Christadelphian Care Homes

Garswood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 November 2016 and was unannounced.

Garswood care home is located in a residential area of Southport close to public transport links and Birkdale village. Accommodation is arranged over four floors with lift access to each floor. The home is registered to accommodate 42 people with a dedicated unit to accommodate seven people who have dementia. The service is part of the Christadelphian community but also offers support to people outside of that faith. During the inspection, there were 33 people living in the home.

A registered manager was 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 looked at the systems in place for managing medicines in the home and found that best practice guidance was not always followed when administering controlled medicines. We looked at people's MAR charts and found that there were a number of missing signatures for medicines that had been administered. Audits completed had identified this issue and the registered manager told us they planned to implement an electronic medicines system in January 2017 and hoped that this new system would help to solve this issues.

Most personnel files we viewed showed that relevant checks had been made prior to staff being employed, however one staff member did not have the required checks completed. Since the inspection the registered manager has told us they have applied for a DBS check for this staff member.

We looked at the environment and found that there were not always fire exit signs in sight to guide people to the nearest emergency exit as required. Since the inspection, we have been provided with evidence to show that additional signage has been put in place to ensure people can locate the nearest emergency exit from all areas within the home.

People told us they felt safe living at Garswood and told us there were adequate numbers of staff on duty to meet their needs. Staff however felt they were quite busy at times and the registered manager was looking at recruiting more bank staff to help support people at busy times throughout the day. Staff had a good understanding of safeguarding and how to report any concerns they may have.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. A fire risk assessment was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Internal and external arrangements were in place for checking the environment and equipment to ensure it was safe and well maintained.

We looked at accident and incident reporting within the home and found that incidents were reported and recorded and appropriate actions taken.

There was no record of annual appraisals and some staff had not received a supervision in 2016. The policy for the service stated that staff should receive three supervisions each year as well as a formal annual appraisal. Since the inspection the registered manager has told us more supervisions have been completed and that this will continue.

Applications had been made to deprive people of their liberty appropriately and systems were in place to monitor these applications. Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit.

When able, people signed to evidence agreement with their plans of care. When people were unable to provide consent, mental capacity assessments were completed, however they were not always decision specific and it was not clear when decisions had been made in people's best interest. The registered manager told us they would review the process and since the inspection, has provided us with a copy of their updated process which follows the principles of the MCA. We have made a recommendation regarding this within the report.

Staff completed an induction when they commenced in post and this was in line with best practice requirements. The induction included training as well as competency being assessed by senior staff. On-going training was available to staff and records showed that most staff completed this regularly.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

People we spoke with told us they always had a choice of meal and enjoyed the food provided. Staff we spoke with were aware of people's nutritional needs, including specialised diets and allergies to certain foods.

We found that the provider had made some adaptations within parts of the home to help support people and promote their independence, such as pictorial signs on bathroom doors and orientation boards which advised people which staff were on duty, what activities were available and what the weather was like that day.

People living at the home spoke very highly of the staff and told us they were kind and caring and treated them with respect. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. Most bathrooms had internal locks on them to help maintain people's privacy and support with personal care was provided in private.

Interactions we viewed between staff and people living in the home were warm, meaningful and familiar. People told us that staff knew them well, including their needs and preferences and encouraged them to maintain their independence.

Care files were stored securely both electronically and in paper format in order to maintain people's confidentiality.

People's faith was acknowledged and respected. Garswood is part of the Christadelphian community and supports people to meet their religious needs. For example, daily bible readings are available for people to

attend as well as a fortnightly service within the home. Garswood also offers support to people outside of this faith and a number people living in the home did not share this faith but told us that their needs were met.

We observed relatives visiting during the inspection and people told us their relatives could visit at any time. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

Details for a local advocacy service were available within the home for people to access, however the registered manager told us all people currently living in the home had family or friends that could help support them and nobody was using advocacy services.

Care plans we viewed showed that people and their families had been involved in the creation and review of their planned care. Care plans were specific to the individual person and were detailed and informative regarding people's needs.

Care files contained information regarding people's life histories. It also included details regarding people's preferences in relation to their care. This helped enable staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences. People told us they were able to make choices about how they spent their day.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff, use of a communication book and through viewing people's care files.

