

CTCH Limited

The Grange

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Good



Is the service effective?

Good



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

This was an unannounced inspection which took place over two days on the 20 and 21 May 2015. The Grange provides nursing and personal care for up to 69 people. Accommodation can be provided for people who wish to live together. People have access to lounges and dining areas on each floor, en suite bedrooms, and assisted bathrooms. An internal courtyard provides an outdoor seating area and is accessible to all people. At the time of our inspection 49 people were living there. There were 18 people who had been assessed as needing nursing support and 20 people had been diagnosed as living with dementia.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were inconsistencies in the records being kept for people. Where some people's needs had changed their care records had not always been updated to reflect this. Monitoring records were not always being kept to confirm

Summary of findings

when people had been repositioned or given food and drink. This could result in people receiving inappropriate care or support. People were not always treated with respect. The registered manager took appropriate action to address this. The provider had not informed us about incidents affecting the well-being of people such as alleged abuse, serious injury or death. The Care Quality Commission monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers. You can see what action we told the provider to take at the back of the full version of the report.

People moving into The Grange were assessed to make sure their needs could be met. Care plans and risk assessments were put in place and developed further as staff got to know them. Some people commented about how they had gained more independence since moving into the home, regaining confidence to stand for transfers or to walk unaided. People's likes, dislikes and routines important to them were highlighted in their records and the care and support they received reflected these. Their background and personal histories had been discussed with them or their families. Staff reminisced with them and talked about their interests and people important to them. Most staff treated people positively, enjoying their company, laughing with them and supporting them with sensitivity. People told us, "They look after us well" and "I can't speak highly enough about the care I have received".

People had access to a range of activities including trips out. These had recently been reviewed and extended as a result of feedback from people. People were supported to continue with interests and hobbies such as gardening.

People attended religious services either within the home or their local community. People's health and well-being was promoted through a balanced and nutritional diet and access to a range of health care professionals.

When people became unwell or their needs changed they were referred to health care professionals. Most people's care records were updated to reflect these changes and staff had a good understanding of people's needs. If equipment such as alarms, special mattresses or easy chairs were needed they were supplied. Accidents and incidents were monitored to prevent further harm to people. People told us they felt safe. Strategies were in place to identify and report suspected abuse. Staff had confidence any concerns they raised would be listened to and followed up.

Recruitment and selection processes made sure all information was obtained about new staff before they were appointed. They completed an induction programme and shadowed existing staff until assessed as competent to carry out their role. Training was provided to develop their skills and knowledge. Staff had individual meetings to discuss their roles and responsibilities and also attended staff meetings.

The provider monitored the quality of the service provided through monthly audits. Actions raised were followed up to make sure any issues had been addressed. The registered manager and staff completed other audits to check on the quality of service provided, for instance health and safety, care records, medicines and the environment. People, their relatives, staff and professionals were asked for feedback about their experience of the service. Their feedback was used to improve the service provided.

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?

The service was safe. People were safeguarded from the risks of harm or abuse. Staff recognised the signs of abuse and the action they needed to take to keep people safe.

People were supported to take risks whilst hazards were reduced as far as possible. Accidents and incidents were monitored to prevent them happening again.

Staff levels reflected people's assessed needs. Staff recruitment checked on their suitability to work with people.

Medicines were safely administered.

Good



Is the service effective?

The service was effective. People were supported by staff who were encouraged to develop their skills and knowledge.

People's consent to provide their care and support was sought in line with the Mental Capacity Act 2005. Checks were being carried out to make sure the relevant authorisations were obtained for people deprived of their liberty.

People's health and well-being was monitored. When people were at risk of losing weight strategies were put in place to help them to eat and drink. People had access to health care professionals to help them to stay well.

Good



Is the service caring?

The service was not always caring. There were times when some people's dignity was not being promoted. Some staff were not always respectful. People's experience of care was mixed not everyone felt their needs were responded to quickly enough.

