Care Quality Commission

Bramble Lodge Care Home Limited

The Grove and The Courtyard

Inspection report

341 Marton Road
Middlesbrough
TS4 2PH
Tel: 01642 819111
Website: www. executivecaregroup.co.uk

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Ratings

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

Overall summary

This inspection took place on 24 November 2015 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 25 November 2015, and was announced.

The Grove and The Courtyard is a purpose built care home providing care across two separate units. The Grove is located on the ground floor and the Courtyard on the first floor. The service previously operated as four separate units, but is undergoing organisational change. It plans to offer care to people with general and specialist mental health needs across the two units. At the time of the inspection 42 people used the service, some of whom were living with dementia.

The home has not had a registered manager in post since July 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider has employed a manager

Summary of findings

since July 2015 and they have commenced the process to become a registered manager. We confirmed with our registration team that the application has been accepted and is being processed.

Care records were not always completed fully or consistently. Risks to people's health and wellbeing were not always assessed and recorded in their care plans. The safety of the premises was regularly monitored but remedial action was not always taken to keep people safe. Checks to ensure that staff were suitable to work with people were not always carried out. Training that the provider thought necessary to support people safely was not always delivered. Staff felt that they needed more training in specialist areas. The quality assurance audits carried out by the service did not always lead to improvement.

These were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

People were supported with their medicines in a safe way, but we made a recommendation about the temperature of one of the treatment rooms.

Staffing levels were assessed when dependency needs changed to ensure there was always a safe number of staff to support people. Staff understood safeguarding issues which helped to protect people from potential abuse. Plans were in place to support people in emergency situations.

Staff received supervisions and appraisals, and felt that they could approach management with any issues they had.

There were procedures in place to protect people's rights under the Mental Capacity Act, though staff did not always understand its principles.

People were supported to maintain a healthy diet, and were encouraged to do this independently where possible. The service worked well with other professionals to ensure people's overall health and wellbeing.

Care was planned and delivered in a person-centred and responsive way, and people were involved in their own care planning. A wide range of activities was provided to people, which was based upon their personal preferences and choices. There was a clear complaints procedure in place to deal with any issues that people might have.

Staff did not always feel included in the changes that were taking place at the service, and could not describe its culture and values. People living at the service were asked to provide feedback, which was generally positive.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people's health and wellbeing were not always assessed and recorded in their care plans.

The safety of the premises was regularly monitored but remedial action was not always taken to keep people safe.

Checks to ensure that staff were suitable to work with people were not always carried out.

People were supported with their medicines in a safe way, but we made a recommendation about the temperature of one of the treatment rooms.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always receive suitable training to ensure that they could appropriately support people.

Staff received supervisions and appraisals, and felt that they could approach management with any issues they had.

People's rights under the Mental Capacity Act and the Deprivation of Liberty Standards were protected.

People received suitable support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff who knew them. Staff took the time to deliver support in a kind a caring way.

The service was aware of the need to offer advocacy services where needed.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered in a person-centred and responsive way, and people were involved in their own care planning.

People were supported to engage with activities that they found interesting.

The complaints procedure was clear and applied when issues arose.

Summary of findings

Is the service well-led?

The service was not always well-led.

The quality assurance audits carried out by the service did not always lead to improvement.

Staff did not always feel included in changes taking place.

Requires improvement

The Grove and The Courtyard

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 24 November 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 25 November 2015 and was announced.

The inspection team consisted of two adult social care inspectors and two specialist advisors.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with five people who lived at the service. We looked at nine care plans, and Medicine Administration Records (MARs) and handover sheers. We spoke with ten members of staff, including the manager, the deputy manager, the operations manager, care staff and members of the domestic and kitchen staff. We also spoke with three external professionals who work with the service. We looked at four staff files, which included recruitment records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Inadequate

Is the service safe?

