London Residential Health Care Limited

Solent Grange

Inspection report

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Date of inspection visit: 9 and 13 October 2014
Date of publication: 29/01/2015

Ratings

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

Overall summary

This inspection took place on 9 and 13 October 2014 and was unannounced. The service provides accommodation for up to 91 people who have nursing or dementia care needs. There were 53 people living at the service when we visited. The service is split into four areas. Sunflower and Daffodil units provided a mix of nursing and dementia care; Bluebell and Juniper areas were joined together to provide dementia care. People and staff lived and worked in each of the units and were able to move freely between them, but spent most of their time in their own areas.

The service had a registered manager in place, who had registered with CQC in December 2013. However, they had given notice of their resignation a few days before our inspection. 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. The lack of a registered manager has been shown to have a detrimental impact on people using the service.

Summary of findings

At the last inspection on 23 June 2014, we issued warning notices requiring the provider to make improvements to the care and welfare of people and the safeguarding practices to keep people safe by 7 August 2014. We also asked the provider to take action to improve the assessing and monitoring of service provision, cleanliness and infection control, safety and suitability of equipment and consent to care and treatment. The provider sent us an action plan on 30 September 2014 stating they were now meeting the requirements of the regulations. We found the provider had improved the safety and suitability of equipment. However, they had not made the necessary improvements to the other areas of concern and were not meeting the requirements of the regulations.

People told us contradictory things about the service they received. Some people were happy and we observed staff showing care, compassion and respect; others were not happy and we heard staff using inappropriate and patronising language. Some staff did not listen to people properly, which resulted in them not receiving the support they wanted. We found there was a wide variation in the quality of care being delivered across the service, so people could not rely on care being delivered in a consistent way.

People's safety was being compromised in a number of areas. The arrangements that were in place to safeguard people from the risk of abuse were not adequate as incidents of unexplained bruising were not reported to the local safeguarding authority for them to investigate. The management of risks relating to people choking or falling were not effective as care plans contained contradictory information and appropriate action was not always taken. This put people at risk of serious harm.

The provider did not have a system to assess the number of staff needed and there were not enough staff on most shifts. Recruitment procedures did not make sure that staff employed had the necessary skills and were suitable to work with vulnerable people.

There was a lack of information for staff about when to administer medicines that people used on an "as required" basis and the administration of people's creams and ointments was not always recorded. Infection control guidance had not been followed in relation to the environment, processes used to clean soiled linen and staff practices. This meant people were not protected from the risk of infection.

Not all staff had received the necessary training and some training material was out of date. There were no systems in place to support staff appropriately, identify their development needs or to check they had learnt from the training. Mental capacity assessments were not carried out and people who knew the person well were not involved in making decisions or helping to plan the person's care.

People were not supported to eat and drink to ensure good health. Some staff did not know how to prepare people's food and drinks to a suitable consistency. Records of what people had eaten and drunk were not fully completed. People's weight was not monitored effectively and action was not always taken when they lost weight. This put them at risk of malnutrition and dehydration.

When personal care was being delivered, or when people became anxious or upset, their privacy and dignity were maintained. However, confidential information about people was left in communal areas and was displayed on notices in people's rooms, which could be seen by visitors.

Some staff knew the people they were supporting well, but others did not. Some people's care plans contained comprehensive information, but others did not or included conflicting information about people's needs. This meant people could not rely on care being delivered in a consistent way.

Although most care plans contained information about people's interests, this was not used to design suitable activities. Most people received little mental stimulation beyond watching televisions that were on in most of the lounges.

There was a complaints policy and a system to record and investigate complaints. We found the latest complaint had not resolved the underlying issue as action had not been taken to update the person's care plan. However, action had been taken in response to a survey of people and their relatives which the provider recently conducted.

Summary of findings

The provider conducted a range of audits. Action had been taken to address some concerns, although the audits had not picked up the issues and causes for concern that we found. The quality of service varied considerably between and within each unit, which meant the system used to assess and monitor quality was not effective.

The provider had recently appointed an operations support manager to provide additional management support to the service by visiting several times each week.

A new deputy manager had also been appointed. Staff were positive about the new management arrangements and said they had started to improve communication and morale.

The service encouraged visitors and family members told us they were kept fully informed about any changes to their relative's condition. Managers were open to feedback and showed a desire to improve.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken 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?

Inadequate

The service was not safe. The provider did not notify the safeguarding authority of incidents of unexplained bruising. Risks of people falling or choking on their food were not managed safely, nor were environmental risks.

There were not always enough staff to provide safe and effective care. Pre-employment checks and processes were not robust to ensure the right staff were employed.