Most people had a positive experience of the care and support they received. They were treated with kindness and were happy with the care they received.

People and their visitors felt able to express their views and were confident they would be listened to.

Requires Improvement



Is the service responsive?

The service was not always responsive. There were inconsistencies in the quality of records reflecting people's care and support. Some people's records were not kept up to date with their changing needs which could potentially put them at risk of inappropriate care.

Concerns and complaints were used to drive improvements in the service. People and those important to them were confident their concerns would be listened to and action would be taken to address any findings.

Requires Improvement



Summary of findings

Is the service well-led?

This service was mostly well-led. The provider was not sending notifications to us for allegations of abuse, serious injury or the death of a person.

People, their relatives, staff and professionals provided feedback about the service. Their views were used to make improvements to people's experience of care.

Quality assurance processes monitored the quality of service delivered and were used to drive up standards.

Requires Improvement



The Grange

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 May 2015 and was unannounced. Two inspectors and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was older people and the needs of people living with dementia.

Prior to the inspection we looked at information we held about the service including feedback from the local authority commissioners and notifications. Services tell us about important events relating to the service they provide

using a notification. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and what improvements they plan to make. We had also received information from the local authority and two health care professionals.

As part of this inspection we spoke with 16 people who use the service, eight visitors, the registered manager, a representative of the provider, a nurse, 12 care staff, the cook, a cleaner and the maintenance person. We also spoke with five health care professionals. We also reviewed records relating to the management of the home which included eight care plans, 12 medicines records, recruitment records for three staff, training records and quality assurance systems.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. After our visit we received feedback from two health care professionals.

Is the service safe?

Our findings

People told us, “Of course I feel safe” and “I don’t have to worry about anything”. Everyone spoken with confirmed they lived in a safe environment and did not feel unsafe with the care provided. A relative commented, “My mum is very safe here.” A comment left on an external website said, “The Grange sounded ideal for what we need to keep her safe and well looked after.” People said they would talk to the registered manager if they had any concerns. They said the registered manager’s door was always open and she was approachable. They were positive she would deal with any issues they raised.

People were kept safe from potential abuse by staff who understood how to recognise and report abuse or harm. Staff described what they would look for and the importance of keeping clear records about such things as unexplained bruising or accident and incidents. They had completed training in the safeguarding of adults and had information about local safeguarding procedures. They were confident when they reported any allegations of abuse the registered manager would take the appropriate action. When safeguarding alerts were raised with the registered manager she followed these up as necessary with an investigation into the issues. Action was taken if needed to address any concerns or to prevent incidents happening again. The registered manager worked with local safeguarding teams, police or social and health care professionals to keep people safe.

People were supported to take risks to maintain their independence. Staff gave examples of how they reduced risks to people. They assessed the risk of falls, loss of weight and developing pressure ulcers. Strategies had been developed to minimise any hazards. For example, providing high /low beds which could be lowered to the floor to reduce the risk of injury or adding supplements to people’s diets. People who had fallen during the night had been provided with alarms to alert staff when they had got out of bed. The least intrusive option had been installed, giving people a specified time limit to return to bed before warning staff to check on them. For people at risk of developing pressure ulcers, special mattresses and cushions had been provided and staff supported them to change their position throughout the day and night.

When people had accidents and incidents a record was kept describing how these had happened with a report of

any follow up action or observations by staff to check on people’s well-being. If needed the GP or emergency services were called. Concerns had been raised that for one person this had not been done in a timely fashion. This was followed up by the relevant social and health care professionals. Accidents and incidents were monitored to assess if the risks for people had increased and to make sure the necessary action had been taken to minimise these happening again. For example, referrals to the falls clinic or health professionals. Records for one person had been updated when necessary to reflect how they were being protected from further falls.

People had individual plans in place describing how they would be evacuated from the home in an emergency. An emergency file kept in the reception area provided staff with information about emergency services and out of normal hours management support. People had individual call bells in their rooms which escalated to an emergency call if left unanswered after a specified length of time.

