

Inverhome Limited

Morton Grange

Inspection report

Stretton Road
Morton
Alfreton
Derbyshire
DE55 6HD

Tel: 01246866888

Website: www.mortongrange.co.uk

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on the 17 and 18 October 2016; the first day was unannounced. The service was last inspected in January 2014, when it was found to be compliant in all areas inspected.

The service is registered to provide residential and nursing care to 66 people, who live in three separate units spread over two buildings. On the day of inspection there were 64 people living there, many of those people were living with dementia.

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

We found that risks were not consistently well managed at Morton Grange. We found examples of repeated incidents which had not been sufficiently analysed. Therefore opportunities to assess how repeat incidents could be reduced had not been fully explored by the management team. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe care and treatment). You can see what action we told the provider to take at the back of the full version of the report.

We found there were times when there were insufficient staff on duty or they had not been deployed effectively. Staff did not always respond positively to requests for assistance. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing). You can see what action we told the provider to take at the back of the full version of the report.

However, people told us they felt safe at Morton Grange. Medicines were managed safely and staff received relevant training. All pre-employment checks were completed before staff started working at Morton Grange and before they cared for people. Staff understood their responsibilities to keep people safe from harm and had policies in place to support them.

Staff knew people's care needs and had the training, knowledge and skills to meet these needs. They worked closely with other healthcare services to ensure people maintained good health and their changing needs were responded to promptly. Staff felt supported by the management team and there was good communication within the service.

People did not always feel they were listened to or included in decisions about their care or daily living arrangements. We saw that staff became very task focussed at busy times and did not always promote people's dignity. At lunch time we saw everyone being given tabards whether they needed them or not. There was not enough room for everyone to sit at the dining tables for their meals, some people had to remain in their seats in the lounge to eat their meals off a tray and some people were left without social interaction or the assistance they required. This was in breach of Regulation 10 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014. (Dignity and respect). You can see what action we told the provider to take at the back of the full version of the report.

People did not always feel included in the decisions regarding their care and treatment, or their wishes and preferences were ignored. It was not clear how people with fluctuating capacity were included in decisions about their care. We have made a recommendation regarding how consent is gained.

At other times people were cared for by staff who were kind and compassionate and we observed some positive and caring interactions based on dignity and respect.

Families told us they were included in decision making about their relatives care and signed care plans and reviews. They were aware of the complaints policy and told us it was included in the admission pack in people's rooms. However, some people felt their wishes and preferences had not been respected. We felt that some decisions had not always been explained to people in a meaningful way which had left them feeling excluded and dissatisfied.

We saw the management sought feedback but it was not clear how this was used to improve the service and the care people experienced.

There were management systems in place but we found they were not always effective in identifying risk or areas for improvement. There was little analysis of audits or incidents which meant that the quality assurance systems did not always lead to a better quality of care for people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good governance). You can see what action we told the provider to take at the back of the full version of the report.

The provider was not following their own supervision policy and people were not receiving regular or robust supervision. Supervision meetings took place on an ad-hoc basis and were not always planned or recorded which made it difficult for the registered manager to manage performance and support people to develop. We made a recommendation regarding supervisions.

However, staff felt supported by the management team and found they were available and responsive to any concerns. There was good partnership working with community health services which had a positive impact on the health of people using the service. The service worked closely with local community groups to offer a wider social experience for people and had access to a minibus to take people out on trips into the community. The service had received and been nominated for many awards over recent years in respect of the care they provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Risks were not consistently managed. We found examples of repeated incidents which had not been sufficiently analysed, in order to reduce the likelihood of them being repeated. Staff were not always deployed effectively and did not always respond positively to requests for assistance.

Safe recruitment policies ensured that staff were suitable to work at Morton Grange and all pre-employment checks were completed before they cared for people. Staff understood their responsibilities to keep people safe from harm. Medicines were managed safely and staff received relevant training.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Some of the care was very prescriptive with set routines and 'regimes' which did not take account of individual need or dignity.

Staff knew people's care needs and had the training, knowledge and skills to meet these needs. They worked closely with other healthcare services to ensure people maintained good health and their changing needs were responded to promptly.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People did not always feel like they were listened to or included in decisions about their care or daily living activities. Staff became very task focussed at busy times and people were left without social interaction or the assistance they required.

At other times people were cared for by staff who were kind and compassionate and we observed some positive and caring interactions based on dignity and respect.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Families were included in decision making about their relatives care; but this was not always communicated to people in a meaningful way, as some people felt their wishes and preferences had not been respected. The management sought feedback but it was not clear how this was used to improve the service and the care people experienced.

