Four Seasons (Granby Care) Limited

Granby Court Extended Care Unit

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?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 22 and 23 September 2015 and was unannounced.

At our last inspection on 5 June 2013 the provider was meeting the regulations that were assessed.

Granby Extended Care Unit (ECU) provides personal care and accommodation for up to 41 older people who require nursing care. The service is a converted hotel with accommodation provided over three floors accessible by a passenger lift. All bedrooms are single occupancy and have en suite facilities. The home is within walking distances of Harrogate town centre and local amenities. On the day of the inspection there were 28 people living at the service.

There was a new manager in post who was in the process of applying to be registered. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

There were adequate numbers of qualified and skilled staff working at the service. However, during our first day of inspection staff were not managed and deployed effectively which placed people at risk of potential harm. We observed staff were not on hand to answer calls bells swiftly or to pre-empt potential risk to people. On the second day of the inspection we observed some improvement, staff were better organised and were available to attend to people's needs in a more timely manner. Staff received ongoing training and management support. They received a range of training specific to the needs of people they supported. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and you can see what action we have asked the provider to take at the back of the full version of this report.**

The service had policies and procedures in place for the recruitment of staff to help ensure that people were protected from unsafe care. However, we found these practices had not always been followed which meant the provider had not verified the quality of practice against professional qualifications prior to staff commencing at the service. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and you can see what action we have asked the provider to take at the back of the full version of this report.**

People and their relatives told us they felt safe at Granby Court. Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They received appropriate safeguarding training and there were policies and procedures to support them in their role.

The service had systems in place for recording and analysing incidents and accidents so that action could be taken to reduce risk to people's safety. Risk assessments were completed so that risks to people could be minimised whilst still supporting people to remain independent.

People received their medicines at the times they needed them. The systems in place meant medicines were administered and recorded properly and this was audited regularly by the service and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

People had their nutritional needs met. People were offered a varied diet and were provided with sufficient drinks and snacks. People who required special diets were catered for. People told us the quality of meals varied and our observations during the inspection indicated the quality of the dining experience was variable.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

People received good end of life care. However, further training with regard to Gold Standard Framework, the six step programme or an equivalent programme of care identified by NHS England as being best practices for Care Homes/Nursing Homes caring for people and their families/carers in the last year of life would enhance end of life care practice and ensure a consistent approach.

People were offered choices, supported to feel involved and staff knew how to communicate effectively with each individual according to their needs. People were relaxed and comfortable in the company of staff.

People told us that they were well cared for and happy with the support they received. We found staff approached people in a caring manner. We found that most of the time people's privacy and dignity was respected. However we observed some incidents where people's dignity was not respected and these were reported to the manager.

People were provided with a range of activities in and outside the service which met their individual needs and interests. Individuals were also supported to maintain relationships with their relatives and friends.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005. This is legislation that protects people who are not able to consent to care and support, and ensures people are

Summary of findings

not unlawfully restricted of their freedom or liberty. The manager and staff understood the requirements and took appropriate action where a person may be deprived of their liberty.

People's needs were regularly assessed, monitored and reviewed. The provider was in the process of amending the current care plan format in order to ensure the information was more easily accessible and person centred.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk to any of the staff if they had a concern or were worried about anything.

Staff and people who used the service spoke positively about the manager. They told us in the short time they had been employed at the home they were supportive and encouraged an open and inclusive atmosphere. People, their relatives and staff were provided with opportunities to make their wishes known and to have their voice heard.

The manager responded well to our feedback after the first day of inspection and we saw immediate improvements and the service had an action plan to address these.

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?

Requires improvement

This service was not consistently safe.

People told us they felt safe. Staff had been trained to recognise and respond to abuse and they followed appropriate procedures.

There were enough staff to provide the support people needed.

However, there were inconsistencies in the way care and support was planned and delivered because of the varying effectiveness of the leadership skills of people deploying staff.

Insufficient checks were completed as part of staff recruitment this placed people at risk of receiving poor care.

People's medicines were managed safely and they received them as prescribed.

Is the service effective?

Requires improvement

This service was not consistently effective.

Staff had the skills and expertise to support people because they received on-going training and effective management supervision. Additional training with regard to end of life care would ensure a consistent approach in line with national strategies.

People received the support they needed to maintain good health and wellbeing.