Our findings

Risk assessments were not always completed fully or consistently and some contained gaps or insufficient information. One person's assessment recorded, 'Is there a history of self-harm?…In the past none recently'. There was no further detail given, which meant that staff may not be able to identify specific risks to the person's wellbeing. In another person's care plan, the 'initial assessment' referred to a moving and handling and a falls risk assessment, but these were absent. We saw that one person was documented as at risk of self-harm during the night and should have been checked on during the night at 15-minute intervals. From night shift records, we saw that this person was not usually checked between 2am and 7am every night. We asked the manager about this. They said that it was the person's choice not to be checked during those hours although there was no risk assessment in place for how this was managed in the context of their risk of self-harm. Another person was identified as being vulnerable to the risk of sexual abuse. There was no risk assessment in place for staff to use to ensure they were protected from harm within the communal living arrangements in the service. Care plans were not always signed or dated by people or an appropriate person and not all staff had signed to indicate they were aware of the person's assessed needs. This meant that that staff supporting those people did not have all the information they needed to do so safely.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and wellbeing were assessed and recorded in their care plans. These included areas such as malnutrition, mobility and falls risk assessments, continence and skin care and pressure relief. Individual risk assessments were in place for people with particular care needs. For example, we saw that one person with asthma and cancer had an assessment in place to restrict, with their consent, the number of cigarettes they had each day to reduce the risk of chest infections.

Risks to people arising from emergencies at the service were assessed and monitored. There was a personal emergency evacuation plan (PEEP) in place for each person, stored in a 'fire grab bag' next to the front door. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. Each PEEP contained details on people's individual support needs and details of how best to support them. There was a business continuity plan, which had recently been reviewed. This contained guidance to staff on dealing with a number of emergency situations, including useful contact details.

However, staff we spoke with had not received recent or appropriate fire, evacuation and emergency training. Although care assistants had an understanding of their responsibilities in the event of a fire alarm, they were not able to tell us who was in overall charge of an evacuation at any one time or how they would communicate to emergency services where people were in the building. There was a notice to staff in the building's main entrance reminding them that the nurse on shift was the named person in charge in the event of an evacuation. The reason for this was unclear as the nursing role had been discontinued and the notice had not been updated. One member of staff said, "Four of us are trained as fire marshals but there's nothing in place to make sure there's always one of us on shift. We'd just go to the manager or the maintenance [member of staff] in an emergency." Another said, "I know where the rendezvous point is outside but not much else, I can't remember ever having a proper practice drill." Staff told us they would like a practice evacuation with people. One member of staff said, "I'm not sure how people would respond to an alarm. I think it'd be a good idea to help them with a practice."

The safety of the premises was regularly monitored but remedial action was not always taken when issues were identified. Records showed that fire alarms and doors were checked on a weekly basis by maintenance staff. Quarterly checks of emergency lighting, fire alarms and firefighting equipment also took place. We noted that a risk assessment on 6 October 2015 identified that the fire alarm panel was, 'not functioning correctly and when activated pressure needs to be applied to the display so it can be seen' before recommending that it was professionally serviced and repaired. This had not been done by the time of our visit. The manager said, "The maintenance manager was in this morning. It hasn't been serviced since 6 October 2015. It does function but needs replacing and we highlighted this again this morning." This meant that the service had not addressed a risk that had been identified in October 2015.

Inadequate

Is the service safe?

Required certificates in areas such as hoist tests, gas safety and hazardous waste management were up to date. However, we noted that the PAT test certificate expired on 16 October 2015. We asked the manager about this, and were told that this had been raised as a priority issue with the provider on 1 October 2015. This meant that potential risks to people's safety in the premises were assessed but remedial action was not always taken to address them.

This was a breach of Regulation 15(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service sought two written references and proof of identity before employing staff. Interview notes showed that they were asked about their skills, knowledge and caring experience. The service also had a policy of carrying out disclosure and barring service checks (DBS) on staff before they were recruited. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. We saw that not all staff had been checked in this way, and that some checks had not been renewed in line with the service's own policy. Three members of staff had no record of any DBS check being carried out. One member of staff had a DBS check on file but this related to a different role at another service and so may not have considered all information relevant to a social care setting. This meant the service did not always have the latest information on whether staff were suitable to work with vulnerable adults.