People’s environment was well maintained and kept as safe as possible. The maintenance person kept records confirming the completion of checks at appropriate intervals for instance for fire equipment and installations, water temperatures and legionella. Equipment including the lift, wheelchairs and assisted baths had been serviced.

People said there were enough staff to meet their needs. Agency nursing staff were employed to cover nurse vacancies. A lead nurse had been employed and was due to start work in July 2015. Staff said there were sufficient staff allocated to each floor but if needed they would help each other out. Care staff providing support for people who needed nursing care asked for additional help during our inspection and care staff from the ground floor were made available. Staff said if there was last minute sickness this was covered either by bank or agency staff. Rota’s confirmed this. The registered manager said each month they used the provider’s care hours calculator to assess the levels of staff needed to meet people’s needs. A relative commented there was some continuity in care, “The same set of faces, which helps”.

There was mixed feedback from people and their relatives about people’s experience of waiting for staff to respond to their call bell. One person said, “The staff always come to your help. If you call or if you ask” but another person commented, “They have taken 20 minutes to answer the bell; they apologise and say they have been with someone

Is the service safe?

else.” A relative mentioned they had spoken with staff about an unanswered call bell and staff had said they were busy with another person. Staff were observed monitoring and responding to call bells in a timely fashion.

An important part of making sure people’s needs were met was allocating staff with the right skills and knowledge to work alongside each other. The registered manager said they made sure new staff worked with experienced staff. Named staff were given key tasks each shift, such as medicines administration or activities. Senior staff had discussed at their team meeting how to make sure the skills of staff were used effectively. Where concerns were raised about staff conduct processes were in place to investigate these and to support staff to further develop their skills and/or to be disciplined.

People were protected against the risks of harm through recruitment and selection processes which checked the competency and experience of new staff. An application form had been completed with an employment history. Where a full employment history had not been provided, the registered manager had requested additional information to complete any gaps. Proof of identity and a satisfactory Disclosure and Barring Service (DBS) check were in place. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. Checks had been made with previous employers to clarify the reason why staff left their employment. These were

confirmed with follow up telephone calls if needed. Nursing staff were employed through an agency. The agency had provided evidence of their recruitment procedure and that nursing staff had the necessary professional registration.

People’s medicines were managed safely. They received their medicines at times when they wanted them and at appropriate intervals. A person confirmed, “Yes, they’re very good like that, very good.” Agency nurses and staff had completed training. Observations to assess the competency of staff had been carried out. The registered manager said she would assess the competency of agency nurses. Monthly medicines audits identified any gaps in records or practice issues. Actions were identified and dealt with through supervision or team meetings. Some minor inconsistencies were found in the medicine administration records which reflected the findings of the medicines audits.

Observation of medicines rounds confirmed people were consulted about their medicines before they took them. People’s consent to have their medicines administered were recorded. If people were prescribed ‘as needed’ medicines they were asked if they needed them. Protocols describing the use of ‘as needed’ medicines were mostly in place. Medicines needing additional security were appropriately stored and records were completed satisfactorily. Stock levels were being monitored for all medicines and any spoiled medicines were returned to the pharmacy.

Is the service effective?

Our findings

A person said, “It’s a testimony to staff (how well I am), staff are so good, can’t fault them” and a relative told us, “There’s a good set of staff who know [name] needs.” People told us they thought their needs were met by staff who had the necessary skills, knowledge and training. One person commented, “They seem to know what they’re doing. I think they do get training” and another person said, “They know what they are doing. They must get training to be able to do this”.