People who required special diets were catered for. People told us the quality of meals varied. Some people's quality of the dining experience was poor.

External professionals were involved in people's care so that each person's health and social care needs were monitored and met.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005. Staff obtained people's consent before they delivered care and support and knew what action to take if someone who lacked capacity was being deprived of their liberty.

Is the service caring?

Requires improvement

This service was not consistently caring.

People were not consistent in there views of staff, however overall people told us staff were kind and attentive towards them.

We observed some staff respond to people in a kind and caring manner on some occasions, however there were some occasions where people's privacy and dignity was not always respected.

Summary of findings

Is the service responsive?

Good

This service was responsive.

People using the service had their care needs met and their needs were regularly reviewed to make sure they received the right care and support.

The provider was in the process of implementing a new care plan format which would make the information more accessible for staff.

Staff responded when people's needs changed, which ensured their individual needs were met. Relevant professionals were involved where needed.

People were involved in activities they liked, both in the home and in the community. Visitors were made welcome to the home and people were supported to maintain relationships with their friends and relatives.

Is the service well-led?

Requires improvement

This service was not consistently well led.

There was a new manager and unit manager; people spoke positively about them and how the service was run. There were opportunities for people who used the service to be involved in determining how the service was run.

Due to a lack of consistent management some areas requiring improvement had not been picked up. The manager was new in post and as such had not had sufficient time to fully implement improvements. However they had a clear vision about what was required and the standard of service they wanted the service to deliver to people.

The systems in place for monitoring and reviewing had not been sufficiently effective to maintain the quality of the service.

Staff told us they felt able to raise concerns in the knowledge they would be addressed.

Granby Court Extended Care Unit

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.

Prior to our inspection we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, previous inspection reports and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. The manager had also completed a Provider Information Return (PIR).The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 22 and 23 September 2015 2015 and was unannounced.

The inspection was carried out by one inspector, a Specialist Professional Advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with nine people who used the service, five relatives, the manager, operations manager and seven members of staff during the course of our visit.

We looked at seven people's care records to see how their care was assessed and planned. We reviewed how medicines were managed and the records relating to this. We checked three staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

We contacted the local authority commissioners and Healthwatch to ask for their views and to ask if they had any concerns about the home. From the feedback we received no one had any concerns.

Requires improvement

Is the service safe?

Our findings

We spoke to people who used the service who told us they felt safe. One person told us "I feel safe and secure and the people looking after me have become friends of mine."

We looked at the policies and procedures for the recruitment of staff and the recruitment files for three members of staff. Recruitment polices and procedure are intended to assist the provider in ensuring only staff who are suitable are recruited We noted the application form did not ask whether applicants had been subject to disciplinary procedures from either their previous employer or a professional body. Failing to request this information means an applicant does not have to declare this. This information would assist the provider in establishing whether the person had the necessary skills and qualifications.

In our review of three recruitment records we found for two members of staff they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and Disclosure and Barring (DBS) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

For the third member of staff who was employed in a professionally qualified capacity we saw the service had not taken up references for this person which related directly to their professional practice. This meant the provider could not be sure this person's practice was of a competent standard. This person was employed prior to the manager starting. Whilst the manager took steps to assure themselves that this member of staff was safe to practice when it was brought to their attention, the provider's systems had not picked up the issues and we had no assurance that this would not happen again.

This is a breach of Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We looked at staffing levels and how staff were deployed to ensure people's needs were safely met. We identified that although ratio of staff to numbers of people appeared appropriate we identified some concerns in relation to the management of staff and how they were deployed around the home.

We spoke with the manager about how they determined staffing levels and deployed staff. They told us they had a staffing dependency tool, Care Home Equation for Safe Staffing tool ("CHESS"), which they completed and this determined how many staff were required. The tool used a scoring system relating to the needs of individuals. The manager explained care staff were supported by ancillary staff such as hostesses who worked in the dining areas and supported staff in ensuring people were provided with regular drinks and snacks and served meals.

We reviewed staffing rotas and saw during the day there were two qualified nurses and five care staff on duty. The unit manager worked as one of the nurses on duty but also had dedicated supernumerary time to carry out management tasks. They were supported by ancillary staff such as kitchen and housekeeping staff and the administrator. Overnight there were three members of staff on duty. According to the service's dependency tool there appeared to be sufficient staff on duty. However, people who used the service and visitors told us they felt there were not enough staff to attend to people's needs.