There was a wide variety of activities, trips and events which people and their families could attend. Activities were suitable for individuals, small groups and larger groups and were planned with people and their families.

Requires Improvement ●

Is the service well-led?

The service was not effectively well-led.

The management systems in place were not always effective in identifying risk or areas for improvement.

Staff were supported by a management team that was available and responsive to any concerns. There was good partnership working with community health services which had a positive impact on the health of people using the service.

Requires Improvement ●

Morton Grange

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.

We carried out the inspection on 17 and 18 October 2016; the first day was unannounced. The inspection team consisted of one inspector, one nurse specialist professional advisor (SPA) and two experts-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who has used older person's or dementia services.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We also reviewed any notifications the provider had sent us and any enquiries or alerts we had received. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred. Enquiries are when we receive information from providers, people or other agencies; and alerts are when we are informed about areas of potential concern that we may need to follow up.

As part of our inspection, we looked at a variety of records and spoke to different people. We reviewed five care plans, which included needs assessments, risk assessments and daily care logs; 15 medicine administration records (MAR); management records which included three staff records, policies, quality assurance and audit systems, training matrix and health and safety records. We spoke to ten staff members including the registered manager, administrative manager and care staff. We also spoke to two visiting healthcare practitioners, 10 people using the service and seven relatives about their experience of care at Morton Grange.

Is the service safe?

Our findings

The service did not always have sufficient staff and they were not always deployed effectively to meet people's care needs. Three people told us they often had to wait for assistance to go to the toilet as there were not always enough staff available to meet their needs. One person told us they had been told to use their pad which they said, "Was very undignified." Another told us they had received a reply of, "You've only just been," another told us they had resorted to using their pad at night which they disliked as staff did not come quickly enough, if at all. When we discussed this with the manager she said some people have sometimes forgotten they had already been to the toilet and others wanted to go again when they saw someone else going. She said, "Staff have to make sure the quieter ones are taken to the toilet too, or at least asked; otherwise it will be the same people going all the time". She said people are asked regularly if they wished to go to the toilet but sometimes they had to wait up to 15 minutes for staff to be available, which she said was not unreasonable. We were concerned that the registered manager found it acceptable for people to have to wait for assistance to use the toilet and to have to use their continence pads at night time, due to fewer staff being on duty.

Another person told us that they were only allowed two showers per week, when they would like more. They also said that their shower day was Monday and Friday but as they were short staffed today (Monday) they had missed their shower day and would have to wait until Friday now. When we asked the registered manager about this and the frequency of showers, she said, "There is not enough money in the budget for everyone to have showers every day, we have to be realistic". She went on to say, "[Name of person that we had spoken to] needs two people for up to two hours to assist with showering, this would impact on other people as two staff are off the floor during this period". When asked what they would do if a person had 'an accident' and needed a shower, she replied they would change the day for their shower. We were concerned this practice appeared to be prescriptive and inflexible and did not promote people's dignity or respect their wishes. Sufficient numbers of staff were not deployed to meet people's needs.

The registered manager told us they used a dependency tool to ensure there were enough staff to meet people's needs. They told us they had, "Long mealtimes, as there were lots of people who required assistance" and they had recently recruited additional staff for the mornings, to cover the busy meal times from 7am – 2pm. However, we observed a person waiting 50 minutes for their meal at lunchtime, with no contact or conversation with people or staff. We also saw pureed meals left out for 30 minutes, on the trolley in the dining area, waiting for staff to assist people to eat, these went cold during this period. The registered manager said they were only allowed to heat them once in the microwave and staff did this when they became available to assist people. This demonstrated there were not enough staff available to support people at lunchtime.

One person told us, "Staff are too busy", to assist them to move from their wheelchair to a chair in the lounge. Another person told us, "I was horrified at how long I had to wait (for the toilet)". People told us they wanted to move about more or go into the garden, but they had been advised not to, or felt unable to ask for assistance as staff were so busy. We also observed a period of 10 minutes in a lounge area during the afternoon when no staff were available to assist people.

These examples demonstrated there were insufficient staff on duty to meet the individual needs of people and staff were not deployed effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw risk assessments in people's care records and saw they were in place for different aspects of care including mobility, personal care, nutrition and pressure care. However, risk assessments were not signed by people and people told us their views were not considered in respect of taking risks. This meant risk assessments did not accurately assess risks to people as they were not involved in the process.