Appropriate arrangements were in place for the safe handling, storage and disposal of medicines, but the obtaining, administering and recording of medicines were not always safe.

Although the home appeared clean and well-maintained, guidance on the prevention and control of infections was not followed, clinical waste was not stored securely, protective equipment was not readily available and the risks of cross infection were not managed effectively in the laundry.

Is the service effective?

Inadequate

The service was not effective. Staff had completed most, but not all, essential training and not all training was effective. There was no system in place to support staff and identify their training and development needs.

The requirements of the Mental Capacity Act were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation. Care staff did not have an understanding of Deprivation of Liberty Safeguards and did not know which people they applied to.

People did not receive appropriate support to eat and drink enough. Food and drinks were not always prepared to the right consistency to meet people's needs. Food and fluid charts were not always accurate or fully completed. Action was not always taken when people lost weight.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring. We received mixed views about people's experience of the care they were given. Some interactions between people and staff were positive, but others demonstrated a lack of respect for people.

Some staff used patronising or inappropriate language whilst others were skilled in comforting people when they became upset. People's privacy was protected when they received personal care, but their confidential information was not kept securely.

People or their relatives were not always involved in decisions about their care and treatment.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive. Not all staff were informed about people's individual needs. Care plans did not always contain sufficient information to allow staff to deliver care in a personalised way.

There was a lack of activity provision to meet people's individual needs. Watching television was the only mental stimulation some people could access regularly.

Most people told us they were happy with their care and treatment. However, records of care delivered were not completed fully, so suitable strategies to support people living with dementia appropriately could not be planned.

The provider conducted regular surveys of people and their relatives and used the information to make changes to the service.

Is the service well-led?

Inadequate 

The service was not well-led. Action had not been taken to address previous breaches of regulations we had identified. There was a considerable variation in the quality of service delivered across the service. Whilst in some cases it met people's needs, in other cases it was not adequate. The system used to assess and monitor quality was not effective.

The manager and the Operations Support Manager conducted a range of audits each month. Where concerns had been identified, they were addressed. However, the audits did not identify all the concerns that we found. An audit of staffing needs had not been conducted and arrangements were not put in place to replace staff who the manager knew were leaving.

There was a process in place for recording accidents and incidents, but this was not used to ensure lessons were learnt and action was taken to prevent them occurring again.

There was a lack of continuity in the management of the service, which had had an impact on staff morale, although there were signs that this was improving. The service encouraged visitors and family members told us they were kept fully informed about any changes to their relative's condition.

Solent 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.

This inspection tool place on 9 and 13 October 2014 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor in the care of older people and an expert by experience in dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We also gathered information from Isle of Wight Council Adult Commissioning Unit.

We spoke with 22 people using the service and 13 family members. We also spoke with the provider's Operations Support Manager, the registered manager, the deputy manager, four nurses, 15 care staff, two activity coordinators, three housekeeping staff and the cook. We looked at care plans and associated records for 24 people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection on 23 June 2014, we found the service was in breach of regulations 9 and 11. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required and there was a lack of activity provision. People were not protected from the risk of abuse and appropriate action was not taken when people were found with skin tears or bruises caused by staff through neglect or poor repositioning techniques. We issued warning notices and required the provider to make improvements by 7 August 2014. We also asked the provider to take action to make improvements to infection control arrangements and the maintenance of oxygen equipment. At this inspection, we found oxygen equipment was being maintained safely, but the requirements of the warning notices had not been met and improvements to infection control arrangements had not been made.

People told us they felt safe at the service. Staff were trained in how to safeguard vulnerable adults and knew how to report abuse. The service had appropriate policies and procedures in place to protect people. However, we identified two incidents where people were found with unexplained bruises and safeguarding procedures had not been followed by staff. The incidents had not been investigated to find out how they had occurred; and neither the manager nor staff had considered whether the bruises may have been caused by abuse or neglect through poor moving and repositioning techniques. The incidents were not reported to the local safeguarding authority, in accordance with the local arrangements, so action could be taken to ensure safeguards were put in place to protect people appropriately from the risk of abuse.

The failure to investigate or report incidents of potential abuse is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks were not managed effectively. Three people had been assessed by specialists as being at risk of choking on their food or drinks and needed full support from staff to prevent this. However, we saw these people eating independently without support or supervision. Information in one person's care records gave conflicting information about the support they needed to reduce this risk and staff gave conflicting views about the level of support the person needed. Another person was trying to eat while laid in an unsafe position and we asked staff to re-position the person so they would be safe. These people were at risk of choking because staff did not understand how to ensure the safety of people when they were eating.