People told us, "Very often there is a shortage of staff, there don't seem to be plans for when people are on holiday or illness or family emergencies there are no contingency plans." and "There were lots of agency staff, at one time but they are cutting down now. If someone falls or needs to go to hospital this puts pressure on staff numbers." Another person commented, "They are under-staffed; always agency staff and new faces."

People also commented on the time they had to wait to be attended to; one person told us they had had to wait for over an hour. One visitor said, "The length of time it takes to respond to buzzers is an issue. There seems to be a lack of staff on the corridor." The service was set out over three floors with all communal areas on the ground floor. The corridors were long and on one floor bedrooms were tucked around a corner up a further small flight of stairs. This meant in some case there were no clear lines of sight between communal areas on the first floor. Many of the people who at lived the service preferred to spend time in their room with the doors open. However, when people used their call bell there was no visual signal, immediately outside their room on the corridor and staff had to go and check which bell was ringing by looking at a wall mounted display system at the nurse's station. A visitor commented in relation to this; "I worry that this is not very efficient and

Is the service safe?

means it takes a longer time than needed getting to the resident who is ringing. Can the staff not have bleepers or something which they wear to tell them the room number to save time?"

On the first day of the inspection we observed that people had to wait for call bells to be answered on three separate occasions; twice call bells rang for a total of 13 minutes each without being answered. There was a further occasion of a call bell ringing for 25 minutes. A staff member told us that this was because the bell was broken. The shortest time period we observed call bells ringing for was five minutes on day one of the inspection.

We noted that although staff were deployed evenly across all three floors of the home but there was a lack of staff presence in the ground floor communal areas. We witnessed an incident in the ground floor lounge area. One member of staff was assisting someone to sit down. There was no other member of staff in the lounge, nor was one visible through the arch into the adjacent lounge area. Suddenly the person started to vomit copiously and uncontrollably, they were still semi-standing, The staff member shouted to "ring the buzzer". We were unable to locate a buzzer anywhere. Extra staff, including a nurse quickly arrived. The nurse in charge arrived but did not take an active role in responding to the incident. The person was helped into a wheel chair and taken away.

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

We fed these concerns back to the manager who gave assurances to investigate the delay in responding to call bells and the incident we had observed. We returned to the service the following day. The unit manager was on duty and led on the daily handover. We observed they passed on relevant information about people's needs and planned event/appointments for the day. Staff were also allocated areas within the home to work and allocated break times in order to ensure there were always sufficient staff available. This helped make sure that people's needs were met. During our second day we noted that although staff were busy they had time to spend with people and that call bells were responded to more quickly. Staff were provided with clear direction and leadership on that day compared to the first day of our inspection

The service had policies and procedures with regard to safeguarding adults and whistleblowing. Information the CQC had received demonstrated the manager was committed to working in partnership with the local authority safeguarding teams. The service had made and responded to safeguarding alerts appropriately. Staff we spoke with confirmed they had received training about safeguarding adults and were able to describe the different types of abuse. Staff knew about situations where people's safety may be at risk and were also aware of the reporting process for any accidents or incidents that occurred.

We looked at how risks were assessed and managed. We saw completed risk assessments for example for weight loss, pressure sores, moving and handling and mobility. These were completed fully and identified hazards that people might face. There was guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take risks as part of their daily lifestyle with the minimum restrictions. The manager had identified that the provider's system for reporting incidents electronically sometimes meant there was a delay in them reviewing the information and agreeing any action. They had implemented a process which included a paper copy of the incident for their attention. This meant the manager or unit manager could review the incident and agree any action and implemented this in a more timely manner.

There were risk assessments in place relating to the safety of the environment and equipment used in the home. For example hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly.

There were emergency contingency plans in place to deal with emergencies, for example power failure. Staff told us that on call support was always available by the manager or senior staff. Staff were trained in first aid to deal with medical emergencies and appropriate arrangements were in place for fire safety. There was an up to date fire risk assessment for the home and practice evacuation drills were regularly held involving both people using the service and staff. People had specific risk plans on how staff should support them to leave the building in the event of a fire.

We walked around the building and saw grab rails and handrails to support people and chairs located in such a way that people could move around independently with places to stop and rest.