Records of individual incidents and accidents were collated every month and reviewed by the registered manager, who told us they were discussed at team meetings with staff. However, we found there was no analysis of this information and no evidence of what had been done to prevent further incidents. For example, the monthly accident analysis records reported: 14 unwitnessed falls in July, 15 in August and 11 in September of this year. We saw no evidence of a plan to analyse any themes or reasons for the falls and no recommendations had been documented that would help reduce the number of falls. We were concerned that this risk was not being prioritised by the management team and people were at continued risk of falls. We also read six staff meeting minutes and found no evidence of the monthly accident analysis being discussed with staff. There were no recommendations made how to reduce ongoing risk to the individuals who had accidents during the previous month. There was not sufficient consideration given to any environmental risks, or the deployment of staff, as well as clinical and behavioural reasons for incidents. This was particularly evident where people had repeated falls and meant people were at risk of further falls and possibly injury.

This demonstrated that the provider did not have effective systems in place to identify and manage risks to people and could not assure us that people were cared for safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Current good practice suggests that demarcation of different areas in care homes helps people maintain some independence and reduces risks. For example, the use of contrasting colours for the wall and floor, and use of different colours to help people recognise they are in different rooms for different activities. We felt the full impact of dementia on the visual senses had not been fully considered when decorating the building; there was no demarcation of different areas or rooms as almost all the walls were the same colour which could lead to confusion for people experiencing visual or sensory difficulties. There was only a handrail on one wall in the corridors and not both, which we felt could increase the risk of falling for people who were able to walk independently. When we discussed this with the registered manager she said she did not wish to label people by painting everything in different colours just because they had dementia. She was unable to comment on why there was only one handrail in the corridors. There had been 5 unwitnessed falls in the corridors during the previous three months and one when a person was being supported by staff.

People told us they felt safe living at Morton Grange. One person told us, "I'm much safer here," another person said, "It seems the security is pretty good". There was a safeguarding adult's policy and staff training in place for staff to follow to safeguard people. Staff were able to explain what they would do to safeguard people if they suspected abuse or harm. They told us they would not hesitate to use the whistleblowing procedure if they felt people were at risk of harm or abuse from staff, or the systems in place. Equipment was checked and serviced to ensure it was safe to use.

We saw that any incidents of behaviour that challenged between people were reported and they were recorded in the incidents log. Staff explained how they would support people who became distressed and anxious and described the tactics they used to support individual people. For instance, one person liked to

spend time outdoors so staff took them out into the enclosed garden, if they became anxious and this would distract and calm them. Another person was calmed by listening to music or singing, so staff used this activity to calm them when necessary. This meant staff knew how to manage any behaviour that challenged to help keep people safe.

We looked at three staff files and found that appropriate pre-employment checks had been completed before staff cared for people. This included asking people to complete an application form, provide evidence of previous work experience, qualifications and fitness to work, along with two references and a disclosure and barring service (DBS) check. This meant the provider took steps to ensure the suitability of staff to care for people. We also saw that the registered manager followed disciplinary procedures to address poor performance or practice that was unsafe. This meant staff were suitable to care for people who were protected from the risks associated with unsafe care practice.

People told us they received their medicine regularly each day; and promptly when it was required. One person said, "I'm on [pain relief medicine] and when I ask for it I get it straightaway". Another person said, "Yes, they bring it round". We found that the arrangements for managing medicines were generally effective, but there were occasions when medicines had not been carried forward on the medicine administration records (MAR) which would make it difficult to accurately complete stock control. We felt the audit process could be improved and the registered manager agreed when we discussed this with them. We found one bottle of medicine in the medicines cabinet that should have been discarded on 1 March 2016, after it had been open for three months. It had been used once since that date, which meant it may not have been fit for the purpose in which it had been prescribed. Medicines have a recommended disposal date as after this date the medicines may not be effective. This was removed when we brought this to the attention of the registered manager.

We found some of the areas where medicines were stored or administered, required cleaning. We also identified occasions when the number of medicines had not been carried forward accurately on MAR charts. However, overall we felt medicines were managed safely. They were ordered and stored appropriately and administered safely. This meant that people received their medicines as prescribed.

We noted that there had been a reduction in the use of medicines to control behaviour. This demonstrated that the service aimed to improve the quality of life for people living with dementia and other mental health issues; by using other methods to manage behaviour and not over relying on medicines to do this. This was good practice.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found DoLS were in place or had been requested for people who required some form of restrictive care to keep them safe. We saw evidence that families and professionals were consulted when 'best interest decisions' were made in respect of the care of a person who did not have capacity to make those decisions. This showed that the provider took responsibility to ensure that they were operating under the principles of the MCA and were not placing unlawful restrictions on people who lacked capacity to make decisions about their care and treatment. They also considered the rights and independence of people when they made 'best interest decisions' on their behalf.