This was a breach of Regulation 19(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy of renewing staff's DBS checks every three years in order to ensure staff were still suitable to work with vulnerable adults. 21 members of staff had not had their DBS status renewed in line with the service's own policy.

Accidents and incidents were clearly recorded, and a log was kept of remedial action taken. The manager told us that they reviewed them every month to see if any trends were emerging.

Staffing levels were determined by people's needs, which ensured there were enough staff deployed to keep people safe. The operations manager said, "A dependency tool is used. It's about changing need." Day staffing (during the week and at weekends) levels were three senior carers, seven carers and two team leaders working from 8am to 8pm. Night staffing levels (during the week and at weekends) were three senior carers and 3 carers working from 8pm to 8am. Staff rotas confirmed this. The deputy manager said that as the occupancy rate increases staffing levels would increase. We asked people if there were enough staff to support them. One person said, "Oh yes." Another said, "The staff are dead good and there are enough to look after me."

People told us they felt safe at the service. One person said, "I feel very safe and looked after." There was a safeguarding policy in place which gave staff information on when and how to make safeguarding alerts. Staff had a working knowledge of the types of possible abuse that might arise and what to do if they suspected anything. From looking at care plans we saw that where a safeguarding concern had been raised, staff had acted appropriately. For example, where financial abuse of a person had occurred in the community, staff had provided support to them by discussing personal budgeting guidance. This meant that people were protected against the risk of abuse. The service kept a log of the safeguarding referrals it had made, which helped it to keep track of issues. We noted that not all of the necessary notifications had been made to the Care Quality Commission, and we are dealing with this outside of the enforcement process.

There were systems in place to ensure people were safely supported with medicines. Medicine administration records (MAR) were appropriately signed by staff to confirm medication had been administered. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Sample signatures of staff authorised to administer medicines were contained in the MAR folder and each person's MAR had a photograph for identification purposes, along with a record of allergies if known. Medicines were audited daily and any discrepancies were reported to the manager, who carried out any required actions. No one was using controlled drugs when we visited but staff were aware of the procedure for ordering, storing, administering and recording these. Controlled drugs are medicines that are liable to abuse. All medicines were stored safely in a locked medicine trolley secured to the wall. Protocols were in place to help support people taking 'as and when required'

Inadequate

Is the service safe?

(PRN) medicines which ensure they received them when needed. The service was encouraging people to manage their medicines independently. A trial of self-administration was taking place, with a protocol for self- administration authorised by a GP.

We did note that the temperature in the treatment room on The Grove unit exceeded the 25° recommended by the Royal Pharmaceutical Society, and saw that temperatures higher than this had been recorded by staff from as early as 13 October 2015. The temperature of the Courtyard's treatment room was well within recommended levels, as was the temperature of the medicine refrigerators in both treatment rooms. We recommend that the provider take remedial action to ensure that The Grove's treatment room temperature was within the limit recommended by the Royal Pharmaceutical Society.

Requires improvement

Is the service effective?

Our findings

Staff did not always receive the training they needed. The completion of mandatory training was at less than 100% for all areas. 80% of staff had up to date training in food safety, 68% in infection control, 82% in mental capacity and 36% in medication awareness. Mandatory training is training that the provider thinks is necessary to enable staff to support people safely. We saw that there were mandatory training sessions advertised around the home, with staff scheduled into specific slots. The schedules had been implemented without consulting staff rotas and staff were told that it was their responsibility to swap shifts if they had been double-booked, with the threat of having pay withheld if they failed to do so. The notices were visible to people and their visitors. We asked all of the staff we spoke with about the notices. One care assistant said, "Yes I've noticed them but I haven't checked yet if I'm double-booked. They only appeared a few days ago and none of the managers have mentioned them, I don't know why they haven't paid attention to rotas." One member of staff said, "We manage our own training. Most of it is e-learning and we have to do it when we're also on an actual shift, there's no protected time for this. The face-to-face training we used to have with [last provider] was really good but this new e-learning is just a cheap way of ticking a box to say we've done it." We asked the manager about this. They said, "The training is a blended approach, some e-learning and some face-to-face training. We provide extra staff on a shift if anyone is behind in their e-learning, so they can catch up."