The risks of people falling were not managed effectively. Records showed some people had had a high number of falls. Although their risk assessments and care plans had been reviewed, additional measures had not always been put in place to prevent further falls and referrals had not been made to the specialist falls service. One person had fallen eight times in one month, then fell again and broke a bone. Following this, their care plan specified the need for staff to accompany them when walking, for protective mats to be in place next to their bed in case they fell out of bed and for an alarm mat to be in place to alert staff if the person moved about. We saw the alarm had been placed on top of the protective mats, rather than next to them; this was not appropriate as it made the surface unstable to walk on and increased the risk of the person falling. Later, we found the person asleep on another person's bed where no mats were in place to protect them if they fell. We also saw the person walking on a hard surface wearing socks on one occasion and an insecure slipper on a second occasion. Inappropriate footwear put the person at greater risk of falling.

A person had been referred to their GP after a series of falls, but the GP did not feel a referral to specialists was appropriate. Staff did not review the person's risk assessment or put other preventative measures in place and care records showed the person continued to fall regularly. The bed rails had failed on another person's bed, causing them to fall out of bed. Two days after the fall, we saw the person was still using the same bed; the bed rails had not been checked to make sure they were operating safely.

A fire risk assessment and an evacuation plan were in place in the event of a fire. However, 19 of the 65 staff had not received up to date fire safety training and three members of staff were not clear about the procedures to follow in the event of a fire or the fire alarm sounding. People had personal evacuation plans, which were kept in an accessible place, although one of these was not accurate in respect of the support they would need if they had to be evacuated. A fire door could not be opened in the Bluebell

unit as no key was available, which put people's safety at risk. We brought this to the attention of the deputy manager, who took immediate action to remedy the problem.

We saw a bottle of sherry and cleaning products left unsupervised in communal areas. These were accessible to people, including people living with dementia, and would put them at risk of harm if they were swallowed. We also saw workmen's tools which were left unattended, presenting a trip hazard to people. These items put people's welfare and safety at risk.

The above issues are a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not use an assessment tool to calculate how many staff were needed on each shift. The deputy manager told us they aimed to have two nurses and 12 care staff in the mornings, two nurses and 10 care staff in the afternoons/evenings and two nurses and five care staff at night. The duty roster showed these numbers were consistently not achieved and day shifts were up to five staff short of the preferred numbers. Although the service sometimes used staff from an agency to cover long-term staff absence, cover for short-notice absence was provided by existing staff working additional hours. The manager told us this was not always possible to arrange due to an overall shortage of staff. They said six staff members had recently left and they were trying to recruit new staff to replace them.

Most people told us staff responded promptly when they called for assistance, although we saw three call bells rang for five minutes before staff responded. One person said, "Staff shortages are common; for example, last night I needed to move as I was uncomfortable and waited nearly an hour for someone to come. I ended up on the floor". Responses to a recent survey of people and their relatives, conducted by the provider, included the following comments: "Staff are very kind, but sometimes, especially at weekends, I feel there is a shortage of staff"; and "[My relative] sometimes slips in the chair and could be there a while if staff are busy".

People were put at risk of unsafe or inappropriate care because staff were unable to spend time ensuring people's needs were met safely. Staff also told us they felt there were not enough staff. We observed staff were rushed, hurrying from person to person to administer medicines, take blood sugar readings or provide personal care. At lunchtime there were not enough staff to support people appropriately; staff repeatedly left people they were supporting on a one-to-one basis to go and help other people.

The above issues are a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment procedures were not robust. The service had recruited several staff using an agency. Staff told us they had obtained and supplied references to the agency themselves. These were addressed to "to whom it may concern", and were not specific to their suitability to work in the care sector. The reference for one staff member was from a person who had known them 10 years ago. Records of interviews with staff members did not provide evidence of their suitability for the role. For overseas staff, a British criminal records check was conducted on their arrival in this country, but there was no evidence of a similar check conducted in their country of origin The checks and procedures conducted did not enable the provider to demonstrate that staff were of good character and had the skills and experience necessary to work with vulnerable adults.

Two prospective staff members had been allowed to live in one of the rooms at Solent Grange before criminal record checks had been completed to ensure they were of good character. Whilst living in this room, they were not supervised and had full access to people using the service and their property.