We asked people to tell us about the social aspects of the home and responses were positive. People described a wide range of activities that were available, including regular trips out in the minibus, bible readings, singing, music, games and reading.

There were processes in place to gather feedback from people, including quality assurance questionnaires and regular resident meetings. People had access to a complaints procedure within the home and this provided contact details of relevant people.

Systems were in place to monitor the quality and safety of the service. Although audits completed had identified some of the concerns highlighted during the inspection, not all of the issues were picked up through the providers audits. We also found that actions identified through audits were not always addressed.

We asked people their views of how the home was managed and feedback was positive. It was clear from our observations that people living in the home knew the registered manager. Relatives we spoke with all told us that they felt the home was managed well.

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had.

Regular staff meetings were held to ensure views were gathered from staff. Staff told us they were able to share their views during these meetings and they felt they were listened to.

The manager had notified CQC of most events and incidents that occurred in the home in accordance with

our statutory notifications.

You can see what actions we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely within the home.

Not all safe recruitment practices were followed prior to staff being employed.

There were not always fire exit signs in sight to guide people to the nearest emergency exit as required.

People felt safe living at Garswood, there were adequate numbers of staff on duty and staff we spoke with were aware of how to raise any concerns they may have.

Is the service effective?

Requires Improvement

The service was not always effective.

There was no record of annual appraisals and some staff had not received a supervision in 2016.

When people were unable to provide consent, mental capacity assessments were completed, however they were not always decision specific and it was not clear when decisions had been made in people's best interest. We made a recommendation regarding this.

Applications had been made to deprive people of their liberty appropriately.

Staff were supported in their role through induction and on-going training.

Feedback regarding meals was positive and people always had a choice of meals.

Is the service caring?

Good

The service was caring.

People living at the home spoke very highly of the staff and told

us they were kind and caring and treated them with respect.

Interactions we viewed between staff and people living in the home were warm, meaningful and familiar. Staff knew people well, including their needs and preferences and encouraged them to maintain their independence.

People's faith was acknowledged and respected.

We observed relatives visiting during the inspection and people told us their relatives could visit at any time.

Is the service responsive?

Good

The service was responsive.

Care plans showed that people and their families had been involved in the creation and review of their planned care. Care plans were specific to the individual person and were detailed and informative regarding people's needs.

Care files contained information regarding people's life histories. It also included details regarding people's preferences in relation to their care.

There was a wide range of activities available for people to participate in.

There were processes in place to gather people's feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective. Actions identified through audits were not always addressed.

Feedback regarding the management of the home was positive.

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had.

Regular staff meetings were held to ensure views were gathered from staff. Staff told us they were able to share their views during these meetings and they felt they were listened to.

The manager had notified CQC of most events and incidents that

occurred in the home in accordance with our statutory notifications.

Garswood

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 4 November 2016 and was unannounced. The inspection team included an adult social care inspector and an expert by experience with an expertise in older people's services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, deputy manager, an activity coordinator, four members of the care staff, 11 people living in the home, one relative and three visitors to the service

We looked at the care files of four people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home.

Controlled drugs were stored in a separate locked cupboard and a register of their administration was in place. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We observed however, that best practice guidance was not always followed when administering controlled medicines. For example, two staff members counted the medicines and signed the controlled drugs register; however the witness did not check the MAR chart or witness the administration. The staff were working within the company's policy; however this is not in line with current safe medicine guidance (NICE guidance 2014).

We looked at people's MAR charts and found that there were a number of missing signatures for medicines that had been administered. Audits completed had identified this issue and the registered manager told us they planned to implement an electronic medicines system in January 2017 with the aim that this new system would help to solve the recording issues.

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

A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Staff told us they staff had completed training in relation to safe medicine administration and records we viewed showed that they had had their competency assessed at least once in the past year.

Medicines were stored in trolleys locked to the wall in a locked clinic room. The temperatures of the room and the medicine fridge were monitored daily and were within the safe range. We saw evidence of appropriate PRN (as required) protocols and records in place. PRN medications are those which are only administered when needed for example for pain relief. When people were self-administering their medicines, relevant risk assessments and records were in place.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place in most files. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found however that the dates of references and DBS checks were often dated after the person had commenced in post. The registered manager told us this was due to staff undertaking induction processes prior to formally commencing in post. We also found that one staff member's file did not have any evidence of a DBS check.