People were supported by staff who had the opportunity to gain the skills and knowledge they needed. New staff would be offered the care certificate which monitors the competency of staff against expected standards of care. A new professional development plan had been put in place by the provider to monitor staff progress through the care certificate. This would include observations of staff practice evidencing their understanding of the training they had received. In addition, staff would be expected to complete questionnaires assessing their knowledge base. Each member of staff had an individual training profile identifying when refresher training was required. The registered manager had a training record enabling her to monitor the training needs of staff and allocate resources as needed. For example, a number of staff needed first aid refresher training and there was a focus on delivering end of life training.

For people living with dementia there was a perception by visitors that staff did not have the skills or understanding to meet their needs. A relative told us, “Personally, I think the staff need more training in dementia.” A health care professional had also raised similar concerns. Staff were delegated lead responsibility for dementia and met with other link workers from the organisation to discuss and exchange ideas about supporting people living with dementia. Staff had completed dementia awareness training. The registered manager had identified dementia care as an area for improvement.

Support for staff was provided through individual meetings with senior staff to reflect on their practice, roles and responsibilities and training needs. These meetings were scheduled throughout the year with an annual appraisal to monitor staff performance. In addition staff meetings had

been held to discuss service developments and improvements and to pass on good practice guidance. Daily handovers between staff kept them up to date with changes in people’s needs.

People’s consent for their care and support was recorded in their care records. Staff asked people for their permission before helping them. People were encouraged to make choices about the way they were supported. Staff had completed training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people’s capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Some people had appointed a person to manage their personal welfare and/or financial matters. The registered manager had copies of the Lasting Power of Attorney (LPA) and people’s care records evidenced this was in place.

The registered manager was aware of changes in case law around Deprivation of Liberty Safeguards (DoLS) and that additional DoLS authorisations needed to be submitted as a result. She said she was using a checklist to assess where people had been deprived of their liberty to keep them safe from potential harm. She would then submit the appropriate authorisations for consideration by the local authority. A DoLS had been submitted for one person. DoLS provide legal protection for those people who are, or may become, deprived of their liberty. Wherever possible the least restrictive solution was found to keep people safe and to minimise restrictions. For example, instead of using bed rails to prevent people falling from their bed, high/low beds were provided with a mat on the floor to reduce the risk of injury.

Some people had a ‘Do not attempt resuscitation’(DNAR) order in place. These had been signed by their GP and most evidenced discussion with either the person, their relatives and staff at the home. People’s end of life wishes were discussed with them and their preferences were recorded. Healthcare professionals commented on the excellent care provided by staff for people at the end of their lives.

People’s nutritional needs were assessed and where people were found to be at risk of dehydration or malnutrition a care plan described how they were to be supported to maintain their health and well-being. The cook described how they fortified food with supplements

Is the service effective?

such as cream, butter and full cream milk. People were also prescribed supplements by their GP. Staff monitored completed food and fluid charts for people assessed as being at risk. People had their weight recorded each week if needed otherwise they were taken monthly. A screening tool was used to illustrate people's weight loss or gain which also summarised the action taken to try to prevent further weight loss. A relative confirmed nutritional smoothies were given to help people maintain their weight. There were also high calorie or carbohydrate snacks, fresh fruit and cold drinks available around the home for people to help themselves. People had hot drinks when they wished. The dietary needs of people with diabetes were also catered for.

People had a choice of two main meals but other meals could be provided if needed. One person told us, "If I don't like anything on the menu they will do me a pasta dish. I love cheese and they always give me extra at night. I also have a cooked breakfast every morning." People chose

where to eat their meals, either in their room or dining rooms on each floor of the home. People who lived on the top floor occasionally had lunch in one of the dining rooms on the ground floor. If people needed help or support to eat their meals this was provided. Brightly coloured crockery was provided for people living with dementia to encourage them to eat and drink. People had complained about the temperature of meals being delivered to their rooms. Heated trolleys had been provided to make sure meals were served at the correct temperatures.

People were supported to stay well. They had access to a range of health care professionals. Records were kept for all their appointments commenting on any advice given and so future appointments could be followed up. People had access to the GP who visited each week, dental appointments, chiropody, physiotherapy and occupational therapy input. One person confirmed the optician had visited and another person said they had been to a "private dentist".