This is a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines. However, the obtaining, administration and recording of medicines were not safe. One person who needed an antibiotic did not receive it for four days after it had been prescribed. This meant their recovery from an infection would have been delayed. Another person who had been prescribed a lotion for a skin condition did not receive it, which meant they would have suffered discomfort due to itching. Records for the administration of topical creams and ointments were not completed and did not contain full information about where they should be applied. Not all creams had a date of opening recorded, so there was a risk they would be used

Inadequate

Is the service safe?

beyond their "use by" date. There was no guidance in place for staff about when to administer some "as required" medicines, such as laxatives and sedatives, so people may not have received these when needed.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. These measures had not been taken in relation to the environment, processes used to clean soiled linen and staff practices. The service had an infection control policy. This required staff to receive refresher training in infection control every year. The manager told us not all staff had received this training. An infection control audit and an 'Annual Statement on infection Control' had been completed and action had been taken to address concerns identified. However, infection control risk assessments had not been completed which are required by the Code of Practice to ensure risks are identified and managed safely to prevent people getting infections.

Clinical waste was not stored securely and was accessible to visitors. One person was suspected of having an infectious skin condition, but staff did not take appropriate precautions to prevent this being spread to other people. Personal protective equipment (PPE), including disposable aprons and gloves, was not readily available to staff in key places, such as bathrooms. We observed a staff member carrying an armful of soiled linen by holding it close to their chest; they were not wearing an apron or gloves and the linen was not bagged.

In the laundry room, there were no disposable aprons available and staff there told us they didn't usually wear them. The sink was used to soak soiled items of clothing, so was not always available for staff to wash their hands. There was no process in place to prevent clean laundry being contaminated by dirty laundry. Cleaning records were not fully completed, so the provider was unable to confirm that cleaning had been completed in accordance with their cleaning schedules. The failure to follow good infection control procedures put people, staff and visitors at risk of developing infections.

The above issues are a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

At our last inspection on 23 June 2014, we asked the provider to take action to make improvements to their arrangements for obtaining and acting in accordance with the consent of people. At this inspection, we found the necessary improvements had not been made.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

Staff showed some understanding of the legislation in relation to people living with dementia. For example, we heard people being asked for their consent before care or treatment was given. However, care plans contained no evidence to show that people who had capacity, had consented to the care and treatment that had been planned for them. Assessments of the ability of people, including those living with dementia, to make decisions had not been made and the principles of the MCA were not followed. For example, bed rails were being used to prevent some people falling out of bed. One person had the capacity to agree to them being used, but this had not been sought. Staff told us another person did not have capacity to give consent but there was no record to show how this had been assessed or that the decision to use bed rails had been taken in their best interests. Decisions had been made on behalf of other people, but there was no evidence to show that people who knew the person well had been involved. The relative of one person had signed their consent to the person receiving a vaccination and a medical investigation. However, the provider was unable to show that the relative had the legal right to make such a decision or that the person lacked the capacity to make the decision. This meant decisions may not have been taken in accordance with people's wishes.

Not all staff had an understanding of Deprivation of Liberty Safeguards (DoLS) and how they should be applied to people's care. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. One person had a DoLS authorisation in place and the manager had made applications in respect of three other people. However, the care record for the person subject to DoLS contained no information about this or how staff should support the person if they tried to leave the building. Staff caring for the person were not aware that the person was subject to DoLS. Another staff member told us people were not allowed to leave the building without supervision. This meant people who were not subject to DoLS authorisation were having restriction placed on their movements.

The above issues are a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A programme of induction training was in place which was completed by all new staff. In addition, new staff 'shadowed' experienced staff by working alongside them until they were confident in their role. The manager told us one staff member had done this over an extended period to ensure they were competent. Training records showed staff had completed most, but not all, of the essential training required by the provider. For example, 21 of the 65 staff had not completed update training about moving and handling people safely. This put people at increased risk of injury when being moved or repositioned.

We found the quality of staff training was not adequate. Staff told us most training was done by viewing DVDs. Some DVDs were not up to date, such as one relating to an end of life pathway that was no longer used. The DVDs included a knowledge check at the end of the training which staff could complete to assess whether they had gained the necessary knowledge. However, there were no records to show which staff had completed these knowledge checks. The provider could not be sure that staff had understood the training, and there were no systems to assess the competence of staff to deliver the care. One person told us staff lacked knowledge of a condition which affected their mobility from one day to the next. They said, "[Staff] say 'you could walk across the room last week, why can't you today?' They just don't understand the condition". This meant people may not have received appropriate support in line with their varying needs.