However, staff did not always ensure that people had given explicit consent to how they were cared for. People told us they were not always involved in risk assessments regarding their care and treatment. They told us they felt restricted by staff and were not allowed to take risks. People's perception of risk management was different to that of staff. One person told us, "They won't let me walk from the bed to the door without someone there – yes I understand but it's restricting my freedom. If someone saw me they'd say – 'you know you're not allowed'." Another person told us, "Staff won't let me get up. I feel safe as long as I have got my wheelchair." A third person said they felt staff were confused between protection and freedom, "They don't allow us to take risks". This person's relative explained to us that the full assessments had not yet been completed and the staff were, "Still weighing up the pros and cons of what they can do", owing to the persons history of falls and the impact of medicines on their mobility.

We saw risk assessments that had been reviewed and relatives told us they were asked to sign reviews. It was not clear whether relatives were signing to give consent, to agree to the decision or just to confirm they had read the assessment. When a person has capacity to make decision, a family member cannot consent to care on their behalf. This was of particular concern where people may have fluctuating capacity and felt they had not been consulted or their wishes were being ignored. We found that information was not always shared with people, in ways that they understood. This meant that people did not always receive a personalised service which respected their rights and preferences; and staff did not always ensure that people had consented to their care at the point of delivery.

We recommend the provider reviews how it obtains consent from people, particularly those with fluctuating capacity; how it involves people in the decision making process, and how it communicates decisions to

people in ways that they understand.

Staff told us they had supervisions with the nurses or one of the management team and we saw supervision records and a matrix that confirmed when they took place. However, these were not planned in advance and took place on an ad-hoc basis. We discussed the frequency and planning of supervisions with the registered manager and administrative manager, as not all people received supervisions in line with the provider's own supervision policy which stated, "Each person will have a formal review of their job role every twelve months and an informal job chat every three months". The records we viewed for some people showed that they had not had supervision for six months. The registered manager said that some of the 'job chats' were informal and staff were, "Pulled off the floor," and if there were no problems, there was nothing to record. This meant that some staff could be at risk of developing poor practice or misinterpreting policies and procedures, if they had no formal opportunity for reflection or discussion with a senior. This in turn could affect the quality of care people experienced. We discussed developing a more structured approach to supervisions, planning them in advance so staff had notice and could prepare; taking place in private to ensure confidentiality; and recording of all supervisions, so managers could check progress and use the information to feed into annual appraisals. The registered manager and administrative manager said they would consider this as part of their improvement plan and review the supervision policy.

We recommend the provider reviews how supervisions are planned, conducted and recorded.

One person told us, "Staff are very good, they use gloves and aprons for personal care, always explaining and they have good training. They are usually well organised. The matron is wonderful". Another person said, "Yes staff know what my needs are definitely" and a relative told us, "They're very good, can't fault them". People and their families felt the staff understood their needs and knew how to care for them.

Staff had access to training relevant to their role. The registered manager showed us the training matrix and training records; and staff confirmed they attended training regularly. A staff member told us, "There are plenty of opportunities for external training, especially through the local hospice, they do some every month. I have completed all mandatory training here". Another staff member told us they felt, "Supported to develop both clinically and professionally". Staff told us they had an induction which included online and face-to-face training with the registered manager or senior staff, observations of other staff and they were observed by the registered manager or nurse before caring for people. This meant staff had the training to help them meet the needs of people using the service.

People enjoyed their food and told us they were offered a choice of meals and had plenty of snacks and drinks throughout the day. One person who clearly enjoyed their food told us, "There's a choice of food. At teatime more often than not it's sandwiches. Lovely puddings, hot lunch and they come round with the snack trolley". Another person told us, "Food, can't fault it. They give you too much. Breakfast, lunch, snacks, teatime. The cook explained the menu options and how they used fresh local ingredients to make meals that people requested. They said people's favourite dishes or special diets were catered for and they knew who needed supplements or food prepared in a special way. We saw food prepared in different ways – pureed, mashed, or cut up small, on the trolleys in the dining rooms; some of these had labels on for people who required a diabetic diet or people with a food allergy. Staff told us people were asked for their menu choices each week and had options for each meal, plus the option to change their mind on the day if they wished. Staff also told us they had taken part in 'puree testing' to ensure that pureed food was a tasty alternative for people who required this consistency of food.