Requires improvement

Is the service safe?

The home was clean and people made positive comments about the cleanliness of the home. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We spoke with the unit manager responsible for handling medicines on the day of our visit about the safe management of medicines, including creams and nutritional supplements within the home. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. Medication records were clear, complete and accurate and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, care workers had clearly recorded the reason why.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required medicines, information was recorded about the circumstances under which the medicine could be administered.

Staff were not permitted to administer medicines until they had completed medication training. The training included a written exam and observation of competency which meant people could be assured they received the medicines they were prescribed safely.

Regular audits were carried out to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted, the senior care workers and manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

Requires improvement

Is the service effective?

Our findings

People we spoke with did not have consistent views of staff skills. Some people who lived at the service and their relatives were complimentary about staff. Other comments referred to a fall in standards and local reputation. Comments made included, "Communication isn't good and we don't always know who to go to" and "I came here because I heard good things about it. It's ok but there are certain things I am not happy with." Another person said, "Staff have told me by the time 8 o'clock comes they are exhausted." However other people who lived at the service told us, "I like it fine. I'm well looked after." And another person commented, "I don't have lot of activities- I am happy to be independent and I am never bored."

We discussed with the manager the training arrangements for staff. They told us newly appointed staff completed a comprehensive induction which included face to face and e learning which included health and safety training such as moving and handling, first aid and safeguarding adults. Staff also completed a period of working alongside more experienced staff before they worked unsupervised. The manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training and it was relevant to their role. They confirmed that they had completed appropriate training courses for lifting and handling, fire precautions and dementia training and this was relevant to their role.

The manager told us when they started at the service their priority was to evaluate the skills and experience of the staff team, to commence regular one to one staff supervision and staff meetings. The manager said the purpose of this was to clarify and embed with the staff group what the provider expected of them in terms of their roles and responsibilities and to begin to build upon good team work. The manager told us they had identified some areas which required a review of competence and these areas were being addressed with individuals. Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. Staff also completed an annual appraisal. This meant that staff were well supported and any training or performance issues were identified.

There had been a recent appointment of a unit manager, who was a qualified nurse. They told us although they were new in post they had begun to review the effectiveness of how nursing care was delivered and the training needs of staff in relations to people's needs.

During our review of notifications the service had sent to the Care Quality Commission (CQC) we noted a steady increase in the number of expected deaths reported. This indicated to us that people were being admitted to the service in the later stages of their lives. We spoke with staff on the first day of our inspection and asked if any of the staff attended Gold Standards Framework (GSF) meetings at the allocated GP practice. The Gold Standards Framework (GSF) is recognised by NICE (National Institute for Health and Care excellence) as best practice for End of Life Care. It identifies people in the last year of life and supports best practice for those people, their families and carers as their condition deteriorates until their death with follow up care for families and carers following the person's death. Staff were not aware of GSF or the six step programme or any equivalent programme of care identified by NHS England as being best practices for Care Homes/ Nursing Homes caring for people and their families/carers in the last year of life.

On the second day of inspection we followed this up with the unit manager, who was able to tell us of her plans to improve the skills and knowledge of staff to improve the quality of end of life care. They had started this and had facilitated nursing staff receiving training with regard to the use of syringe drivers; equipment which facilitates the administration of medication particularly in relation to end of life care. We observed this taking place on the second day of our inspection.

We recommend additional training with regard to end of life care to ensure a consistent approach in line with national strategies.

The manager explained that they or the unit manager completed pre admission assessments of people's needs. They said they involved other people in the process such as relatives and health and social care professionals, to ensure as much information was gathered as possible in order to determine whether they would be able to meet those needs. We reviewed four people's care plans and saw a pre admission assessment which detailed personal information about the person's needs.

Requires improvement

Is the service effective?

We also looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty, these are assessed by trained professionals to determine whether the restriction is appropriate. The manager told us they had a good working relationship with the local authority DoLs team and Community Mental Health Team. They told us at the time of the inspection they had made one application for a DoLs authorisation and were awaiting an outcome. We saw evidence of best interest decisions made for people as part of the care planning process. Best interest decisions are made on behalf of the person following consultation with professionals, relatives and if appropriate independent advocates making a collective decision about a specific aspect of a person's care and support. Following this process demonstrated openness and transparency in providing services for people who lack capacity as defined within the Mental Capacity Act 2005 (MCA).