There was no system in place to support staff development through the use of one-to-one sessions of supervision and appraisal. Although some staff had received sessions of supervision, these had been held as part of a disciplinary process rather than to support them with their personal and professional development. One member of staff told

us about a group session of supervision they attended following our previous inspection, which they described as a "telling off". One staff member had been given one-to-one supervision following two errors in the administration of medicines. The recorded outcome was for them to receive additional training, but there was no record to show they had received this. The deputy manager told us this person still administered medicines regularly. Another staff member was given a session of supervision because they were unable to communicate effectively with people living with dementia. However, no action was planned or taken to address this to help them understand and meet people's needs better.

Staff did not receive appraisals to assess their performance or identify training and development needs. The records for a staff member who had been employed for 18 months showed they had not received any sessions of supervision, appraisals or reviews of their performance. This meant the provider was unable to confirm staff were working to an appropriate standard.

The above issues are a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not supported to eat and drink enough to meet their needs. We observed the lunchtime meal on the first day of our inspection. People who had been assessed as needing one-to-one support to eat did not receive it in a consistent way. While staff were supporting these people they were also trying to prompt and serve food to other people. This meant that people did not receive the support they needed in a timely manner. We saw two people tried unsuccessfully to use their fingers to eat a meal of 'Lancaster hotpot'. Two other people were unable to use their cutlery, and were not given support to do so. Not all people who took lunch in their rooms were supported appropriately and two were seen trying, unsuccessfully, to eat the hotpot with their fingers too. On the second day of our inspection, we saw one person was given tea and sandwiches in their room for breakfast, but did not receive any support from staff to eat them. As a result, their tea went cold and they only ate half of one sandwich. We saw staff take cold, uneaten breakfasts from the rooms of other people who had not been given the necessary support.

Care records showed some people had developed repeated urine infections. When the infection was present, people were encouraged to drink well and staff were instructed to monitor the person's fluid intake. However, once the person had recovered from their infection this encouragement and monitoring did not continue. Adequate fluid intake is not only important to help treat a urine infection but is also important to reduce the risk of repeat infections. Failure to encourage and monitor the fluid intake of people who had a history of urine infections put them at risk of developing further infections.

A notice on the bedroom wall of a person who was receiving nursing care said, "I like to have jam sandwiches", but did not specify that the person needed jam suitable for a diabetic diet. Another person was given juice drink by one member of staff but another member of staff said the person was allergic to the drink and took it from them before they had drunk very much. These failures put people at risk of adverse reactions.

Not all staff knew how to thicken drinks to a suitable consistency to meet people's needs and prevent them choking. For example, we saw one person's drink had been thickened more than it needed to be and was almost solid. Some staff did not understand what a 'soft diet' was. A person who needed a soft diet was given a meal, without any support, that had not been softened. Another was given a meal that had been softened, but was not supported to eat it for 20 minutes, during which time it had gone cold.

Some people had their weight monitored effectively and action was taken if they started to lose weight. However, three people who had lost weight were not weighed regularly and did not always receive the nutritional drinks as specified in their care plans.

The above issues are a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The food and fluid charts used to monitor the amount people ate and drank were not always accurate and fully completed. For example, we observed one person eat less than half their main meal, but their records later said they had eaten all their meal. There were also gaps in the records, where people's fluids intake had not been recorded. Information recorded in the kitchen about people's dietary needs was not up to date and conflicted with information found in other records, which put people at risk of receiving unsuitable food.

Inadequate

Is the service effective?

This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People received healthcare from the trained nurses at Solent Grange. This included wound dressings, blood sugar monitoring and insulin injections. Records showed people were seen regularly by GPs, dentists, opticians and chiropodists. Where people needed to see specialists, such as speech and language therapists, records showed they saw them promptly in most cases. The relative of one person said, "If [my relative] is poorly, a doctor is always called and one of the nurses always calls to tell me".

Requires Improvement

Is the service caring?

Our findings

Records showed people, or their families, had been involved in decisions about resuscitation and one family member told us they had been involved in discussing their relative's care plan. However, all but one person we spoke with were unaware of their care plans and said they had not been involved in making decisions about their care. One person told us that before arriving at Solent Grange they had been involved in decisions about the medicines they took for a particular condition. However, since arriving, they had not been given the opportunity to be involved in these decisions and were now not aware of which medicines they were being given. Care plans contained no records to show this person, or other people, had been involved in planning their care and treatment. Where people had dementia, there were no records to show family members and people who knew them well had been consulted about the person's values or wishes in relation to their care. Consequently, people may not have been receiving care and treatment in the way they wished to receive it.