We discussed this with the registered manager who told us they believed, because of the person's role, they did not require these checks. Since the inspection the registered manager told us they had applied for a DBS check for this staff member. They also said that the organisation had looked at their responsibilities as a whole company in relation to DBS checks and changed their procedures across all homes accordingly. Evidence of this was subsequently provided.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home was staffed. On the first day of inspection there were nine members of the care staff on duty, as well as the registered manager, deputy manager, activity co-ordinator and kitchen and domestic staff. The registered manager told us there was no staffing analysis used to determine staffing levels, but that they altered staffing levels based on feedback from staff. The registered manager told us that they believed staff had less time to talk to residents recently and so they were looking at increasing staffing levels and recruiting more bank staff to ensure staffing levels are adequate to meet people's needs.

People living in the home told us there were always enough staff on duty and that staff responded in a timely way when they requested support. People told us when they pressed their call bell, "[Staff] come very quickly" and "[Staff] come as quickly as they can; 2 to 3 minutes usually." Staff we spoke with told us that staffing levels were generally fine although they could be quite busy at times, especially in the evening when there are less staff on duty.

All people we spoke with told us they felt safe living in Garswood. When asked if they felt safe, one person told us, "Totally safe; I'm not aware of what the regulations are, but [staff] are. There are two types of fire extinguisher and [staff] remind us to use [walking aid] and the lift." Another person replied, "Yes, the doors are locked but you're not locked in." A third person told us, "We know we are safe here."

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, bed rails, choking, nutrition, moving and handling and pressure relief. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as the use of pressure relieving equipment when necessary. A fire risk assessment was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire.

We looked at the environment and found that there was not always fire exit signs in sight to guide people to the nearest emergency exit as required. We discussed this with the registered manager and since the inspection, we have been provided with evidence to show that additional signage has been put in place to ensure people can locate the nearest emergency exit from all areas within the home.

We looked at accident and incident reporting within the home and found that incidents were reported and recorded and appropriate actions taken.

Arrangements were in place for checking the environment and equipment to ensure it was safe. External contracts were in place to ensure safe provision of gas, electricity, passenger lift, fire fighting equipment, lifting equipment and the fire alarm system. We viewed certificates from these checks and they were in date. Regular internal checks were also completed and recorded for the fire alarm, emergency lights, hot water boiler, profiling beds, water temperatures, fire doors, automatic door closures and portable appliance (PAT) testing.

We spoke with staff about adult safeguarding and how they would report any concerns. All staff we spoke with had a good understanding of the safeguarding process and told us they would inform the manager or deputy and that one of them were always available out of hours. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made to the local safeguarding team.

There were no concerns raised regarding the cleanliness of the home. One person living in the home told us the home was, "Very clean. I wouldn't be here if it wasn't" and another person told us, "My family did the research and that's one of the things they looked for; it's very clean."
We found that the home to be clean and well maintained. Hand gel, liquid soap and paper towels were available in line with best practice to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

Staff told us they felt very well supported in their role and that they could approach the registered manager or deputy if they had any issues they needed to discuss. We found however, that there was no record of annual appraisals and some staff had not received a supervision in 2016. The policy for the service stated that staff should receive three supervisions each year as well as a formal annual appraisal. The registered manager was aware of this and an audit completed in October 2016 identified that staff supervisions and appraisals were behind and were to be the main area for improvement in the next quarter. Since the inspection the registered manager has told us more supervisions have been completed and that this will continue.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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).

The registered manager told us there were four authorised DoLS in place and records showed that other applications had been made appropriately. An electronic care file system alerted staff as to who had an authorised DoLS in place and also when an application had been made. Expiry dates were recorded on the system so staff were alerted when a new application was required. Records showed that all senior staff had completed MCA and DoLS training and staff we spoke with confirmed this.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we heard a staff member explaining to people the medicines they were administering to them and asked each person if they were happy to take it.

Care files we viewed included a care plan agreement document and when able, people signed these on a regular basis to evidence their consent to the planned care. When people were unable to provide consent, mental capacity assessments were completed and these were evident in people's care files. We found however, that these were not always decision specific. The second part of the process, once a person's capacity had been established, looked at individual decisions in areas such as medical needs and finances. When it was recorded that a person lacked capacity, there was no clear evidence that decisions had been made in their best interest, involving the relevant people. The registered manager told us they would review the process and since the inspection, has provided us with a copy of their updated process which follows the principle of the MCA.