We observed the lunchtime experience in all three dining areas and found it to be of varied quality. None of the dining rooms were large enough for everyone to eat their lunch at the dining tables if they wished. One

dining room was out of use on the day of inspection as its adjoining kitchenette was being refurbished; however it was not large enough for all residents to sit at a table to eat their meals, if they wished. This meant people did not always have the opportunity for a different experience during the day. We saw many people had their lunch taken to them in the lounge where they had been sitting during the morning; these meals were plated up on trays and placed on small mobile tray tables beside or in front of them. This often made it difficult for people to reach their plates and eat without spilling food on them. In two dining areas we observed everyone was given a tabard to cover their clothes. People were not asked if they would like one, it was just given or placed around them. We saw one person clearly did not want to wear this, but it was put on them by a member of staff. The tabards may have been beneficial for people eating in the lounge from low side tables, but if they had the opportunity to sit at the dining tables it may not have been necessary. We felt this was not a very dignified experience for people, with very few options or choice given to people about where they were able to eat and what they wanted to wear. We felt that lunchtime was a task for staff to complete rather than an experience for people to enjoy and socialise.

People who could eat their meals independently received their meals first. However, people who required assistance to eat, had to wait varied lengths of time as there were not enough staff available to assist people at the same time. Another person sitting in the lounge had their meal placed on a tray table in front of them but they then fell asleep. They were woken by a member of staff and handed the plate to eat, they tried the food but it had gone cold so they pulled a face. The carer asked if they wanted an alternative meal but they said no, they were offered pudding instead and agreed. The carer came back with ice cream which we felt was not a substantial alternative to a main meal. We felt the lunchtime experience was not a very positive or sociable experience for some people.

We spoke to two healthcare practitioners who told us they visited weekly. They told us there was good communication between themselves, the nurses and carers. They said information was shared appropriately and ensured people received the most effective care and treatment to meet their needs. One of them told us that staff were very good at referring people to them and staff were good at following instructions. The second healthcare practitioner told us they felt there was a good standard of nursing care at Morton Grange, particularly pressure care. People told us they are supported to access the opticians and the chiropodist who make home visits. The registered manager told us everyone is registered with the local GP who is very responsive to home visits when required. We also saw evidence of referrals for specialist healthcare including falls clinic, dietician and speech and language therapy (SALT). This meant people were supported to access community healthcare services and maintained good health.

Is the service caring?

Our findings

People did not always feel they were involved in their care planning or in decisions made about their care. One person told us, "I haven't had a care plan meeting for a long time. One of my sons comes to that". The registered manager confirmed that this person's son attends the care review meetings, on this person's behalf as was agreed in their care plan. Two people told us they felt their mobility restricted what they were able to do. We found that some people had not been consulted or informed about decisions that affected them, in ways that they understood. People felt the focus was on what they could not do, rather than what they could do. For example, one person, who was sitting in a wheelchair in the lounge, told us they would like to spend some time out of the wheelchair. They said, "My legs are hurting in this chair, the chair feels so tight. They said I've got to keep it because I'm better in this chair. They seem to want to keep me in it because it's a wheelchair and they only have to push but it's not the answer to everything. It feels like I'm sitting in a vice. My bottom cheek hurts and aches". Another person told us, "I feel I could do more. I am eager to get moving but I haven't had any sort of training. I haven't got out of this wheelchair. No one has come to help me walk".

People's views on whether the service supported them to maintain their independence were mixed. One person told us they were happy with how staff helped them to maintain their independence. This person told us, "Oh yes they do, they'll get my hands and walk me from the chair to the table" (rather than use a wheelchair). Another person explained how staff respected their privacy and promoted their dignity and told us, "When I go to the toilet they stand outside the door".

However, other people told us their independence was not always supported. People told us their views and wishes had not been respected, as they felt they had no choice about where to sit. One person told us, "I get up to go to the toilet then I have to go back to bed for an hour. I've got no choice. They won't let me get up". This person also expressed a desire to start walking again but felt their wishes were being ignored, they told us they felt the service was, "A bit institutionalised". People were not always supported to express their views, or when they did they felt their views were ignored. People felt that nobody was listening to them. Some people felt they were not involved in their care plans, or information was not presented in ways that they understood. This left some people feeling dissatisfied with the care they experienced.