Staff had varying degrees of understanding regarding their training needs. For example, some staff could not remember the training they had undertaken in the past year. One individual said, "I don't think I've had mental health training. I can't remember it if I have. The same for infection control, I'm not sure about that." According to training records, staff had received training in infection control, first aid, hygiene, nutrition and hydration, end of life care and safeguarding. Staff told us that they needed and had requested training in the management of people with diabetes but this had yet to be provided. One individual said, "Until we get the training we just manage it the best way we can. Luckily most of the people who are diabetic can manage it themselves to some extent." From looking at training records and speaking with staff we found that the provider had not delivered appropriate training for the change in service provision. For instance, staff who had previously worked with elderly people with a dementia diagnosis now provided care for people with complex mental health and behavioural needs. One member of staff said, "We don't get enough mental health training. We've had practical breakaway training in case of aggression or violence, as well as restraint training but not de-escalation training. We need more detailed training on how to manage the daily living needs of people with mental health problems, such as what this means for safeguarding and how to help them with their daily living allowance." Some people living in the home had complex psychological needs and had a history of unpredictable or aggressive behaviour. As staff could be isolated in some areas of the home, it was not clear how staff would be protected from harm without de-escalation and restraint training.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received supervisions and appraisals but records relating to them were not always consistently kept. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. From looking at the supervision records of staff, we found that the usefulness and management of these had been of varying quality. For instance, we saw that a supervision for a member of maintenance staff had involved a focus on needle disposal, an area they were not trained to be involved in. Other supervision records were not focused on individual staff achievement or supported improvement. For example, one supervision record stated simply, "Needs to be more proactive." This meant that supervisions were not always fit for purpose and we could not find evidence that they were in place to ensure high-quality, person-centred care was delivered by a well-supported team. Supervisions indicated that staff had been asked to cover shifts in a role other than their usual responsibility without appropriate training. For instance, we saw that a member of staff had been asked to cover care shifts with a note in their supervision record that mandatory training was to be provided retrospectively. Staff we spoke with were happy with supervisions and said that their experiences had been much more positive than was reflected in the records. One care assistant said, "The supervisions are regular enough but the managers and

Is the service effective?

team leaders are all approachable anyway, I wouldn't wait for a supervision to bring something up. Supervisions are all about how you feel, what's going well, what's not going well and so on."

We found that most members of staff had received an annual appraisal. Appraisals were focused on staff development and demonstrated an empowering, supportive tone. For instance, one member of staff had been praised for being, "committed and enthusiastic…and a great asset to the team." Another member of staff had been referred to as, "an absolute pleasure to work with." We saw that managers had been flexible in supporting staff to improve their skills, such as in changing an individual's shifts so they could attend college to study for their NVQ Level 3 in social care.

Senior care assistants had undergone an induction that included strategies for communicating with health professionals, the completion of shift handover documentation and understanding when a change in a person's care was needed.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, two people had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. In both cases, best interests meetings had taken place with appropriate professionals, including a best interests assessor, a social worker, a community psychiatric nurse and a family member. External doors were fitted with security keypads and people who were not subject to DoLS had the codes to these.