We recommend the service review's its processes in relation to gaining and recording consent and updates it's practices accordingly.

We looked at how staff were inducted into their job role. The deputy manager explained that all staff completed a questionnaire based on the requirements of the Care Certificate to establish what elements were required for each individual staff member. The care certificate is an identified set of standards that health and social care workers need to achieve and have signed off by a senior member of staff. We viewed completed observation logs for new staff which covered the required standards.

Induction records also showed that staff completed training considered mandatory by the provider as part of their induction. Training was provided on a regular basis in areas such as medicines management, first aid, food safety, moving and handling, safeguarding and infection control. Staff we spoke with told us they received adequate training and could always request additional courses if they wanted to develop further. Courses that the provider did not consider mandatory were also available to staff and records showed that staff had completed training in areas such as diabetes, dementia, challenging behaviour and palliative care. People we spoke with told us they felt staff had the necessary skills to support them

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The registered manager told us they had a very effective working relationship with the local GP practice. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, dietician, chiropodist and optician. People living in the home told us they could see a doctor if they were unwell and that staff arranged this for them quickly.

We observed the lunch time meal in the dining room and found that tables were laid and there was a relaxed atmosphere in the dining room. Lunch began with a person living in the home saying grace and people appeared relaxed and chatted to each other during the meal. Meals were appetising and nutritionally well-balanced. People appeared to enjoy their meals and when asked about the food people told us, "The food's very good" and, "Meals are super." There were menus available and all people we spoke with told us they always had a choice of meal. We observed staff checking that people were happy with their meal and support was provided discreetly when required. For instance, we observed one person who was eating very little and was prescribed fortified drinks, but was not drinking them. Three different staff members took the time to offer encouragement to drink sufficient amounts. They warmed the drink up, changed the cup it was served in and offered reassurance and support. Staff we spoke with were aware of people's nutritional needs, including specialised diets and allergies to certain foods.

Hazlewood is a small unit within Garswood that provides support for up to seven people living with dementia. We found that the provider had made some adaptations within this unit to help support people and promote their independence. For example, there were pictorial signs on a bathroom door to help orientate people and bedrooms contained pictures of something significant to each individual. There were orientation boards in the lounge which advised people which staff were on duty, what activities were available and what the weather was like that day.

Good

Is the service caring?

Our findings

People living at the home spoke very highly of the staff and told us they were kind and caring and treated them with respect. One person told us, "The staff are all very helpful" and another person said, "[staff member] is lovely." When asked what it was like living in Garswood, people told us they enjoyed it and comments included, "I love it", "It's very nice here, like a hotel", "The atmosphere of the place is friendly" and "It's wonderful." Another person said, "That's the spirit of the place, friendliness and cooperation; adaptability of staff to residents and residents to staff."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. We observed one person being supported to transfer using a hoist. Staff explained what they were doing each step of the way and offered the person reassurance. Staff used blankets to ensure the person's privacy was maintained whilst using the hoist. Most bathrooms had internal locks on them to help maintain people's privacy and support with personal care was provided in private. The registered manager told us the bathroom we observed with no lock in place was usually only used by people who received support from staff to access the bathroom. We also saw staff receiving training on how to support a person with a new piece of equipment and this was completed discreetly, with staff focus on the person and assuring their comfort, as well as the learning.

Interactions we viewed between staff and people living in the home were warm, meaningful and familiar. We heard a conversation between staff and people living in Hazlewood regarding matters of interest to them, such as the pet cat they shared and outings they had been on together.

People told us that staff knew them well, including their needs and preferences. One person told us how they enjoyed music and the registered manager was in the process of arranging a CD player so they could listen to their favourite music in their room. Another person told us that staff knew people so well; they bought each person living in the home an individually chosen Christmas present based on what they liked. This person also told us that staff knew what they enjoyed doing and arranged individual activities for them, such as cake decorating. Another person told us, "They know their people here."

People told us staff encouraged them to maintain their independence. One person told us, "If you need help, they'll help you; if you don't you can just get on with things, but you'll always get the help you need." Care plans we viewed were written in such a way as to guide staff to encourage people to be independent and clearly recorded care people needed support with, as well as care needs people were able to meet themselves.