When we spoke with staff they demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA) with particular regard to day to day care practice ensuring people's liberty was not unduly restricted.

We spoke with people about the quality of meals available in the home. Comments made included "The food is awful" and "Food has gone downhill."

On the first day of the inspection we joined people in the dining room at lunch time. We saw that one table had people who were holding conversations, another had three people sitting together one was eating but the other two people were asleep throughout most of the lunch service, another distressed person was wheeled into the room later and sat alone at a table visibly upset.

There were ancillary staff in the dining room but no care workers initially. When a care worker did arrive they chose to sit and chat at the table of more animated people but did not offer to help any of the other people who may have benefitted from help to ensure they had a nutritious meal and were able to cut the meat up. The food did not look appetising. At the end of the day we fed back our observations and concerns about people's experience. The manager explained they were aware of the concerns about the quality of food and explained within the next few weeks catering services were to be provider by a specialist outside provider. The manager gave us assurances that the issues we had raised with them would be addressed immediately.

The following day we spent lunchtime in the dining room and observed a notable difference. There were more care staff available and assisting people. There was some soft music playing in the background and the general atmosphere was more pleasant and people seemed to be enjoying their dining experience.

We recommend the manager reviews the dining experience to ensure people living at the home receive a consistently positive experience.

Whilst we were in the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

For those people who were at nutritional risk we saw completed the Malnutrition Universal Screening Tool (MUST) which aided staff in determining appropriate action to take. For example those people who needed monitoring were weighed more frequently and their food and fluid intake recorded and monitored. A relative commented to us that when their relative was discharged from hospital they were only able to eat a liquidised diet but can now eat 'normal' food with a knife and fork.

The arrangement of the care plan format meant it was difficult to track where people had been referred to speech and language therapists, tissue viability nurses and/or specialist nurses such as Macmillan nurses. This was particularly true for end of life care planning. The care plan format directed staff to remove all care plans and complete an end of life care plan. This was in line with NICE guidance and the provider's care planning procedures. This was to ensure all the relevant information was recorded in one place so that the best possible support can be provided in the last days of a person's life when they are unable to express their wishes, pain or anxiety. However, when we reviewed two people's care plans who had died, although we could see that the care provided was appropriate and supportive for the person, the information was not recorded as it was required Staff, therefore had to search through multiple care plans to identify the person's current care plan needs.

Requires improvement

Is the service effective?

The local area operated a system where each service was linked to a specific general practitioner surgery, although people who lived at the service had the choice to remain with the doctor they had been registered with prior to admission. The doctor held a surgery in the home every week and responded to emergency visits if required.

Staff reported good working relationships with healthcare professionals. The unit manager told us, their previous employment was assisting in developing and forging improved links with healthcare professionals.

The home was an adapted property with a purpose built extension. Some parts of the home were less accessible than others. The manager explained consideration was given to this during the preadmission assessment to ensure people's mobility meant they were able to access their bedrooms. We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms.

Requires improvement

Is the service caring?

Our findings

We spoke to people about the quality of care they received and heard very contrasting views. One person commented, "I think it's horrible here. It's very badly organised and they don't care about you at least, not in the way I think care should be." And another said "They are a bit rough but I am full of sympathy as they have a lot to do. I would hate this job." One person spoke of how staff responded to a delay in answering their bell saying they were made to feel guilty for calling for help. However in contrast, one person commented," They will do things over and above what is required." And another person said, "They are falling over themselves to do things for you."

On the first day of our inspection we observed that the person in charge of the unit failed to direct and deploy staff effectively; our observations indicated that staff were frustrated by this which meant staff were disorganised and busy. This was reflected in how they responded to people. We saw staff did not have the time to spend with people and witnessed less thoughtfulness in their interactions.

Although when we spoke with staff they knew the importance of maintaining confidentiality and had received training on the principles of privacy and dignity and person centred care. We observed people's records left unattended at the nursing station and personal information about people pinned to the wall and visible to other people living at the home and visitors. We viewed some records relating to monitoring and assessing an individual's distressed behaviour. The language used to describe this person's distress was derogatory and judgemental. We also saw similar language used in people's daily records.