People were supported to maintain a healthy diet. Some people had a restricted diet to help them manage diabetes. We saw that staff knew who this applied to and offered them appropriate food. When a person was upset they couldn't have more than one portion of dessert because of this, staff enthusiastically and successfully encouraged them to have an alternative. Staff demonstrated similar empathy and encouragement to a person who was on a weight management plan and had already prepared a healthy dessert for them, in place of a hot pudding. We saw mealtimes were sociable occasions that people enjoyed and during which they were well supported by staff. For example, staff knew that each person had a favourite seat and also that friends liked to sit together. When someone sat alone, a care assistant gently asked if they wanted some company. During lunch, staff made conversation with people, who were visibly relaxed and content. Where someone wanted to eat in the privacy of their bedroom or in a quiet lounge, staff ensured they were able to do so. Each person had chosen their meal earlier in the day and staff had prepared a plate of each hot meal option as an example, in case someone wanted to change their mind. Staff encouraged people to drink water or juice before and during the meal and each person was offered tea or coffee afterwards. This meant that people were supported to ensure they were sufficiently hydrated.

The home was equipped with a training kitchen and three smaller kitchen units that people could use to prepare their own meals and snacks. A weekly rota of responsibilities was maintained that enabled everyone who was able to, to prepare a meal for each other. This meant that people were supported to understand the importance of nutrition and to develop their independence whilst remaining safe with appropriate supervision from staff. We saw that this worked well in practice and that people looked forward to experimenting with their cooking skills. This meant that people were supported to maintain a healthy diet.

Staff were proactive in engaging the support of professionals to make sure that people maintained good health. We saw that care assistants had a good relationship with community psychiatric nurses and the community mental health team, with whom they worked closely to support people with complex mental health needs. Care records indicated that GPs, social workers and community liaison teams were in regular contact with the home and staff updated care needs appropriately. For instance, one person had asked that they be allowed to self-medicate

Requires improvement

Is the service effective?

with an inhaler for the management of asthma but was being cared for under a CTO. Staff had liaised with the person's social worker and had created a risk assessment for the person, to allow them to use an inhaler without staff supervision. This helped the person to maintain their health whilst also developing their independence. Where a person had co-morbidities and complex needs, staff had been effective in ensuring that specialist input was given as appropriate to support their health. For example, one person's care needs were complex. Their care and treatment plan was completed in a sensitive and caring manner with an agreed restriction on cigarettes to reduce the risk of chest infections. This meant that people had access to services to maintain their health.

External professionals spoke positively about the service. One described the staff as giving, "fantastic care" and commented on the "friendly, helpful staff" and the "very good communication." Another reported all people they visit are "happy" and one person whom they had visited for eight years had told them, "they never want to leave". Another visiting professional said, "staff deal with very difficult and very challenging behaviours very well" and are "good at giving feedback, work well with people and do a lot of individual work with people."

Good

Is the service caring?

Our findings

We saw that staff had a good relationship with people and treated them with dignity and respect. For instance, we saw staff support a person who was upset and anxious to move to a quiet area and sit with them to talk over a cup of coffee. The member of staff did this discreetly and whilst addressing the person politely and in a manner that had a calming influence. We observed a number of interactions between staff and people that demonstrated the ability of staff to understand the needs of people and provide them with person-centred care. In one observation we saw that a member of staff sat with a person who was uncertain about going out with others for a game of bowling. Staff explained what the schedule for the day was and gently encouraged the person to take part whilst making sure they knew they didn't have to if they didn't want to. We saw another member of staff respond very positively when challenged to a game of pool by a person and staff were proactive in spending time with people whenever they wanted.

Staff took time to talk to people in a meaningful way that helped them to develop their own skills and feel like they were in control of their own care. We saw one member of staff talking to a person about what they would like to cook for their evening meal. This turned into a lengthy conversation about the person's likes and dislikes, with the member of staff encouraging the person to vary their diet in a joking but considerate way. It ended with the person deciding that they would like to go to the shops to buy something different for their meal, with the member of staff arranging to go with them to help them decide. The person said, "That would be brilliant" and was clearly happy with what had been decided. Staff had a positive impact on people and on a number of occasions we saw that people had a noticeable improvement in mood and spirit when staff spoke with them.