We observed examples where staff were not attentive and caring towards people, particularly towards people who were unable to communicate their needs. While supporting people to eat, two staff members repeatedly called across the dining room to check if other people needed any support. The people they called to were unable to respond, so this was not effective and disturbed other people, including those living with dementia, who needed a peaceful environment to encourage them to eat well. There were times when staff offered some people a choice of dessert but not others. We observed staff using patronising language, such as "are you eating nicely?" and using child-like versions of people's names. One person told us that when two members of staff were supporting them, "sometimes they revert to their own language between themselves". They added that a staff member had referred to their personal possessions by asking, "What's all this rubbish?" which they said upset them and "wasn't a nice way to refer to my worldly possessions".

Some staff demonstrated a lack of respect for people. One person became restless while waiting for their meal at lunchtime and left the dining room. A staff member responded positively and encouraged the person to return by offering to get them some soup, which they liked. The person sat down and the staff member asked kitchen staff for a bowl of soup for the person. The kitchen staff member responded by using an offensive expression which was audible to people in the dining room. When another person got up from the table during lunch, a staff member held them firmly by the arm and steered them to another table without checking this was where they wanted to go.

Staff did not always communicate effectively with the people they were supporting. For example, referring to a food item they were being given, one person said, "Don't give me that stuff, please", but the staff member continued to give the person more of that food item. Another person asked, "Can I have some more swede please?", but the staff member replied, "Would you like some cheesecake?", which they then gave them. Other people, such as those living with dementia, appeared to be confused by questions they were asked by staff; this resulted in one person being left alone in the lounge, when they had wanted to be taken to the dining room.

However, other staff treated people with warmth and interest. They knew the people they were caring for well and were able to deliver care in the way the person preferred. We observed some positive interactions between staff and people. For example, when a staff member helped one person put their socks on and gave another person a cup of tea, they spent time chatting and engaging with them. When people became upset or anxious, staff offered comfort and support by speaking kindly and using touch appropriately. In one of the dining rooms at lunchtime, some staff showed care and compassion while supporting people to eat. They asked people where they wanted to sit, whether they wanted the radio on and gave them a choice of meals.

People's privacy and dignity were maintained when they became anxious or upset. When one person started to undress in view of other people, staff responded quickly to cover them with a blanket and take them to a private place where they were supported appropriately. Staff knocked on people's doors before entering and ensured doors were closed when they were delivering personal care. When a large group of family members visited their relative, we saw they were given the privacy of one of the lounges to spend time with them.

When we asked people about their experience of living at Solent Grange, we received mixed views. One person said, "It is alright here". Another person said of the staff, "They're

Requires Improvement

Is the service caring?

very gentle with me; they're very helpful". The relative of another person said of the staff, "They are very good to [the person]", but added that some staff members had "less bedside manner" than others. Another person told us "I don't like it here".

Responses to a recent survey of people and their relatives, conducted by the provider, included the following positive comments: "Staff are cheerful, smiling, gentle and helpful"; "Staff evidently care"; and "All the staff are very approachable. Less positive comments included: "Some of the newer nursing staff seem to be at a loss about how to relate to patients as well as they should"; and "Do so many radios and TVs need to be on so loudly?"

The failure to involve people in decisions about their care and the lack of dignity and respect show to people are a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In people's bedrooms, we saw notices and sensitive information prominently displayed in people's rooms about the care and support they needed. This was intended to provide staff with key information to support the person appropriately, but it was visible to visitors and other people using the service. We saw people's care plans left in one of the dining rooms and two of the lounges; these contained confidential information about people and were accessible to people not authorised to view it. This compromised the privacy and confidentiality of people's personal information.

This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had recently attended "dignity training". Although one staff member could not tell us what they had learned, other staff described the training as "really good" and explained how they would use it in their day to day practice. The service had also appointed "dignity champions" recently, to take the lead on dignity issues and pass on good practice to others, but these roles were still being developed.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 23 June 2014, we found the service was in breach of regulation 9. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required and there was a lack of activity provision. We issued a warning notice and required the provider to make improvements by 7 August 2014. At this inspection, we found the requirements of the warning notice had not been met.

There was a lack of activity provision to meet people's individual needs. A notice in one of the lounges advertised activities including "foot spa, manicure, quiz or anything else of your choosing, just ask a member of staff". A family member told us their relative received aromatherapy and said, "there is bingo, cooking and outside BBQ's in the summer". We saw two people were provided with daily newspapers. Besides this, we found most people received little mental stimulation beyond watching televisions that were on in most of the lounges. Care plans for people living with dementia, who were unable to communicate well contained information about their backgrounds and interests; however, this information had not been used to design activities that were relevant to them and provide appropriate mental stimulation. A response by a relative to a survey conducted by the provider said, "TV alone is not enough to stimulate [the person]". Activities staff told us of trips they organised to local attractions and of plans to increase the level and relevance of activities they organised. However, they said the current provision was "not really enough". Consequently, people's welfare needs were not met.