In contrast on the second day of the inspection there was a more effective management of the day; staff were more confident in their work because they had been given clear instruction about their responsibilities for the day and this was reflected in the atmosphere in the home and the approach given to people. Records were put away in a lockable cupboard.

On the second day of the inspection we saw staff knocked on bedroom doors and awaited a response before they entered. Staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. For example we heard staff referring to family and known interests. We saw that staff acted in a kind and respectful way and people looked well cared for and appeared at ease with staff. We saw that staff crouched down to talk to people at eye level and they spoke at a pace that was comfortable for the person.

We spoke with the manager about our observations and they were able to tell us of their intentions to appoint 'dignity champions' whose role it would be to promote practice which maintained people's dignity. However, we were concerned that while the manager was responsive when issues were raised this had not prevented the concerns arising and they had not been picked up.

We looked at how people were cared for in the last days of their life. We spoke to the unit manager who explained the importance of ensuring people's advanced decisions were known and that appropriate medicines were administered to ensure people were pain free and calm. They told us they had good links with district and Macmillan nurses and planned to source further training to support staff in improving the quality of how the service delivers an end of life pathway. However, from our review of records we could see that the provider's guidance for end of life care had not been consistently followed. We saw not everyone had a specific end of life care plan and although from other records we could see people had been cared for sensitively there was a potential risk that that people would not be care for in line with good practice guidance.

T**o ensure a consistent approach we recommend staff receive updated training and review their care practise which assures people in their care are treated according to the provider's ethos of dignity, respect and caring and receive appropriate end of life care.**

Our observations indicated that people who used the service were able to spend their day as they wished. One person had a jigsaw puzzle in their room and told us, "the staff know I like them" They talked to us about the activities programme and explained there were two sessions a day and they had the schedule for the activities in their room. They explained they liked to attend the afternoon session because that was their choice. They said, "I want to have a lie in in the morning so I do the afternoon sessions".

We saw people's bedrooms were personalised with their own furniture and possessions or family photographs.

We were told people had access to an external advocacy service if required and details were included in the service's

Requires improvement

Is the service caring?

welcome pack and were seen on the noticeboard .The manager told us they promoted an open door policy for people who live at the service and their relatives. During the day we saw visitors coming and going; they were offered a warm welcome by staff. We spoke to two visitors who said they were very happy with the care their relatives received.

Good

Is the service responsive?

Our findings

The manager explained the service was in the process of introducing a new format for care planning because the current format contained too many sections and was difficult to find information in a logical chronological way.

We looked at four care plans and agreed with the view of the manager. Although care plans contained detailed information about people's needs the amount of cross referencing required from one section to another to gain a full picture of the person's needs was difficult. This meant unless staff knew people's needs well there was a potential that staff would find information confusing. For example in one care plan we saw information recorded which contradicted information in another section. This had happened because staff had interpreted differently where the information need to be recorded, therefore updated changes had been recorded in only one section of the care plan. Staff we spoke with said the care plan document was cumbersome and time consuming to complete. Those care plans we did look at contained an assessment completed on admission which detailed people's needs and further care plans covering areas such as personal care, mobility, nutrition, daily and social preferences and health conditions. We could see that people's care had been reviewed his meant that the person's changing needs had been being monitored.

We did review the new care plan format and could see the way it was set out would be easier to follow and reduce the risk of there being confusing information. When we spoke with staff they were all knowledgeable and able to provide detailed information about individual's needs and this reduced the risk of providing inappropriate care. This was reflected in our observations of staff throughout the day.

On the second day of the inspection we observed the handover meeting at the change of shift; where staff received written and verbal reports of each person. Changes to people's needs were made known so staff were able to provide appropriate care.

There was a full programme of activities on offer supported by three activities organisers. We spoke to these members of staff. They talked about their role in extremely positive terms and demonstrated that they were more than prepared to go the extra mile to do a good job so that the people who used the service would benefit. They all said that they really enjoyed spending what they said was real, quality time with people. They all agreed that the best way to find out what people wanted was by talking to them. They also said they used their own time to research ideas on line and use extra time to prepare for activities.

We observed activities organisers spending time with people either in groups or individually. One person told us they could not take part in all of the activities they used to but can still do flower arranging and card making. Another person told us "There's always something on, I pick and choose depending if I'm interested or not." Another person said, "They know me well, I can have a pint of lager if I want it".