Staff knew people well, which meant that they could talk to them about things that they found interesting or important. For example, we saw one member of staff talking to a person about the football team they supported and recent results. Staff made an effort to stop and speak to people as they were moving around the building. Where support was being delivered, we saw that it was done in a kind and caring way and that staff spoke to people throughout to explain what they were doing. This meant that people were relaxed around staff, and contributed to the caring atmosphere of the service.

Staff were able to tailor their communication and manner to each individual to make them feel secure and included in the running of the home. For example, one member of staff who was responsible for maintenance in the home used a lightweight hammer and spirit measure to support a person in putting up their own pictures in their bedroom. Another member of staff was able to skilfully encourage two people to help wash up after the lunch service, using the weekly cleaning rota to help remind them it was their task that day. The people were initially unmotivated in this task but the manner of the member of staff, which was one of empowerment and support, resulted in them happily taking the lead in the task and doing so with obvious pride in their contribution.

We asked the deputy manager about advocacy services. Advocates help to ensure that people's views and preferences are heard. They said, "There is an advocacy service made available to people. I'm not sure if it is advertised." The manager said, "If there was somebody we felt an advocate could support we would seek one."

Good

Is the service responsive?

Our findings

Care was planned and delivered in a person-centred and responsive way. Each person had a 'daily record of living skills' in their care plan, along with a daily record of medical appointments, oral hygiene and care and their food and drink intake. This was maintained by the senior member of staff on duty and was used to make sure people received adequate food and drink and were supported to remain healthy. From looking at daily notes we saw staff recorded when people had completed tasks designed to support their independence, such as contributing to cooking, changing their bed and socialising with people who were at risk of isolation. We saw evidence that people had been involved in their own care planning, including in regular updates. A care assistant said, "We try and encourage everyone to update their care updates with us but they can refuse if they want to." From looking at records we saw that some were very personalised and detailed in terms of assessing people's needs and developmental goals. For example, one person had been noted to be consistently withdrawn and disengaged after returning from weekly home visits. Staff had spoken with the person about this and had implemented a planned time for quiet reflection on a one-to-one basis whenever the person returned to the home. At the time of our inspection the person had returned from a home visit and we saw that staff used the reflection as a coping strategy for them and that it was effective in practice. Each care plan contained a 'Hospital Passport' of information the person would want a receiving hospital to know about them. These were detailed and people themselves had completed two we looked at. Another positive feature was a 'Life memories of [person]' section. This was a personalised document and included photographs of the person with their friends and family. One person had a small bird in a cage in their bedroom, and the care plan reflected this along with detailed areas of responsibility for its safekeeping.

People were able to make requests for how their care and experience could be improved. For instance, one person had asked for a weekly pamper day to include a manicure and staff had been able to facilitate this. We saw that staff were supporting the person to enjoy the weekly nails sessions as part of their preparation for starting a college course. Some people were looked after under a community treatment order (CTO) for the treatment and management of specific conditions. We saw that staff had documented the person's capacity to understand the CTO and had facilitated them to take part in negotiated interviews with social services staff as a tool to encourage them to be involved in their care and treatment.

People had access to a wide range of activities tailored to their specific needs and interests. Activities were planned on a weekly basis with the input of everyone at the service. Staff used their knowledge of people as well as each person's risk assessments to ensure that activities were planned safely and with adequate staffing. For example, everyone in the home had been invited to a trip to a bowling alley during our inspection, which we saw was well attended. Staff were able to support other people to go out shopping or to visit family and friends by helping with transport or accompanying them when needed. At the time of our visit there were a number of activities displayed on noticeboards for people around the home, including putting up Christmas decorations, assisted exercise outdoors and an afternoon of arts and crafts. Facilities in the home meant that people could find quiet space for watching films or reading as well as playing pool. Recent activities had included a fundraising event for Children in Need and a Halloween party and staff told us that there was a trip to the cinema organised every weekend. People we spoke with told us they were happy with the activities. One person said, "Yeah we do some really good stuff here. But I like that you're not forced to do anything. Sometimes I just want to sit outside or have a game of pool and they're happy to let me do that." Another said, "I can go out whenever I want, I go to the shops…I do the garden for them, which I enjoy…We can do whatever we want."