Some staff demonstrated a good understanding of certain people, their health status and current care needs, particularly those staff who worked consistently in areas of Solent Grange with people they knew well. Other staff, for example those who were not working with people they supported often, were less informed about people's needs. In these cases, where people were living with dementia and were unable to communicate their needs well, staff had to rely on people's care plans to guide them. Some care plans we viewed contained a high level of detail about people's daily routines, how they preferred to be supported and what actions staff should take to meet their individual needs. However, other care plans lacked this level of detail, were not up to date or contained conflicting information about people's current needs. Where staff did not know the people well, and care plans were not adequate, people were at risk of receiving care and treatment that was not personalised to their individual needs.

Care plans consisted of a main record, an abbreviated version which contained monitoring charts, and notices of key information which were kept in people's rooms. The main care plan for one person showed they were registered blind, could only hear clearly in one ear and required a diabetic diet. However, none of this information was available in the abbreviated version or on the notice in the person's room. Staff who did not know the person well would not have known how to communicate with them, or care for them appropriately, without reading through the full care plan. Care staff told us they rarely had time to do this.

The care plan for a person who had been assessed as unable to express their needs or wishes stated that staff should "encourage [the person] to verbalise [their] needs and worries", but did not explain how staff could achieve this or whether alternative means of communication, such as pictures, should be used. The objective of the care plan was stated as "to ensure care needs are met and remains compliant with care in safe environment", but provided no guidance to staff about how they should do this. Two people were unable to use their call bells and no other arrangements, such as regular checks, had been put in place to make sure their needs were being met. The care plan for another person stated that when they were in a "really bad mood" staff should "try to avoid situations which makes [the person] agitated and aggressive"; however, it did not explain which situations made the person agitated or aggressive.

We observed staff respond quickly when a person fell and banged their head. A hoist was used to recover them from the floor; staff explained what they were doing throughout and then conducted observations to check the person had not suffered a neurological injury. However, records showed the same observations were not conducted when another person had a fall from their bed and suffered a head injury. This meant potentially serious injuries may not have been identified.

The above issues are a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Records of care delivered were not always fully completed. For example, one person's behaviour, which was affected by their dementia, was being monitored using a "behaviour chart". This did not give clear information about the behaviour the person displayed or what had triggered it. Therefore, it could not be used to design suitable strategies to support the person appropriately. Records of checks conducted at night and when people were supported to change position were also not always completed. Other records did not confirm that people had received the care and treatment that had been planned; and some used subjective comments such as: "[The person] seems fine today" rather than giving an objective account of the care provided. Therefore it could not be confirmed whether people's assessed needs were being met or that their care was delivered as planned.

This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a complaints policy and a system to record and investigate complaints. We viewed one complaint, relating to a person being socially isolated due to communication difficulties. Following an investigation, the provider's head of operations had responded to the complainant and the manager told us the matter had been resolved. However, we found the underlying issue had not been resolved as the person's care plan had not been developed to reduce their risk of social isolation. The provider had not taken account of this complaint to improve the quality of service provided to the person.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us they were happy with their care and treatment. One person said, "I like to listen to music and they put it on for me; but today I wanted to be quiet, so they didn't put it on". A relative had responded to a survey conducted by the provider saying, "Am very pleased with the level of care [my relative] is receiving". Another relative told us "The care is pretty good, I'm very impressed". A third relative said they were happy with the care their relative was receiving. They told us their relative had developed a pressure injury and we later saw the person had been turned to take pressure off the site of the injury. They also told us the service was trying to obtain a special chair for the person as they tended to slide out of normal chairs, although this was taking a long time.

The provider conducted regular surveys of people and their relatives. We viewed the latest survey and saw comments were mixed. Whilst some people were happy with the service, others were not. The manager told us they had analysed the results and identified a number of concerns about the food and the provision of activities. They had taken disciplinary action and had recruited a new chef; they had also recruited an additional activities coordinator, which showed that had taken account of people's feedback.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 23 June 2014, we identified breaches of six regulations. We issued warning notices requiring the provider to make improvements to the care and welfare of people and the safeguarding practices to protect people who used the service. We also asked the provider to take action to make improvements to four other areas of concern, including the systems used to assess and monitor the quality of service provided. The provider sent us an action plan on 30 September 2014 stating they had addressed all areas of concern and were now meeting the requirements of the regulations.