People felt their independence and dignity was not respected by the staff, especially when they were busy. We observed when staff were busy they were less caring in their approach to people. For example, one person was left for 50 minutes at a dining table without food or social interaction, during the busy lunchtime period. We also observed ten people waiting for assistance at lunchtime, whilst their pureed meals sat on a trolley in the dining hall for over 30 minutes. In addition, one person told us, "There's not enough staff, you wait to go to the toilet... they said 'you've only just been'. I say I'm sorry but I do... they say 'use your pad'... but I don't want to at night, it's degrading". One staff member told us, "We have an excellent toileting regime"; and another staff member explained the daily routine to us which included when they, "Do toileting". People told us staff did not take them to the toilet when needed. We were concerned that the routine of the home was quite prescriptive and some people felt they were an inconvenience if they required support at different times. People were not always treated with dignity and respect.

In two dining rooms, we observed everyone being given a tabard at lunchtime, even though some people did not appear to need them. We saw a staff member attempting to put a tabard on one person and had caught this person's hair in the fastening, causing them to cry out in pain. One person told us, "If they're in a hurry they are a bit rough". People did not appear to be given a choice over whether they would like a tabard; there was an expectation that they would wear them, even if they clearly stated they did not want to. Staff did not always provide care that was gentle and respectful to people's views.

We felt the lunchtime experience was not a dignified, personalised or sociable experience for some people. There appeared to be little choice of where to sit as the dining rooms were not large enough to seat everyone. Some people remained in the same seats in the lounges where they had been all morning, this provided no opportunity to move around or sit with other people for a change of scenery or conversation. Although we observed some good examples of care and communication when staff had time to talk to people, we found staff were mainly task focussed when they were busy and did not have time for chatting or talking to people.

These examples demonstrate that the staff did not always promote the dignity of people or respect their views and preferences. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, people told us they felt staff were caring. One person told us, "Staff understand me, we've got used to each other. I like it here, it feels like home". Another person told us, "I've made friends with one lady; they know we talk together so they try and put me where she is. They're all pretty friendly". This person's relative told us, "Staff are superb, brilliant. It's clean, doesn't smell, staff are lovely and caring. They all know her". This demonstrated that people were happy with their care and staff supported the development of new friendships to help people settle in and promoted their wellbeing.

Staff told us they really enjoyed their work and enjoyed caring for people. One carer told us, "It is so important that people have a good quality of life and that they have some independence". Another carer said, "I love spending time with people, I like talking to them about their lives and things they liked to do". We saw some caring and sensitive interactions between staff and people which demonstrated respect and compassion.

Staff told us and we saw photographs of social events and outings that were arranged for individuals and groups, including family members; which enabled people to maintain the relationships that were important to them. For example: a 'mother and daughter' afternoon tea; a 'couples dinner' for partners to come and eat with their husband or wife in a restaurant setting; a 'trip to the races' for a horse enthusiast to spend time with their family and create lasting memories; people were also invited to the owners own home for afternoon tea. This demonstrated that staff cared about people and their families and supported them to maintain important relationships and share occasions together which promoted their wellbeing.

Is the service responsive?

Our findings

People told us which activities they liked and took part in. One person told us, "They have singing and dancing and all sorts", another person said, "Blind man's bluff and singers – I like that." Even though there was a programme of planned activities and events arranged by staff, some people told us they got bored sometimes and would go to their room and watch TV. One person said they like to do this because, "I've got a choice; I've got the controller". Another person said they "Sometimes" got bored, "But not when I'm up here (in their room) watching telly". There were three part time activity workers who arranged activities and events for people including regular 'pub nights' with entertainers, when relatives were invited to join them for a social occasion. Other activities included trips to local garden centres, shops, seaside, afternoon teas, theatre, couples dining, exercise sessions and drives around the peak district to places of interest for people to 'keep in touch' with the local community or reminisce about their lives. They also provided indoor group activities for people to take part in, for example, skittles, quizzes and bingo or more personalised one-to-one activities – colouring books, jigsaws, knitting and sewing. We saw examples of art work around the building that people had created during art sessions, along with photographs of people taking part in various activities and events. People were supported to enjoy a range of activities and maintain their interests and hobbies, either independently or with other people.

The registered manager told us that where possible they encouraged and supported people to maintain their hobbies and interests. On the day of the inspection they were planning to celebrate the 100th birthday of a person the following week with a tea party. The administration manager told us about their latest innovation for capturing people's wishes and aspirations – a book titled, "I Wish I Could". This was where people recorded their wishes and dreams and staff tried to arrange these where possible. For example, they arranged a trip to the horse racing for a person who loved horses and had not been for many years; and a skype call to another person's relatives in a different country. They showed us a letter they had received from Buckingham Palace, when The Queen declined their invitation to attend their summer garden party, which they had arranged to celebrate her birthday. The registered manager told us this invitation was sent at the request of one of the residents, when they were planning the garden party. This demonstrated that the provider supported and enabled people to participate in a varied activity programme, designed with their personal likes and interests in mind.

