced and distributed to each person and their families. The newsletter for May contained photographs of activities that had taken place in April, requests for gardening items for planned activities and a list of planned trips away from the home.

Requires Improvement

Is the service responsive?

There was a weekly programme of activities for people to participate in, led by two members of staff employed as activity organisers. The first day of the inspection they were not available because they were attending an Activity Champions Network – they link with other activity organisers from other services and share ideas and resources. The week we were in the service the activity programme included a number of trips out to local amenities, baking sessions and arts and crafts, mind song singing and a gardening session. There was a packed programme of activities. One person said "I am told about all the things that are happening but I want to stay in my room and do my crossword". Another person said, "We can pick and choose what we take part in. Sometimes I just like to sit and watch what the others are doing".

A relative told us about various activities such as singing and dancing that had been arranged in the past. They told us a ukulele band had visited recently and a trip to Weston super Mare was planned. On a noticeboard in the main hallway, there was notice advertising the trip to Weston super Mare and a request for volunteers to help on the day.

Good

Is the service well-led?

Our findings

People were not able to tell us whether they thought the home was well-led or not but made the following comments: "Everything seems to run like clockwork", "All seems fine by me" and "Yes, I think it is". A relative described the manager as a "good organiser". They told us they were "very impressed" by the clinical lead (senior nurse), adding that "they know the people".

The registered manager told us they visited each unit every day and made a point of talking to as many people as possible. Whilst we were being shown around the home, it was evident that the registered manager had a good knowledge of people and the staff team. The registered manager was supported by a clinical lead nurse. This nurse had supernumerary hours to complete management tasks and also worked nursing shifts alongside other nurses and care staff. On the second day of the inspection this nurse was leading the shift on the upper floor and a newly recruited nurse was leading the shift on the ground floor.

Staff said the service was well run and the registered manager and clinical lead nurse were effective leaders. One staff member said the registered manager was approachable and "you can go to her if you have any problems". Another said, "We are listened to most of the time but she doesn't stand any nonsense. She has addressed some staffing problems".

Staff said they generally worked in one particular unit for a period of time and this enabled them to get to know each person well. The staffing structure within the service was as follows: the registered manager, the clinical lead nurse, nurses, senior care staff and care staff. The care team were supported by catering staff, housekeeping staff and an administrator in order to meet people's daily living needs.

Staff meetings were held regularly and records were kept of all meetings. The last night staff meeting was held on 7 April, a meeting with the kitchen staff on 8 April and care staff and nurses meetings on the 24 and 26 March 2015. Staff confirmed there were regular meetings and copies of the meeting notes were posted in the staff room.

Up until recently the providers visited the service on a regular basis, however there has been a change of directors in the last month. One of the new directors planned to visit the home and attend the next resident and relatives meeting.

In order to monitor the quality of the service there was a programme of audits in place. The registered manager had a number of monthly reports to complete in respect of training, care plans, staffing, resident issues and health and safety. In February 2015 we noted that only three care plans had been audited and this seemed a very small percentage now that the service is almost fully occupied. On a quarterly basis a more thorough report was submitted to the directors. The supplying pharmacist had undertaken a recent audit and had identified four areas for improvement but there was no date this had been completed. The four improvement area's had been addressed. As we have already reported the maintenance person had a programme of weekly, monthly and quarterly checks to complete and the registered manager maintained an overview to ensure these were all completed.

Any falls, accidents or incidents were logged. In January 2015 the registered manager had analysed the number of falls one person had during that month in order to look for ways to reduce or eliminate the risk. Since then there had been specific patterns to the falls, accidents of injuries reported on.

The registered manager and clinical lead nurse were aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about. The registered manager was aware that notifications about deprivation of liberty applications had to be submitted after the outcome of that application was known.

A copy of the complaints procedure was displayed in the main entrance and also included in the service user guide. Relatives were given a copy of the guide so they would know what to do if they wanted to raise a concern or complaint. The procedure stated all complaints would be investigated and responded to in writing. The service had received four formal complaints in the previous six months. The records we looked at evidenced the actions taken by the management team.

A resident/relatives questionnaire had been sent out at the beginning of the year and 50% of completed forms had been returned. Comments had been made about the gardens, the high use of agency staff, housekeeping issues and suggestions about activities. The registered manager had written out an action plan addressing each of the issues. A copy of this was displayed on the notice board.

Good

Is the service well-led?

The registered manager had plans for the service now that the home was near full occupancy. The landscaping of the gardens had just begun but there were plans for a conservatory to be built at the back of the property. Some carpets had already been replaced with washable flooring and there were plans for more carpets to be replaced. In the dementia units there were plans to paint the bedroom doors different colours to aid people in locating their own room and to replace toilet seats and grab rails with brightly coloured ones.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered provider must ensure that staff are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005 and are able to apply those when appropriate, for any of the people they are caring for. Regulation 11 (1) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider must ensure that accurate, complete and contemporaneous records are maintained in respect of each service user. This includes a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (2)(c).