Is the service caring?

Our findings

People's experience of the care they received varied. There were inconsistencies in the way people were observed being cared for and looked after. Most people were treated kindly and were heard to be chatting and laughing with staff. Staff were attentive and responded sensitively and patiently. On occasion some staff were heard to be abrupt with people. For example, telling one person who asked for help they were "busy at the moment" and telling another person to "sshh" and not to "keep shouting". Staff meeting minutes evidenced where action had been taken to address the conduct of staff. The registered manager had commented, "Poor practice will not be tolerated." However, this was not everyone's experience and some staff were observed working closely with people, engaging positively and offering reassurance when needed. People who stayed in their rooms spoke highly of staff.

People gave mixed feedback about how staff responded to their needs. Some felt call bells were answered in a timely fashion whilst others said they had to wait for staff to respond. One person said staff would let them know if they were busy and a relative commented there appeared to be times, such as mealtimes, when call bells were ringing a great deal. When people were unwell staff alerted the nurse or community nurses to help relieve their pain or discomfort. Community nurses said, "Staff keep us really informed" and "They give really good care, we have no concerns".

People told us their care was either "excellent" or "good" and their personal needs were being met. Comments included, "Happy, I am very happy with the care", "They look after us well" and "I can't speak highly enough about the care I have received". A relative told us, "Excellent care" and thanked the registered manager "for everything you do for mum". Another relative said, "I am very happy with my mother's care. She is happy here." Staff told us, "We provide homely care", "We look after people well, we are warm and caring".

People's personal histories had been discussed with them and provided staff with background information about their likes, dislikes and routines important to them. Staff were heard reminiscing with people about their past or their hobbies. Visitors joined relatives at mealtimes if they wished or spent time sitting in the courtyard. One visitor commented they were worried about their relative who

had been unwell and so called in late one evening. Staff had made them welcome and they were reassured everything was fine. Another person said staff had set up a small dining room to have a private lunch with their wife when she visited.

People's spiritual and cultural needs were identified in their care records. People were able to go to religious services or to take part in the religious service at the home. If people had a preference for the gender of care staff providing their personal care this was highlighted and wherever possible respected. Accommodation could be provided if people wished to share rooms. For people living with dementia some signs had been displayed to indicate the purpose of rooms. Photographs around the home reflected activities they had taken part in.

People were able to give feedback about the service they received in a variety of ways. People said, "I always tell them what I want" and "If there is anything I want, staff ensure I get it". Each month people had a talk with their key worker to make sure their care records reflected the way they wished to be supported. Some people had said they had forgotten who their key worker was and so a photograph of their key worker was being put with their care records in their rooms. People were also able to attend residents' meetings where they talked about the quality of meals, activities and problems with the laundry. Any action taken in response to these meetings was relayed back to people. For example, appointing two staff to take a lead on providing activities.

People had access to information about local and national advocacy organisations. This was displayed around the home, in easy to read formats using photographs and pictures. They had information in the service user guide about what service they would expect to receive from the home. This included how to make a complaint. A person said, "If there are problems, you can go to the desk and speak to someone." People's personal information was handled confidentially. Their care records were kept in secure offices.

People were supported to be independent in their daily tasks. Their care records clearly stated what they could do for themselves and what they needed help with. For instance, using walking aids or transferring from chairs with only prompting from staff. People were offered the opportunity of helping around the home. Two people had been asked if they would like to help around the garden

Is the service caring?

and another person said they would like to help on the reception desk. Staff said one person looked out for some people living with dementia, helping them to relearn skills they had lost such as playing games.

Is the service responsive?