Relatives told us they were involved in care plan reviews, were notified of changes to care plans and were invited to feedback through annual satisfaction surveys. One relative told us they were invited to meetings to discuss the care of their family member and were asked to sign reviews. They told us, "We went through the care plan together. They expect us to look through them (the care plans) on a regular basis. They want us to contribute so they can get to know her". However, people who used the service were not always included in discussions regarding their care and they were not directly asked to feedback their experiences of care. We found that information was not always shared with people, in ways that they understood. This was of particular concern where people appeared to have fluctuating capacity and clearly felt they were excluded from the review process, and had not been consulted or their wishes were being ignored. This meant that people did not always receive a personalised service which respected their rights and preferences.

People told us they had not been invited to any 'residents meetings' and the registered manager confirmed that they did not have 'residents meetings'. However, they told us about the 'Friends of Morton Grange' (FOMG) meetings, where staff, people and relatives were invited to discuss plans for improvements and plan events. These minutes were included in the monthly newsletter which was available for people, families and visitors. We saw minutes to five meetings and found that the focus of the meetings was planning events and activities. We saw that people and families were informed that windows and carpets were being upgraded in one of the newsletters, but there was no record of consultation or discussion regarding general improvement.

We also saw the results of the latest two 'customer surveys'. The results indicated high levels of satisfaction in the areas reviewed; however, there was no analysis of responses, no separation of responses from people and their families and there was no indication of what had been done in response to the surveys. The registered manager told us they had contacted people individually to discuss their suggestions and fed back results to people and families in their monthly newsletter. We saw the bar chart had been included in the newsletter, but there was no reference to suggestions or comments or areas identified for improvement. This meant that although there were opportunities to feedback, the provider could not assure us they had responded to people's feedback adequately and used it to improve the quality of care.

The provider had a complaints policy in place, families told us they were aware of this and a copy was included in the admission pack and in the bedrooms. People told us they would complain to the registered manager or owner if they were unhappy, or ask their relatives to do it for them. We saw the complaints made during the last six months and were satisfied that they had been processed and concluded to people's satisfaction. However, we found there was no analysis of complaints and no learning had been highlighted in response to the complaints received. This meant that although the provider responded to complaints, there was no evidence to demonstrate that this was used to improve practice or the quality of care for people.

Is the service well-led?

Our findings

We found there were quality assurance systems in place but they were not always effective in identifying areas for improvement. There was a lack of analysis of incidents and accidents which meant that similar incidents occurred repeatedly, as there had been no themes identified or changes put in place to reduce the likelihood of them happening again. For example to reduce the number of unwitnessed falls that had been reported as incidents. There was also no analysis of complaints. The 'spot checks' conducted by the management and nursing team had not addressed the continued problem of unclean medicine trolleys, inaccurate recording of medicines carried forward on MAR charts and the out-of-date medicine in the medicine cupboard. The management team could not demonstrate how they had used feedback or complaints to identify and address areas for improvement. The systems and processes designed to assess, monitor and improve the quality and safety of services were not always effective in reducing risks to people.

We found that record keeping was not always thorough and files were disorganised. When looking at staff records the inspector found it difficult to locate information or identify if information was missing or misfiled. We found examples of poor management of records which made it difficult for the provider to demonstrate that they were following their own procedures. For example, there were two job application forms in one file, it was not clear if they were for different jobs, one of the forms was incomplete, was not signed or dated and did not evidence a full employment history. However, there was a second completed application form at the back of the file. We found this confusing, as it was not clear which application was for the job they were actually doing. In another example, we were told by the administration manager that every staff member completed an annual disclaimer in lieu of renewing Disclosure and Barring Service (DBS) checks and these were filed in their staff file. However, only one could be found for a person who had been employed for over 15 years. The administration manager could offer no explanation for this. A third example found a DBS online was located in one staff file but not the other two. We were told these were kept separate from staff files, but no explanation was offered why this one was in the staff file. Care records were in bulging files and it was not always easy to locate information quickly.

We found not all staff had received supervision in line with the organisations policy, supervisions were not planned in advance and some supervisions had not been recorded. We felt this was not an effective supervision process and did not promote equality in the process, as it was always the senior or supervisor who was in control and supervisions should be a two-way process. There was little opportunity for staff to prepare by not planning in advance; and by not recording the discussions, it would have been difficult for people to keep a track of their progress. We also felt that the emphasis on using supervision to address poor performance or poor practice, meant that staff could consider it to be a negative experience and something to be avoided; rather than a positive experience, which acknowledged their success and supported them to improve. We felt this was poor management practice and not an effective use of the supervision or staff time.