Care files were stored securely both electronically and in paper format in order to maintain people's confidentiality.

The registered manager told us that people's faith was acknowledged and respected. Garswood is part of the Christadelphian community and supports people to meet their religious needs. For example, daily bible

readings are available for people to attend as well as a fortnightly service within the home. Garswood also offers support to people outside of this faith and a number people living in the home did not share this faith but told us that their needs were met. One person told us they felt under no pressure to attend the daily bible readings and the registered manager told us clergy from the Roman Catholic church attended the home at people's request.

We observed relatives visiting during the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with agreed and relatives told us they were able to visit their family members in private. When people move into the home, they are also matched with a member of the Christadelphian community who the registered manager told us were referred to as 'special friends'. Their role was to provide friendship and support to people and visit them regularly. We observed a number of these friends visiting during the inspection.

Details for a local advocacy service were available within the home for people to access, however the registered manager told us all people currently living in the home had family or friends that could help support them and nobody was using advocacy services.

Good

Is the service responsive?

Our findings

Most care plans we viewed showed that people and their families had been involved in the creation and review of their planned care. This was evident through signed care plan agreements and records from family confirming they had read their family member's care plan. The care plans we viewed were reviewed regularly and the reviews were detailed and informative. This helped to ensure that care plans provided clear information regarding people's current care needs.

Care plans were specific to the individual person and were detailed and informative regarding people's needs. We observed care plans in areas such as hygiene, mobility, nutrition, communication and continence. A care plan summary was available which provided an overview of people's care needs and helped to ensure all staff had accessible information about the person and the support they required.

We viewed a number of care files that contained a pre admission assessment; this helped to ensure the service was aware of people's needs and that they could be met effectively as soon as people moved into the home.

Care files contained a 'This is me' document which provided information regarding people's life histories, occupations and family members. It also included details regarding people's preferences in relation to their care, such as what activities they liked to participate in, what time they usually chose to get up of a morning and nutritional preferences. Care plans also reflected people's preferences and wishes in areas such as end of life care, how their medicines were managed and daily routines. For instance, one person's plan advised staff they liked to be woken each morning at 6.30am with a cup of tea. Another person's plan advised staff they liked to read the bible at night time if they were unable to sleep. This helped enable staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences and told us they were able to get to know people well. For example, all staff we spoke with were aware of people specific dietary requirements, such as whether fluids needed to be thickened or if people had any allergies.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff, use of a communication book and through viewing people's care files. Staff told us that if they had been on holiday, they always received a very detailed handover to ensure they were aware of any changes and that they could meet people's current needs. Relatives we spoke with agreed they were kept informed of any changes and one relative told us, "We are always informed of any medical needs, even something slight."

People told us they had choice as to how they spent their day, such as where to eat their meals, where to sit and socialise, whether to join in activities, listen to bible readings or spend time in their rooms. Care files also evidenced people's choice with regards to the support they received on a daily basis. Staff we spoke with agreed and told us people always had choice in how they spent their day, what food they ate and what

activities they wanted to participate in.

We asked people to tell us about the social aspects of the home and responses were positive. People described a wide range of activities that were available, including regular trips out in the minibus, bible readings, singing, music, games and reading. Activity 'menus' were available on dining room tables which advised people what was on offer and people we spoke with found these really useful. When asked about activities, people's comments included, "They like to keep us busy and there are dozens of magazines and papers", "There are papers every day, like a hotel. We have lots of things to do" and, "There's plenty of activities going on."

Relatives we spoke with told us about the 'Friends of Garwood' who visited and supported people to visit places regularly, such as Martin Mere, garden centres and a model railway village. One relative told us, "There's always a lot going on."

There were two activity coordinators employed within the service and one of the coordinators told us they tailored activities to meet the individual needs and capabilities of people living within the home. During the inspection we observed a number of people participating in a bible reading and later in the day there was a word game activity, based on current affairs which people appeared to enjoy and was both humorous and challenging for people. We also observed music being played in one area of the home, there was a piano, fish tank and reminiscence boxes designed to stimulate conversations with people. People had individual activity care plans which reflected what activities they enjoyed. One activity plan we viewed, for a person who was unable to inform staff what they enjoyed due to confusion, showed that they enjoyed music and this had been established when staff observed them tapping their feet in time with the music.