Information about how to make a complaint was available. We saw details located in communal areas and included in information given to people on admission to the service. People we spoke with knew how they could make a complaint if they were unhappy and said that they had confidence that any complaints would be responded to. The manager told us they met with people who used the service regularly and encouraged people to raise any concerns in order they could be addressed quickly and efficiently.

The provider completed an annual survey of people who used the service, their relatives, staff and other professionals to gather feedback on all aspects of the service provided including care, privacy, staffing, activities, food, quality of life, laundry and the environment. Results were published with appropriate action plans put in place in response. We saw the results of the most recent survey and noted comments about the quality of meals were being addressed with the implementation of a new catering provider.

Requires improvement

Is the service well-led?

Our findings

The service had been without a permanent manager for 12 months. During that time a manager had been appointed but moved on after a short period. During the intervening periods a peripatetic manager had been appointed by the provider. The current manager started working at the service five weeks prior to the inspection as had the unit manager in charge of the day to day running of the service and supervision of nursing care. The manager was in the process of applying to the commission (CQC) to become registered.

People who lived at the service told us, "It has gone downhill; several managers come and gone." And another said, "Lots of different managers, that's no good." However since the manager started people who lived at the service and their relatives told us they knew who the manager was and saw them regularly around the home; they confirmed they were approachable and responded to concerns and queries. One person commented, "The staff need a more settled regime."

At the end of the first day of the inspection we gave the manager feedback about our concerns about how the staff team that day had been directed and managed, and the impact this had had on the care and support people received. The manager accepted this feedback not as a criticism of the particularly staff providing direct care and support but as a reflection of the whole staff team including themselves. They gave assurances to address the issues and our observations the following day indicated some immediate action had been taken. In addition the second day of the inspection benefited from the unit nurse manager being on duty and the skills they demonstrated in supervising and directing staff.

The staff we spoke with were all complimentary about the manager. Staff told us the manager was very approachable and supportive and felt they had already made a difference and was recognising and addressing low morale. They said they were fair and addressed issues directly with staff but also acknowledged when staff had worked well and provided good care and support. One member of staff said, "(The manager) will change the place for the better. I think (the manager) puts residents at the centre of the whole process." And another member of staff said "Families are being kept abreast of proposed changes 100%. Within first week (the manager) met all relatives, They also use email and letters to communicate with them."

Staff meetings had been held at regular intervals, which had given staff the opportunity to

share their views and to receive information about the service. Staff told us that they felt

able to voice their opinions, share their views and felt there was a two way communication

process with managers and we saw this reflected in the meeting minutes we looked at. They said the manager offered an open door and was fair and honest with them.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us that the manager had a regular presence in the service. They told us the manager spent time in the home talking with and working alongside staff.

During our inspection we spoke with the manager about people who used the service. They were able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening. They told us they were proactive in developing good working relationships with partner agencies in health and social care. The feedback we received from these agencies supported these statements.

The manager was knowledgeable and experienced. From evidence gathered through this inspection we could see they placed a lot of emphasis on people receiving high quality care. They told us they aimed to invest in the staff team to deliver this and hoped staff felt valued and supported.

The manager spoke enthusiastically about developing care and support for people living at the service and ensuring the care people received was personalised. They acknowledged the previous lack of strong leadership and that it would take time to rebuild the confidence of people who used the service their relatives and staff. They had in place an action plan which included involving people who used the service in future improvements to the service.

The manager explained there were a range of quality assurance systems in place to help monitor the quality of

Requires improvement

Is the service well-led?

the service the home offered. This included formal auditing, meeting with the provider and talking to people and their relatives. Audits included regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, firefighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop.

Monthly audits and monitoring undertaken by regional managers helped managers and staff to learn from events such as accidents and incidents, complaints, concerns and whistleblowing. However we were concerned the systems in place for monitoring and reviewing had not been sufficiently effective to maintain the quality of the service.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.

Although the manager now had systems in place to monitor the service, there were action plans for improving the service and the manager had a clear vision for improving the quality of care, these were at an early stage and had not yet impacted on the quality of care provided. We have asked the manager to keep us regularly updated with improvements and we will continue to monitor these through our inspection programme.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to check the competence of staff against their professional qualifications.**

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 (RA) Regulations 2014 Staffing **The provider failed to ensure staff were deployed effectively to ensure people's needs were met.**