We saw minutes of meetings with nursing staff, where poor cleaning of medicine storage and trolleys had been brought to their attention in June this year, but standards appeared not to have improved. This demonstrated that the quality assurance processes and spot checks were not effective at bringing about

improvements.

People we spoke with did not always express satisfaction with the care they experienced and the response to their requests for assistance. This had not been identified or acknowledged in the audits we saw. This meant the systems in place were not always effective at capturing people's experience of care and the management team could not therefore; make the necessary changes to improve the personal experience for people using the service.

We felt the full impact of dementia on the visual senses had not been fully considered when decorating the building; there was no demarcation of different areas or rooms as almost all the walls were the same colour which could lead to confusion for people experiencing visual or sensory difficulties. There was also a handrail on only one side of the corridors. We felt that environmental and staffing issues had not been fully considered when assessing risks to people, the focus appeared to be on physical and behavioural risks which indicated that risk assessing was not managed effectively.

These examples demonstrated that the management and governance of the service was not effective at identifying and addressing areas for improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff spoke highly of the registered manager and owners of the organisation. They were described as, "Lovely", "Caring" and "In it for the residents"; and we were frequently told that the management team put people first. One person described the registered manager as, "Lovely. She's like a mother hen" and another said, "She's very good". Staff frequently described the registered manager as, "Very approachable" and "Hands-on". One staff member told us, "She is amazing, strict but effective. She gains respect as she is so on-the-ball with everything". They went on to say, "Everything is transparent, mistakes dealt with and move-on". This meant people had confidence in the registered manager and described her management style as open and approachable.

Staff were encouraged to challenge and feedback to each other, in order to improve practice and the quality of care people experienced. There were effective communication channels within the organisation and a member of the management team attended the various staff meetings. This gave them opportunity to give and receive feedback and keep up-to-date with what was happening in the different departments and staff teams. There was an extensive entertainment programme for people, which staff could volunteer to support, or they could attend by paying a small admission fee. Admission fees went into the 'wishing fund' for future activities and events. There were also staff reward evenings planned, which included meals out to a choice of restaurants, as a thank you to staff and volunteers. The service worked closely with the community homecare service based on the same site and invited people from both services to events and activities. There were also strong links with local community services which people visited and representatives of local churches visited people in Morton Grange, if they were unable to access services at the church. This showed the service was open and inclusive. In addition, the service promoted links with the local community.

There was visible leadership and management of the service with both the registered manager and the owner present on the day of the inspection. We were told the owners were heavily involved in the service and it was clear they were well known to the residents, who referred to them by name and spoke easily with them. Staff told us the owners did some of their supervisions and were "Always around". The registered manager said they had good support from the owners and nothing was too much trouble, "Whatever the residents want, they get". They told us about the recent improvements to the accommodation which included new windows, new flooring and new kitchens. One of the units was having a new kitchen fitted on

the day of inspection and a new enclosed BBQ garden had been created outside one of the buildings, which had been well used this year.

Nursing staff told us they were well supported by the management team and felt empowered; as they also had responsibility for supervising care staff and 'management time' to complete audits. They told us there was good support and a budget available for them to complete additional training. This enabled them to improve their own skills and practice, brought benefits to the service and improved the care experience for people. For example, nursing staff had recently completed end of life training, which they told us had already improved the quality of care for people nearing end of life and opened up discussions with people and families, about their options and preferences. Staff were motivated to improve their knowledge and skills; and provide the best possible care for people.

The registered manager understood their responsibilities and met the registration requirements of the CQC by sending in appropriate notifications and providing information as requested. There were clear roles, responsibilities and lines of supervision within the organisation and staff told us they felt supported by the management team and each other.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Diagnostic and screening procedures	People who used the service were not always treated with dignity and their views were not always respected.
Treatment of disease, disorder or injury	
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	Incidents were not analysed and they were not used to bring about improvements to care or to reduce risks to people. People's views and preferences were not routinely considered as part of risk management.
Treatment of disease, disorder or injury	
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 quality assurance systems in place were not effective at identifying poor practice or the dissatisfaction of people using the service. Staff supervisions were not planned or recorded effectively which made it difficult for the provider to manage the performance of the staff team.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	There was not always sufficient staff available to care for people. Staff were not deployed effectively, to meet the needs of individual

Treatment of disease, disorder or injury

people.