People were able to choose how their bedroom was decorated and furnished. We spent time with a maintenance member of staff who told us that they supported people to choose the colour of their bedroom walls and said that they were able to help them decorate in any way they wanted. They said, "This is their home and we will do anything we can to make sure we listen to what they want." Staff were aware of the individual needs of people based on culture and religion. One care assistant said, "We do offer very individualised care that is always led by [people]". Staff had listened to people in preparing the weekly living skills rota that assigned people to daily tasks such as cleaning their room, helping to wash up after lunch and tidying up their wardrobe. Where a person had expressed a dislike for a task, or was unable to complete this safely, staff ensured they were not asked to do this.

Good

Is the service responsive?

There was a complaints procedure in place and this was available to people, their families and visitors. We found that there had been no formal complaints in the year to our inspection and all of the staff we spoke with were able to explain what they would do if they received a complaint. We saw that where a neighbour had raised a safety concern about people crossing the road in front of the home, staff had responded quickly by providing people with road safety guidance and advice.

When a person was due to move into the home, staff prepared them using a 'staged process'. For instance, a person could come to the home a week before they moved in and spend two or three nights sleeping there to get used to the environment and meet others. Staff used this as a feedback process and made sure that requests or concerns by the person were addressed before they moved in.

There were three 'communities' organised in the home, based on different sections of the building. People and staff that belonged to each community met once a month to discuss activities, concerns and the running of the home. From looking at the minutes of meetings, we saw that they were well-attended by people and that staff encouraged people to speak openly and frankly about what they wanted. We saw that the meetings had been used to plan Christmas in the home, with people able to request specific foods and invite their friends and family. We saw that meetings were also used to reduce the risk of social isolation amongst people and that people were encouraged to spend time together.

Requires improvement

Is the service well-led?

Our findings

The manager undertook a number of audits and checks around the service to monitor quality. This included monthly reviews of medicines, dependency levels, health and safety, catering, nutrition, pressure damage and care plans. The manager told us that team leaders also carried out audits of medicines and care plans, and that they (the manager) reviewed the results. The manager said, "The audits are very good and I know they address things but it isn't recorded. I probably need an extra page to record it. I am working on a tool like that." We saw that audits had not always been carried out fully or consistently. Where audits had identified issues it was not always clear what – if any – remedial action had been taken to address them. For example, the pressure damage monthly assessment was last carried out in March 2015. The October 2015 medicines audit did not have an overall score recorded. It identified an issue with medicine record keeping, but there was no evidence that this had been investigated or remedied. The September 2015 health and safety audit identified that health and safety meetings were not taking place. This was highlighted again in the October 2015 audit, which also had a blank 'accident reporting' section. A 'quarterly audit' of health and safety on 13 July 2015 identified the service had, 'old risk assessments dated 2012. New risk assessments were ready to be used but need to be completed.' There was action plan generated or record of remedial action taken.

The provider carried out monitoring visits to the service. The most recent had taken place in August 2015, when a number of issues had been identified. It was found that, 'Training is not up to date for some staff. Compliant in some areas (e.g. first aid) is low', 'There is no planner in place for supervisions and appraisals' and, following a visit from Cleveland Fire Service, 'Five requirements were identified…there is no information in the file on whether the requirements have been met.' There was no evidence of what – if any – remedial action had been taken following this monitoring visit. We asked the manager and operations manager about this, and they told us that they were working on developing a central action plan to record all necessary remedial action. Our judgment was that the audits currently undertaken were not always identifying or addressing issues concerning the quality and safety of the service.