At this inspection, we found the provider had addressed one of the areas of concern, but had not met the requirements of the warning notices or taken action to address the other areas of concern. This demonstrated that the service was not well led. Concerns which had been highlighted to the management were not addressed adequately and the impact this had on people living at Solent Grange had not been considered.

The manager conducted a range of audits each month. These included medication and staff training. In addition, the Operations Support Manager conducted a monthly audit, using a "monitoring record". This included staffing, infection control, training, recruitment and safeguarding. We found that the audits had not picked up the issues and causes for concern that we found in each of these areas.

Six members of staff had left in the week before our inspection, four of whom management had known about for several weeks. Plans had not been put in place to replace these staff. An audit of staffing needs had not been conducted and there was no system in place to ensure enough staff were employed to allow the service to operate in a safe and appropriate way.

There was a process in place for recording accidents and incidents. These included falls and incidents of urinary infections. The manager told us they reviewed these regularly, but we found there was no clear system in place for learning lessons and taking action to prevent recurrence. This meant the system used to manage risks was not always effective.

We found considerable variations in the quality of service between and within each of the three units currently operating in Solent Grange. Some staff were well trained, experienced and competent, while others were not. Some people's care plans were comprehensive and they received safe, effective care while other people's plans were not adequate and they did not receive appropriate care. This variation, coupled with the failure to address concerns identified at our last inspection, showed there was no effective system in place to assess and monitor the quality of care people received. Consequently, people were not protected from the risk of receiving unsafe or inappropriate care and treatment.

The above issues are a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a registered manager, who had worked at Solent Grange for two years and was registered as the manager in December 2013. The management of the service had not been stable in recent years due to repeated changes of manager; we were told the current manager had also resigned and was due to leave in the week following our inspection. This meant people were not cared for by staff who were motivated and led by a stable, consistent management team. Several members of staff told us morale was not good; a member of staff who had been at the service for several years said of the morale, "It's the worst it's ever been". The instability of management also meant that an appropriate culture and shared values by the staff team had not been developed for the benefit of people using the service.

The provider had recently appointed a regional Operations Support Manager to provide additional management support to their services. A new deputy manager for Solent Grange had also been appointed. Staff were positive about the new management arrangements and felt they would improve communication and morale. For example, nursing and care staff had started attending meetings at the beginning of each shift to share information. However, staff said they had to arrive early, and were not paid, to attend these meetings.

Senior staff told us they felt valued and received support from the provider, including visits by the Operations Support Manager several times each week. Senior representatives of the provider also attended safeguarding strategy meetings to support the manager and obtain

Inadequate

Is the service well-led?

feedback from other professionals about the service. Regular staff meetings were held and minutes showed these had been used to discuss areas of improvement that were required.

The service had a whistle blowing policy in place and staff told us they would be supported if they identified concerns. However, this referred to old legislation and did not contain contact numbers for local agencies. We also we noted that a CQC inspection report on display in the foyer was not the latest report, which had identified some concerns, but a previous report which showed the service to be compliant with the regulations. This demonstrated a lack of openness and transparency.

The service encouraged visitors and family members told us they were kept fully informed about any changes to their relative's condition. Where the performance of staff was raised as a concern, action was taken in a transparent way in accordance with the provider's policies and recorded in staff records. During the inspection, we found the management team was open to receiving our feedback about the service and showed a desire to improve. They told us they had identified the priorities as increasing the levels of staffing and improving the quality of staff training.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs. Regulation 9(1)(b).

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users, and others, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly asses and monitor the quality of services provided and identifying, assessing and monitoring risks relating to the health, welfare and safety of service users and others. Regulation 10(1).

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse. Allegations of abuse were not responded to appropriately. Regulation 11(1) and 11(2).

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person had not ensured that service users and others were protected against the risks of infection. Regulation 12 (1) and 12(2).**

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected service users against the risks associated with the unsafe use and management of medicines. Regulation 13.**

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration. Regulation 14.**

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure people were treated with dignity and respect and involved in making decisions about their care. Regulation 17(1) and 17(2).**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided. Regulation 18.

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them. Regulation 20(1)(a).

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures in order to ensure that people employed for the purposes of carrying on a regulated activity were of good character, and had the necessary skills and experience. The registered person did not ensure that information specified in Schedule 3 was available. Regulation 21(a)(i) and (ii), 21(b) and Schedule 3(1), (2)(b), (3), (4), (5) and (6).

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22.**

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that persons employed for the purpose of carrying out the regulated activity were appropriately supported by receiving appropriate professional development, supervision and appraisal. Regulation 23.**

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.