We looked at processes in place to gather feedback from people and listen to their views. Records showed that residents and relative meetings took place regularly and included discussions on topics such as activities, role of the trustees, developments within the home and discussions regarding the newsletter. People we spoke with told us that they held meetings every few weeks that they were able to have their say and were listened to. One person said, "Yes they listen to us. For example, when someone asked if we have to have The Times newspaper, we had it changed to the Manchester Guardian instead."

Quality assurance surveys were also issued to people to gather their views and those completed in 2016 contained positive comments regarding the service, but as not all had yet been completed, they had not been summarised. The analysis of completed surveys is usually finalised before April each year to allow for any necessary changes to be finances or planned for the following year. The quality assurance report from 2015 provided information on all responses received, including people's satisfaction with communal areas of the home, their bedroom, activities, food, care received and overall satisfaction.

People had access to call bells in their rooms to enable them to call for staff support when required.

People had access to a complaints procedure within the home and this provided contact details of relevant people. People we spoke with told us they knew how to make a complaint and would feel comfortable raising any concerns they had, though nobody we spoke with had had any reason to make a complaint. A complaints log was maintained by the registered manager and the complaints we viewed had been investigated and managed in line with the provider's procedures.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we looked at how the registered manager and provider ensured the quality and safety of the service provided. There were monthly provider inspections recorded, which reviewed areas such as building maintenance, activities, complaints, accidents, review of the quality assurance file and discussions with staff and service users. Following the last inspection in November 2016, no actions were required. The service also had a welfare committee who visited the home and completed audits four times per year. The provider had also arranged for external medicine audits to be completed and actions identified had been addressed. Required improvements identified by other agencies were also completed, such as those identified by the fire service. Cross corridor doors and heat detectors in bathrooms were recommended by the fire service in May 2016 and we saw during the inspections that these had been fitted.

We viewed completed internal audits which included areas such as training, medicines, activities, care plans and health and safety. Although the audits completed had identified some of the concerns highlighted during the inspection, such as the lack of staff supervision and appraisal, not all of the issues were picked up through the provider's audits. For example, an audit of staff files had been completed in August 2016 but this did not identify the lack of DBS check in place for one staff member. We also found that actions identified through audits were not always addressed. For example, the fire risk assessment identified that all staff required training in the use of the newly purchased emergency evacuation equipment. Staff we spoke with however told us they had not been trained to use the evacuation equipment. The registered manager told us this training had been arranged but was cancelled and that it was due to be rearranged. Since the inspection the registered manager has told us this training has been booked and would be completed by the end of November 2016. This meant that systems in place to monitor the quality and safety of the service were not always effective.

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

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. It was clear from our observations that people living in the home knew the registered manager and we saw people chatting to him regularly throughout the inspection. At lunchtime the registered manager joined people for lunch in the dining room which he told us he does every day as it is a good opportunity to speak with people. Relatives we spoke with all told us that they felt the home was managed well. One relative told us, "We haven't been disappointed. The manager does a good job and the staff are really good." Another relative said, "It's got a nice atmosphere here and everyone works hard." Staff told us they enjoyed working in Garswood and comments included, "It's a nice place to work", "People's needs are put first", "We have good bosses, we get kept informed" and "It is one of the best places I have worked."

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

We looked at processes in place to gather feedback from people and listen to their views. As well as resident meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered from staff. Records we viewed showed that separate meetings were held for key workers, senior carers, night staff and care staff. The meetings covered areas such as training, people's care needs, ensuring people had choice and reminders and updates regarding use of equipment. Staff told us they were able to share their views during these meetings and that the registered manager regularly asked them for their views in different areas and they felt they were listened to.

The manager had notified CQC of most events and incidents that occurred in the home in accordance with our statutory notifications. We identified one issue that had occurred within the home that the registered manager had referred appropriately to the local authority for investigation, but had not notified CQC. We discussed this with the registered manager who was unaware they needed to complete the notification as the referral was not progressed, but assured us that they would notify us of any future incidents. This meant that CQC were able to monitor information and risks regarding Garswood.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not always followed when recruiting new staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported in their role through appraisal and regular supervision.