This was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not clear from our discussions with staff that they understood the vision and strategy of the service. Some staff had previously been employed at the home with the responsibility of providing care for people with dementia. They had not received tangible support for the change of care they were expected to provide. One said, "I really don't know what's happening. There's nothing clear to me about what's going on with the home or what'll happen next." Staff told us that the new manager was supportive and visible and they felt that they could approach her. One care assistant said, "The new manager has been really lovely, she's very easy to approach and I know we can go to her with anything. The same with the deputy manager, she's been really supportive while we've had so many changes. The managers here don't seem very involved with all of the changes we're going through about the change of care, I'm not sure head office have made this clear at all."

At the time of our inspection, the service was undergoing a change in its provision of care and no longer provided dementia or older people care. We asked staff about this change. One said, "We had a staff meeting in July in which some managers from head office came to visit us. They told us they were changing who would be living here but other than 'no more dementia care' we weren't told anything. I've understood their strategy only from the people who have come through the door, which I assume means we are turning into a home for people with mental health needs." Another said, "We haven't been involved in the changes at all. I know when we last had a meeting in July; a manager from head office asked what we'd like them to do. We told them that parts of the home were looking really shabby and that we needed some refurbishment works. Their response was to tell us we could buy paint and do it ourselves." One member of staff out of the five we spoke with told us that they felt the change of service was very clear and they felt that everyone had been involved.

All of the staff we spoke with told us how happy they were working there. One care assistant said, "We're like one big family in here. We know each other and all of the [people] very well, it's why it's such a nice place to be."

The provider had not always provided staff with the tools or equipment they needed to be able to fulfil their role effectively and safely. For example, we found that the

Requires improvement

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maintenance role in the home was shared between two members of staff, neither of whom had been provided with tools. Both members of staff brought their own tools in to work to ensure the premises were safe and fit for purpose. We saw from looking at supervision records that this had been raised with a manager as an issue in July 2015 but we were unable to find out why it had not been resolved. The member of staff was not able to tell us what the insurance or safety arrangements were for using their own tools in the home. They said, "[Provider] has never provided me with tools, there were none here other than a few screwdrivers when I started and I've been asking for months for them but nothing has been given. If I didn't bring my own tools in, nothing would get done."

Staff meetings had taken place sporadically but staff we spoke with were positive about these. One member of staff said, "The meetings keep us up to date with what's happening around the home." Records confirmed that meetings were held for day and night staff. Minutes showed that a wide range of topics were discussed, including rotas, training, whistleblowing and respect.

The service sent questionnaires to people and their relatives asking for feedback. These asked questions about whether people felt safe, their knowledge of the complaints procedure and whether they were involved in writing their care plan. The manager said, 'The biggest issue of feedback was probably people knowing that they had a care plan. There wasn't any major issue. People are happy with care and the staff." Completed questionnaires we saw confirmed this.

The manager had been in post since July 2015, and we asked their about their understanding of the role and responsibilities of the job. They understood their legal responsibilities and duties as a manager.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Quality assurance audits did not always identify or address issues concerning the quality and safety of the service. Regulation 17(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff had completed training deemed mandatory by the service. Staff did not receive specialist training despite having requested it. Regulation 18(2)(a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not always completed fully, and did not always contain sufficient information to allow people to be supported safely. Regulations 12(1), 12(2)(a) and 12(2)(b).

The enforcement action we took:
We issued a warning notice requiring The Grove and The Courtyard to be compliant with this regulation by 15 January 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Actions necessary to keep the premises in a state of safety and good repair had not been undertaken despite the service being aware of them. Regulation 15(1)(e).

The enforcement action we took:
We issued a warning notice requiring The Grove and The Courtyard to be compliant with this regulation by 15 January 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Not all staff had completed a current Disclosure and Barring Service checks to confirm they were suitable to work with vulnerable adults. Regulation 19(1)(a).

The enforcement action we took:
We issued a warning notice requiring The Grove and The Courtyard to be compliant with this regulation by 15 January 2016.