Our findings

People's needs had been assessed prior to admission and from this an interim care plan was put in place whilst staff assessed and monitored their needs to formulate their care records. People's needs were reassessed usually monthly and their care records would be updated to reflect any changes in their health or well-being. Most of these were for people in receipt of nursing care. Where some people's needs had changed their care records had not been reviewed or amended to reflect this. For example, one person's mobility care plan stated they were immobile and needed two carers to hoist them, although care staff and the daily notes confirmed they had been able to stand whilst transferring to a chair. For another person at risk of developing pressure ulcers, their care plan guided staff to reposition them every one to two hours but then contradicted this stating every three hours when in bed and every two hours when sitting. Inconsistencies with record keeping could potentially impact on the care being provided to people putting them at risk of harm or becoming unwell.

Where people were at risk of falling, developing pressure ulcers or dehydration or malnutrition additional monitoring charts were in place to make sure they were receiving the appropriate care and support. These were not always being completed at the appropriate intervals and some records appeared to have been completed in advance, for instance repositioning a person or giving a person fluids. Staff said monitoring forms should not be completed until after the person had been repositioned or they had a drink or eaten their meal. Where people had developed pressure ulcers, robust records monitoring the skin condition were not being maintained in line with best practice for example monitoring through photographs and recording the progress of the wound. There were no monitoring records in place for one person at risk of malnutrition because 12 months previously they were considered to be "at the end of life". Incorrect records in relation to care and support could result in people not receiving the appropriate care or support leading to further deterioration in their health.

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

The registered manager said they had identified issues with the maintenance and upkeep of care records. A new auditing process had been put in place to monitor and check that care records were being kept up to date. The records for people receiving care and support from care staff were being amended and changed to reflect any changes in their needs and the response of staff. These reflected what action had been taken for example where people had falls, referrals were made to health professionals to assess them for equipment or to check on their physical health. Where people were at risk of developing pressure ulcers, strategies were in place to monitor their skin condition such as using special mattresses, cushions and making sure they were repositioned. Community Nurses said, "They are really hot at tissue viability" and "Staff keep us informed, they get in touch if they notice any pinkness on the skin".

Concerns had been raised about some people spending long amounts of time in their wheelchairs. The registered manager said some people had refused to transfer to ordinary chairs in the lounge or dining room. For one person a referral had been made for a special easy chair which they could use when out of their room similar to one they already had in their bedroom. Staff had been prompted to encourage people to transfer from their wheelchairs to other chairs and this was observed to be happening. A health care professional had observed staff helping people with moving and handling tasks which they reflected was done well.

Most relatives said they were given feedback about the care and well-being of people living in the home. One person said, "If anything changes or is needed they let us know." Although one relative said they had not been informed as soon as they would have wished about a person being admitted to hospital. Visitors commented about the positive changes in their relatives. One told us, "When she arrived she was susceptible to falls, they changed her room to a bigger one and the falls reduced drastically." Another visitor said, "Now my Mum is safe and seldom has a fall." A person told us, "This is the best thing that could have happened to me. When I arrived I couldn't walk, I can walk unaided and am looking towards going home." The registered manager said they involved the family as much as possible telling them, "You know the person best and we are learning from you."

Is the service responsive?

People had raised concerns about the lack of activities. Some people said they were “bored” but others said, “We do have entertainment now and again”. New activities had been arranged in response to people’s feedback. People had enjoyed a trip out to a local shop and were planning to go to a local festival. Staff had organised musical entertainment and a baking session. People enjoyed a musical entertainer and also inviting relatives to themed events. People organised games such as scrabble or cards. Staff also spent time with people who preferred to stay in their rooms, whether having a chat or taking tea with them. Staff described how they had tried to encourage people with former hobbies. One person liked to grow vegetables and had grown seeds in their room which were later planted out. Another person had been offered a plot in the garden.

People knew how to raise concerns and said the registered manager was always available if they had any issues. Information about how to complain was displayed around the home and people were given a personal copy. Complaints were looked into and investigated by the registered manager. Complainants were informed about any action taken to address their concerns. Some people had commented they felt they had not been listened to and the appropriate action had not been taken. The representative of the provider said all complaints were fully investigated. A full record was kept of all complaints which the provider monitored. The registered manager said they learnt from previous complaints and invited feedback from people and their relatives so that minor issues could be dealt with as they arose.

Is the service well-led?

Our findings

Allegations of abuse had been raised and investigated on behalf of people. The provider had discussed these issues with the appropriate authorities and social care professionals. The safeguarding authority had been notified of these incidents. The Care Quality Commission (CQC) had not been notified of all allegations of abuse. CQC had also not been informed about serious injuries to people and expected or unexpected deaths since January 2015. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and those important to them said they were able to give feedback about the service provided and action would be taken to improve their experience. They commented, “She [registered manager] has an open door policy”, “They never sweep anything under the carpet” and “You can say whatever you want”. An annual quality assurance survey conducted in 2015 invited people and others involved in their care to comment on the service provided. Actions included to maintain staffing levels. People also provided feedback through residents’ meetings, complaints and informal talks with the registered manager. Staff said they would raise concerns and were confident the registered manager would take the necessary action in response. A member of staff said, “Trust me, we would raise concerns if we had any.”

The registered manager was supported by a residential care lead. A lead nurse had been appointed and would also be part of the management team. Feedback was given to the registered manager after the first day of our inspection about our findings. On the second day she had dealt with concerns about pressure relief mattresses which had not been set to the correct inflation pressure. She confirmed they had been adjusted to the correct pressures and staff would include checking these as part of their equipment checks. Feedback about staff performance was being looked into. Health care professionals said the registered manager and staff were always accessible “no matter how busy” and had “information and documents at hand when needed”. People and their visitors complimented the management of the home saying they were “approachable”.

The registered manager said their vision was to “maintain a happy, homely atmosphere. Offering different activities, give dementia care more focus and offer excellent end of life care”. The provider’s website stated their values for the organisation were that, “All staff believe that every person is an individual and as such is unique. All staff acknowledge that residents have the right to expect a high standard of care, delivered by safe, competent team members.” The provider carried out monthly quality assurance visits to monitor the quality of care provided. These visits generated an action plan identifying issues such as improving medicines administration records, updating care plans and monitoring staff conduct.

Audits were completed by the registered manager and staff to assess the quality of service provided. They checked the upkeep and maintenance of the environment, the review and updating of care records, the servicing and checks on health and safety systems and the administration of medicines. Action plans were developed if any issues were identified and these were being followed up to make sure they had been addressed. Accident and incidents were monitored to assess for any trends to prevent further harm to people. The registered manager said they learnt from complaints and made improvements or changes to the service where needed.

Challenges for the provider and for the registered manager continued to be the employment of nurses rather than a reliance on agency nurses. They had also reflected on the experience of people staying for emergency respite. Concerns had been raised about the care they received. In response the registered manager had discussed with staff how they would not “fail respite residents”. A new pre-admission assessment would be used to assess whether their needs could be met and if staff had any doubts they were to refuse admission. The registered manager had also responded to on-going problems with the review and update of people’s care records by allocating each member of staff protected time each week to complete this work. Staff commented this would help them to maintain people’s records.

The registered manager described how the registered managers for all locations managed by CTCH Limited met and exchanged views and service improvements. The provider also had representatives who attended local networks and a providers’ association. Information and guidance from these was cascaded to the registered

Is the service well-led?

manager. A local commissioning group had completed a medicines audit of the home as part of a pilot scheme for

Gloucestershire. They commented, “Staff knew the residents well and were able to provide valuable information about their medicines and associated conditions.”

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not being protected against the risks of inappropriate care or support, an accurate, complete and contemporaneous record in respect of each service user was not being kept. Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission of incidents which occurred whilst services were being provided in the carrying on of a regulated activity. This included informing us about safeguarding alerts, serious injuries and deaths. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications