Shaw Healthcare (Wraxall) Limited

The Granary Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Granary Care Centre is a care home providing care for up to 78 people living with dementia. Within the home there is a unit called Crofter's Lodge for people with complex needs. Crofter's Lodge can provide treatment for people detained under the Mental Health Act 1983. The Granary comprises two floors, the first floor is for residential care and the second floor is for nursing care.

The home is purpose built and all bedrooms are for single occupancy. During our inspection there were 14 people living on the first floor and 22 people living on the second floor in The Granary and eight people living in Crofter's Lodge.

We inspected The Granary Care Centre in August 2015. At that Inspection we found the provider to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulations included; safe care and treatment, need for consent and receiving and acting on complaints. We also completed a Mental Health Act visit inspection in Crofters Lodge on 6th January 2016.

The provider wrote to us with an action plan of improvements that would be made. They told us they would make the necessary improvements by March 2016. During this inspection we saw the improvements identified had been made. However we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

The inspection took place on 10, 11 and 13 October 2016 and was unannounced.

There was a manager in post but they were not registered with us. 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 manager was in the process of completing their registration application with us.

Risks to people were not always identified. Where risk assessments were in place they did not always contain accurate and up to date information. The home was not regularly assessing risks relating to people when they were granted leave from Crofters Lodge which put the safety of people at risk.

There was some information missing from records relating to how people took their medicines. Authorisation was not always sought around changing medicines where this was a legal requirement. Medicines were stored securely.

People were supported by staff who were not directly employed by the service. Relatives and staff raised concerns about the number of agency staff the home used at times to cover their vacant posts. There were times when night shifts were covered predominantly with agency staff. We saw the same agency staff were requested to work at the home to provide consistency.

There were some gaps in staff training and the manager had plans in place to address this. New members of staff received an induction which included shadowing experienced staff; they told us this prepared them for the role.

Staff did not always feel supported, listened to and valued. Staff did not always receive regular one to one supervision with their line manager. Where improvements were identified with staff performance, this was monitored and reviewed by their manager.

Care plans did not always include accurate and up to date information. Records were not always fully completed by staff.

The provider had a system in place to audit the service, whilst the audit identified some of the concerns we identified during our inspection there were areas of concern that were not covered in the audits.

The provider was not notifying us of all incidents in line with their legal responsibility.

Relatives said the home was a safe place. Systems were in place to protect people from harm and abuse and staff knew how to follow them.

A recruitment procedure was in place and staff received pre-employment checks before starting work with the service.

Relatives told us their family members were happy with the food provided.

Relatives told us they were confident they could raise concerns or complaints with the staff and they would be listened to.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were not always authorised to be administered to people in line with legal requirements.

People were at an increased risk of being exposed to an infection because safe procedures were not always being followed.

People were supported by staff who knew how to recognise and report abuse.

People were supported by staff who had received satisfactory checks prior to commencing their employment.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People were not supported by staff who had regular one to one supervision with their line manager.

People had access to healthcare services.

Relatives told us people were happy with the food provided.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People's privacy was not always respected.

Staff were not always aware of important information relating to people.

People were supported by staff who were caring in their approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain accurate and up to date information relating to people. Staff were not always recording information relating to people's needs.

People and relatives were supported to take part in activities. There were not always enough activities to meet people's needs.

Relatives felt confident to raise concerns about people's care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The quality assurance systems in place did not make sure all areas for improvement were identified and addressed.

People's relatives and staff raised concerns about the frequent changes of managers there had been in the service.

The provider was not always notifying us of incidents relating to people in line with their legal responsibilities.

The Granary Care Centre

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 10, 11 and 13 October 2016 and was unannounced.

The inspection was completed by one adult social care inspector, two mental health inspectors, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports. We also viewed other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We requested this information during our inspection. We also obtained the views of service commissioners from the local council who also monitored the service provided by the home.

During the inspection we spoke with five relatives about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore 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.

We also spoke with the manager, the deputy manager, the project manager, the operations manager and 23 staff members including registered nurses, occupational therapist, agency staff, the cook, laundry worker and domestic staff. We also spoke with a visiting health professional. We looked at documentation relating to 18 people who used the service, nine staff recruitment and training records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

Some improvements were needed to make sure people's medicines were always given safely. People who were given medication under the provisions of the Mental Health Act did not always have their legal rights properly managed and recorded.

At our last inspection we found that medicines were not always administered safely due to staff not ensuring they followed infection control guidelines and washing their hands. During this inspection we saw that staff used safe infection control procedures when giving people their medicines. The nurse used disposable gloves when they administered people's eye drops. Staff checked the medicines administration record sheet and the medicines labels to make sure they gave people the correct medicines.

We looked at 31 people's medicines administration records (MARs). Some people were prescribed medicines to be given 'when required' for example for pain relief or anxiety. Additional information was available to help staff give these in a safe and consistent way. Some of these medicines were only used occasionally. There was no record of how much stock was carried forward from one month to the next, so it was difficult for staff to check these medicines had been given as recorded. Crofters Lodge had access to a monthly check list and staff used this to check each person's medicines. However, this was not used in The Granary.

Some people on Crofters Lodge were detained under the Mental Health Act 1983 and had their medicines authorised by a Second Opinion Appointed Doctor (SOAD), in line with the Mental Health Act 1983 Code of Practice. However we saw three examples where the psychiatrist had prescribed people additional medicines without requesting a SOAD to visit and authorise the changes. This could put people at increased risk of harm from the administration of inappropriate medicines.

Several people using the service had authorisation for their medicines to be given covertly. This meant that if the person declined to take them staff would disguise them in food or a drink. People's records included a list of the medicines, which staff could give covertly. However, we saw that this was often completed as 'See hospital discharge letter' or 'See Mar chart'. Also it was not clear that the person's medicines had been reviewed to decide which medicines needed to be given covertly, if they were declined. There was no information to describe to staff how they should give the medicines, for example mixed in food; so it was not clear that staff had checked with the pharmacist that the methods used were appropriate and safe for the medicines prescribed. One nurse told us she would only give medicines covertly after the person had been offered them, and declined them twice. We saw two examples of care plans which supported this. However, the MAR charts did not show whether people had willingly taken their medicines or they had been given covertly. This meant it wasn't clear when people received their medicines covertly or which medicines had been administered in this way.

Some people were prescribed creams and ointments which were applied by care staff. Whilst there were

clear instructions for staff to follow on where they should be applied we found records were not always being written for when they were applied. This meant it was not clear if people were receiving the creams as prescribed by their GP.

Where there were risks to people these were not always identified and measures implemented to reduce the risk. For example, in Crofters Lodge there were a number of ligature points present in each person's room. A ligature point is anything, which a person could use to attach a cord, rope or other material for the purpose of hanging or strangulation. These included a strong coat hook on the back of each en-suite bathroom door, curtains that did not have collapsible rails and a solid metal bar in each person's wardrobe. Communal areas also contained a number of ligature risks. Staff we spoke with had no awareness of the ligature risks present on the ward and how these would be mitigated if a patient at risk of self-harm was admitted. The provider had not supplied either ligature cutters or the training staff needed to use these items safely and effectively. This could place people at risk of harm if they attempted to ligature. During our inspection the managers started removing the ligature points from the environment.

There were two clinic rooms available in Crofters Lodge and staff used one of these as an office and staff room. Both of the clinics were cluttered and untidy. There was no examination couch or emergency resuscitation equipment available in Crofters Lodge for staff to use in the event of an emergency. We discussed this with the manager who informed us the equipment had been ordered and was present in the service. We saw that the defibrillator was in Crofters Lodge before the end of the inspection. However, only the manager and the deputy manager were trained how to use this. They planned to arrange training for staff to use the defibrillator.

Staff on Crofters Lodge told us they supported people who were sectioned under the Mental Health Act 1983 (MHA) to go out without completing ongoing assessments of their risks. For people who are detained under the Mental Health Act 1983, the only way they may be allowed, lawfully, to go outside the hospital grounds is if the responsible clinician (RC) has granted leave of absence under section 17 of the MHA. Whilst the provider provided us with copies of authorisations for leave from the RC, there was no evidence of a risk assessment being completed prior to the person going on leave. Staff we spoke with told us risk assessments were not undertaken prior to any person taking leave. It is important for assessments to be carried out before each period of leave to ensure the person is suitable for the leave before it occurs. We saw no records that the outcome of leave was assessed or recorded on return.
When we asked managers about this, one said it was because people did not go out and another manager told us they did go out and staff did not know they had to complete documentation before going on leave. This meant people were leaving the home without the proper assessment to ensure they remained safe.

Some people received support in their beds and had pressure relieving mattresses in place to prevent them from developing pressure ulcers. We found there were no systems in place to check the mattresses were set at the correct pressure, as they did not automatically adjust to the person's weight. We looked at the mattress settings and noted seven were not set at the correct pressure. Staff were not aware of this. This meant people could be at increased risk of developing pressure ulcers. Two people living in the home had pressure ulcers, we found these minor and were being managed appropriately. We discussed the mattress settings with the manager who arranged for the pressure to be checked and altered to reflect the correct pressure. The manager confirmed this would be recorded in people's care plans and all staff would be made aware.

At our last inspection in August 2015 we found people were at risk of receiving care from staff who were unfamiliar to them because the home were using high levels of agency staff. We found there were not always measures in place to mitigate the risk. During this inspection we found the provider had taken some action

to address our concerns. For example, the manager told us how they had significantly improved their permanent staffing allocation since January 2016. They told us they had an on-going recruitment programme and they had recently successfully recruited new workers. The manager told us they were running on the same staffing levels as if they were fully occupied on the second floor and they had an additional nurse working at the weekends. On Crofters Lodge there was a Psychiatrist available two days a week. There was an on call manager available out of hours and at least one registered nurse on duty at all times for the whole home.

We received mixed feedback from staff regarding staffing levels and the agency booking arrangements. Comments included "We don't always have the same agency, late booking often means getting new staff and this has the potential to compromise care". However, our observations were that regular agency staff were mostly used. The manager told us they were block booking agency staff in advance to ensure staff consistency. We looked at the previous six weeks staff rotas and noted where agency staff were booked the majority of these had worked in the home on more than one occasion, which meant these staff were familiar with the people they were supporting. Other comments from staff included "We use regular agency and staffing levels are safe" and "Lots of regular staff have left, one weekend is particularly bad for regular staff and we generally use regular agency". An agency staff member told us "I work with regular permanent staff and regular agency; I am almost like a permanent staff member". Whilst some staff raised concerns about the amount of agency staff used at times, they all commented that they felt people were safe.

Relatives views on staffing was also mixed, one relative said "There are too many agency staff. Management do try to mix agency staff with experienced staff." Other comments included "There are lots of agency staff", "There seems to be a big turnover of staff so there isn't any continuity" and "Regular staff and regular agency staff are best, as continuity is needed." Another relative raised concerns about staff availability in communal areas at times. The manager told us a staff member should always be present in the communal area and staff confirmed this. On each day of our inspection we observed a staff member was available in the communal area at all times.

Three staff members raised concerns about the high use of agency staff on the second floor during the night. One staff member said "Sometimes we work with a lot of agency staff, it can be difficult and you feel worn out." Another commented "We generally have 11 to 12 people to support to bed at night. It can be a struggle when you work with all agency, you have to check everything has been done. Although some agency staff are really good."

We looked at the night rotas for the second floor and noted over a six week period on 17 occasions the second floor was running on one permanent staff and three agency staff. On three occasions the home was running on solely agency staff. We saw the majority of the agency staff were used regularly. However, because information relating to people and potential risks to their safety was not always kept up to date this meant people were at risk of receiving unsafe care.

People were at an increased risk of being exposed to an infection because safe procedures were not always being followed. For example, one person in Crofters Lodge was being nursed in their bedroom in isolation because they had an infection. We noted they had their bedroom door open during the majority of the inspection. This included when a staff member was providing them with fluids. When the member of staff was not in the room, they sat outside with the door open maintaining one to one observations. Staff did not acknowledge that having the door open put other people at risk because of the increased risk of the infection spreading. We also observed trolleys in the corridors with soiled laundry on and one of the areas had a strong smell of urine. By having soiled laundry exposed this meant there was an increased risk of an infection spreading.

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

Staff had recorded the medicines they had given to people and the reason, if regular medicines were not given. A small number of people had additional information with their MAR charts including a description of how they liked to take their medicines. This helped to make sure staff would give people their medicine in the most appropriate way. Staff said this had been in place for everyone in the past.

Where people were given their medicines covertly suitable checks were done to make sure this was appropriate and in the person's best interest. The doctor, nursing staff, the person's next of kin and the pharmacist were involved in these decisions.

Suitable systems were in place for ordering medicines. Staff told us the system worked well. People's medicines were available for them. We saw examples of medicines audits from April and July 2016. These looked at a sample of three medicines from two peoples MAR charts and the 'when required' medicines protocols for another two people. Crofters Lodge used a monthly medication check list, which was kept with the medicines administration record sheets.

Medicines were stored securely. Each floor of the home had suitable storage areas for medicines. Staff used locked medicines trolleys to transport medicines around the home securely. Staff monitored the temperature of both medicines storerooms and medicines refrigerators to make sure they were kept in the safe range for storing medicines. Suitable storage was available for medicines which need additional security. Staff made regular checks of these medicines to make sure they were looked after safely.

During the inspection the manager showed us a 'weekly clinical checklist' they had created for nurses to complete on Crofters Lodge. The areas in the checklist covered availability of emergency equipment and checks on medicines storage, stock and records.

Whilst the home was using high levels of agency staff at times, the rotas demonstrated there were enough staff available to meet people's needs. The manager informed us they were staffing the service as if they were fully occupied with people. We looked at four weeks staffing rotas and noted staffing levels were consistently met in line with this.

We looked at risk assessments and noted where there were other risks to people's personal safety had been assessed and plans were in place to minimise these risks; such as using bedrails and the risk of falls. We found where risk assessments were in place these included measures for staff to follow to keep people safe. Staff we spoke with were aware of the measures in place to reduce risks.

Relatives thought their family members were safe at The Granary Care Centre. Comments included; "Yes I trust there are enough trustworthy people to ensure any others are too, if you know what I mean", "Generally I trust the staff they're well-meaning and hardworking" and "Yes I do up here."

All staff felt people were safe and were able to demonstrate an understanding of what might constitute abuse and how to report it, both within the service or to other external agencies such as the Care Quality Commission and the local authority. Staff felt able to raise any concerns with the managers or externally to the safeguarding agency. One staff member told us "We have to report any concerns straight away." Another commented "I have never seen anything that concerned me and I would report anything to my line manager." Staff including the agency staff had received training in safeguarding adults and training records confirmed this. We observed information around the home instructing staff on what action to take if they

thought a person was being abused. Staff were aware of the whistleblowing policy and told us they would use it if they had concerns. Where concerns had been raised we saw the manager had taken the appropriate action to keep people safe.

Staff were aware of what could make people become anxious and how they should respond to them in response to this. During our inspection we observed staff in The Granary reassuring people and using techniques to distract them where people were showing signs of anxiety.

Staff were aware of what incidents they needed to report. These included personal care provided under restraint, falls, trips, verbal aggression and hostility and unexplained bruising. Staff that had received specific training and qualified nurses completed the incident forms. The nurse signed off any incident forms completed by care staff.

A recruitment procedure was in place to ensure people were supported by staff with the appropriate experience and character. Staff told us they were not able to work with people until the pre-employment checks had been undertaken. We looked at staff files to ensure these checks had been carried out before staff worked with people and found these were in place. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people. Records confirmed the checks had been completed.

Requires Improvement

Is the service effective?

Our findings

Some aspects of the service were not effective.

People were not supported by staff who had regular supervisions (one to one meeting) with their line manager. Staff told us supervision meetings were important to them as they enabled them to discuss any training needs or concerns they had. Each staff member spoken with said supervision was irregular, often with months between meetings. One member of staff told us "Supervisions are not regular; I know managers are busy but it's not very supportive." Another said, "I don't have regular supervisions; I know I would benefit from some constructive criticism." The records we looked at confirmed the views of staff. For example, we looked at nine staff files; two staff members had not had supervisions recorded in the past five months, six files had no record of any staff supervision and one had not received supervision in the past year. The provider's supervision policy stated 'All employees are to receive a minimum of six formal supervision sessions each year. Of these, no more than two can be Group Supervision sessions'.

Staff we spoke with told us that they felt able to raise concerns. However, not all of them felt confident managers would listen to them. One staff member commented they felt senior managers dis empowered them and prevented them from improving the service. They said they felt their ideas were over ridden by managers and they were not allowed to implement new procedures that they thought would benefit people. There was a lack of opportunities for staff to express their views because supervisions were not regularly being held. Staff told us the manager was not visible on Crofters Lodge and they did not have any interaction with more senior managers. Managers confirmed they did not spend time in Crofters Lodge because the staff working there were qualified in working with people who have mental health needs. This meant people were being supported by staff who were not fully supported to enable them to carry out their duties.

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

The manager acknowledged they needed to improve the regularity of staff supervisions, they told us they had allocated a line manager for all staff and they would be undertaking supervisions. Records demonstrated where staff were working below the required standard this was formally discussed with them and included details of the required improvement. We also noted 'feedback' forms were used for positive feedback to be given to staff. One staff member told us they had received positive feedback from an external professional and expressed how pleased they were at being recognised for this. During our inspection supervisions were being carried out by the project manager for staff working in Crofters Lodge.

At our last inspection in August 2015 we found people were not receiving effective care because there were not effective processes in place to support people to make best interest decisions in accordance with the Mental Capacity Act 2005. During this inspection we found improvements had been made.

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. Any restrictions placed on people should be regularly reviewed.

People living in The Granary had their capacity assessed where they lacked capacity to make decisions and we saw evidence of best interest decisions being made with the relevant people involved. Areas covered included, covert medicines administration, the use of bedrails and where people were resistive of personal care.

All staff received training in the MCA. However, staff we spoke with on Crofters Lodge were not confident in discussing the five main principles of the Act. Some of the staff we spoke with in The Granary told us they thought they would benefit from more training on the MCA and how this related to the people they supported. The operations manager told us they would look at arranging further training for staff in the subject.

People can only be deprived of their liberty so that they can 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 any conditions on authorisations to deprive a person of their liberty were being met.

The service had submitted Deprivation of Liberty Safeguards (DoLS) applications for all the people living in The Granary and one person living in Crofters Lodge because people would not be safe if they did not have certain restrictions in place. The manager told us they were waiting for the outcome of these.
At the time of our inspection there were four people subject to the Mental Health Act 1983 (MHA) living on Crofters Lodge. Section 132 of the Mental Health Act 1983 (MHA) places a responsibility upon managers to take all practicable steps to ensure that all detained patients are given information about their rights upon admission. Staff made people aware of their rights under Section 132 of the MHA on admission and they were repeating the process at regular intervals. This was in line with the MHA code of practice guidance.

Staff said they received an induction when they joined the service and records we saw confirmed this. They said the induction included a period of shadowing experienced staff and looking through records. They also told us they completed their mandatory training during their induction and said it prepared them for working in the role. We saw the induction linked to the Care Certificate Standards. The Care Certificate Standards are standards set by Skills for Care to ensure staff have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff felt they had enough training to keep people safe and meet their needs. However staff commented they thought they would benefit from training in supporting people who had stiffness and lack of movement in their limbs to move. They told us they had to move these people's limbs as part of their daily personal care routine and at times this could be difficult. We discussed this with the operations manager who told us this would form part of the moving and handling training in future for all staff.

We looked at the training records and found there were some gaps where staff required refresher training. The manager had plans in place to address the gaps. Training included core skills training that the provider had identified such as moving and handling, safeguarding adults from abuse and infection control. Staff also received training in caring for people living with dementia.

Relatives told us they were happy with the food provided although one relative did comment on the

regularity of their family member having mashed potatoes commenting, "It's good quality but very repetitive and too much mashed potato, virtually every day." Other comments from relatives included, "It's good. [Name of relative] likes it, particularly the puddings and cakes" and "The standard of food is good. The way they serve from the hot trolley ensures the food is warm and the chopping up seems consistent. [Name of relative] has coeliac disease and they deal with it well. There is a constant influx of drinks and snacks. Very happy." There was a 'food comments' book in the reception area of the home and we saw where comments were made regarding the food the cook responded to these.

There were four hot meal options on the menu daily. Staff asked people each day what they would like to eat. The cook told us there were alternative options they could offer if people did not like what was on the menu. The cook had a record of people's likes and dislikes, allergies and dietary needs in the kitchen. We also saw a record of this in people's care plans. The cook told us when people were identified as losing weight the care staff would communicate this to them and they would fortify people's meals with additional calories. Guidelines were in place to ensure people received a diet in line with their needs and staff were following these.

We observed lunchtime on the second floor of The Granary. A high level of people required staff support with their meal. Meals were served from a heated trolley and care staff were responsible for serving meals. We observed one person was sat in the dining room waiting for their meal for 45 minutes. Another person had their meal placed in from of them and then subsequently removed because the staff member was called to help another staff member support another person. The staff member did not communicate to the person why they took their meal away, although this was placed back in the heated trolley to keep it warm. One person's care records stated they liked to 'eat in a quiet environment'. We observed this person was being supported with their meal in the lounge which was very noisy. This meant people were not always supported to have a positive mealtime experience.

We discussed this with the manager and dementia lead who told us they were considering staggering meal times to ensure there were enough staff available to support people. The dementia lead told us they had been working with staff and focusing on mealtimes to make this a better experience for people. This involved them completing observations and giving feedback. They told us in response to their observations they had moved the timing of lunch being served as they noticed it was rushed. They also told us they had recommended staff were allocated to support people during lunch and we observed this during our inspection.

Staff told us the activity coordinators helped out at meal times and described them as a "Godsend." We observed the activity coordinators helping out at breakfast and lunchtime on the second floor. Staff also confirmed at times when they were busy the project manager and manager would help out on the second floor.

Where staff supported people with their meals this was completed in an unrushed manner. Staff explained to the person what the meal was and checked they were ok with the meal and the temperature. Staff sat on the same level as the people they were supporting and maintained a good level of eye contact.

On Crofters Lodge staff recorded that they encouraged and monitored food and fluid intake for people in their care. Staff documented this in care records. However, at the time of the inspection, we observed staff gave one person toast for breakfast, staff placed it beside the person and then encouraged them to get up and dance to music playing on the radio. This meant the person was not given time to eat their breakfast and the toast was left to go cold.

People saw a GP when required. A local GP visited the home routinely every week or sooner if required and relatives told us they were happy that staff responded to their family member's health needs. One relative told us "[Name of relatives] health needs are looked after. Staff told us there was a good working relationship with the local GP practice and people were supported to see other health professionals such as a chiropodist and speech and language therapist where required.
On Crofters Lodge staff told us they were involved in a 'ward round' each week with the consultant. This also included the Occupational Therapist and the qualified nurse on shift. Occasionally the manager attended. Once a month the physiotherapist attached to the ward also attended. This meant staff had the opportunity to discuss each person with these health professionals each week.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring.

People's preferences around their care were not always respected. People's care plans included information relating to the preferred gender of staff supporting them. We saw one person's care plan stated they preferred 'female staff at all times' when being supported with personal care. Staff confirmed the person required two members of staff to support them and regularly the second member of staff would be a male. This meant the persons preferred choices were not being acted on and respected.

Staff working on The Granary were not always aware of important information relating to people and their past life history. For example, one person's care plan stated they could become anxious whilst being supported with personal care. It went on to say for staff to 'support with a non-rushed approach' and it was 'essential to discuss their family and the navy'. The care plan also stated '[name of person] responds well when you talk about the navy'. Whilst staff were clear the person's family were important to them and how they should support the person without rushing, they were not aware of the importance of the navy. We spoke to five permanent care staff and two agency staff about what was important to this person and none of them were able to tell us about the navy.

On Crofters Lodge we saw care plans which focussed on the individual. However, people had not been offered a copy of their care plan. Care plans had not been discussed with people and meetings were not held with people to discuss their care. Staff did not include people in decision making and staff were not supporting people to enable them to express their views and suggest improvements. All the staff we spoke with in Crofters Lodge told us people were not involved in decision making. One staff member said "What the Drs says goes; he makes the decisions no one else". We discussed this with managers who told us people living on Crofters Lodge were not involved in their care. This meant people living in Crofters Lodge were not involved in decisions about their care and treatment.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy was not always respected. On Crofters Lodge we also observed staff giving one person nursing care with the door open. This meant that staff had compromised the person's dignity. All bedroom doors had vistamatic windows, (these are privacy vision panels made up of three sheets of glass sealed as a single panel with evenly spaced, alternating lines and a handle to allow privacy or observation). These were open on every bedroom door which meant staff and people could see into people's rooms. Staff told us they did not know they could shut them.

On Crofters Lodge we observed an unlocked office with the door wide open and no staff present. We saw people's care records with personal details exposed on an open bookshelf. This meant confidential information about people was not being kept securely.

We received mixed feedback from relatives of people living in The Granary about their involvement in the assessment and planning of their family members care. One relative commented, I can't remember them asking, but they did ask when they changed a time for his medication." Other comments included; "I wouldn't say that I have much say in care plans", "I have been involved in care plans, but not for a while now" and "As things have evolved, I have been involved."

We saw examples of person centred care being delivered in The Granary. For example, one person who was an ex farmer and loved animals, and being with them had a pretend pig. They appeared to be happy engaging with the pig and their care plan confirmed they enjoyed this. We saw another person had a baby doll in a pushchair, they were engaging in conversation about this with other people living in the home.

Staff on The Granary described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains, covering people's body parts whilst supporting them with personal care and knocking on people's bedroom doors. One staff member said "We make sure we knock on people's doors and ask them what help they want."

Staff told us how one person could become anxious whilst they were supporting them with personal care. They told us how they responded to the person by reassuring them and letting them know what they were doing. They said if the person continued to be anxious they would leave the person for a short period of time and go back and try again. This reflected what was in the persons care records.

Relatives were happy with how the staff treated their family member. When asked if they were happy comments included; Yes, absolutely", "The regular staff yes" and "Very well cared for particularly by two of the regular staff."

Relatives also commented that staff were kind and caring. Comments included; "They are very kind and caring and work so, so hard", "Very caring and considerate, especially the regulars" and "Very caring especially the regular staff. [Name of relative] has a better rapport with some than others."

During our inspection we observed caring and kind interactions from staff towards people. For example, staff engaged in friendly conversations, one staff member commented on how 'lovely' a person looked and staff gave people reassurance where they appeared to be anxious or confused. We observed staff supporting people to transfer using a hoist, staff checked the person was alright throughout the transfers reassuring them and telling them what was about to happen at each step. People appeared to be relaxed and comfortable around staff.

Each person who lived at the home had a single occupancy room where they were able to see personal or professional visitors in private. Relatives told us visitors could visit at any time, there were no restrictions and they were made to feel welcome. During our inspection we observed visitors coming to the home throughout the day, there was a visitors signing in book in the reception so the staff knew what visitors were present in the building.

The service had received compliments from family members; these were shared with the staff team verbally. Any specific compliments relating to a staff member were recorded on a 'good performance' form that was kept on the staff members file. We saw one recent compliment from a family member that referred to a staff member supporting their relative during lunchtime. They commented the support their family member received was 'First class'.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive.

Each person had a care plan that was personal to them. We found that care plans did not always include accurate, clear and up to date information. For example, one person had been assessed by a physiotherapist because their muscles were contracting causing them to become stiff and have limited movement. The outcome of the assessment was for staff to 'place a towel between their knees, using a wedge to assist positioning and gradually increasing the depth of the wedge and reposition her legs every 2 hours'. Whilst the person's care plan made reference to these instructions in 2015 we found where the care plan had been updated it did not make further reference to review how effective this had been in supporting the persons movement. Staff told us they were positioning the towel in between the persons legs in line with the guidance. However, we found the daily records of the person's care did not make reference to this to enable staff to review how effective the positioning had been.

Another person's mobility had changed; they were no longer able to stand and required hoisting by two staff. The person's moving and handling assessment made reference to the person standing and was written on by staff to state that it needed updating. Whilst the evaluation section of the care plan made reference to the person needing to be hoisted, there was no moving and handling guidelines in place for the person to use the hoist. This meant there was a risk the person could be supported to stand by staff because clear guidance was not available to staff. Whilst the staff we spoke with knew the person was to be hoisted with two staff, this information would not be clearly available for staff who were unfamiliar to the home, which could put the safety and quality of care to people at risk.

Staff were required to complete daily records to ensure people were receiving the care they required. We found the records were not always completed, accurate and up to date. For example, one person's care plan stated they were prone to urinary tract infections (UTI) and were required to drink one to one and a half litres of fluid each day. The person did not have a record of daily fluid intake in their care records. We asked staff how this was monitored and they told us the person was drinking well. The person's daily records stated they 'drank a fair amount' and 'good fluid intake' with no specific amount recorded. This meant the person could be at risk of not receiving enough fluid because accurate records were not being kept. Staff confirmed the person had not recently had a UTI. We discussed this with manager who spoke with the nurse and arranged for a fluid chart to be implemented straight away.

We also found where staff were required to record specific aspects of a person's care routine this was not consistently recorded. For example, where people required staff support with changing of their continence wear and to record urinary output the records were not always kept up to date. Records indicated one person did not receive support to change their continence wear for 17 hours and another for 16 hours. Staff told us this was because the staff were not recording this accurately rather than the person not receiving the care.

This meant people were at risk of receiving care that did not meet their needs because accurate, complete and contemporaneous were not kept in respect of these service users.

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

Some of the staff we spoke with told us they did not have time to read through all the care plans; however they said they read through people's daily record files which included information relating to specific needs such as repositioning and food and fluid intake. They also said important information was given to them during the daily handover.

Some of the care plans we looked at contained informative information for staff such as how a person indicated they were in pain where they were unable to communicate verbally. They also contained clear guidance for staff to support people when they became anxious and staff demonstrated they were following this.

We received mixed feedback about relatives input into care plans. They all stated they were happy with the care plan; however one relative did raise concerns with us over accurate recording of information. This is comparable to what we found during our inspection.

The project manager told us they had been given the task of overseeing the updating of all the care plans and planned to complete this within six months. They showed us the new care plan template they planned on using and explained this would encompass the important information relating to people's needs and preferences. They described how they planned on involving the nurses and staff in this process to enable them to have some input and take ownership over the process.

Staff told us important information relating to people and their changing needs was discussed during the daily handover. We observed handover on the first and second floor in the morning and this involved the nurse from the night shift giving a detailed verbal handover relating to relevant information about each person to the whole of the team on duty during the day. The nurse also kept a written record of the handover. This meant important information relating to people was being communicated to the staff on shift each day.

We received mixed feedback from people's relatives about the activities on offer. This was generally due to their family member not being able to or preferring not to engage in the activities on offer. However we observed people appearing to enjoy engaging in the activities on offer during our inspection.

There were two activity coordinators in post and one activity coordinator post vacant. The activity coordinators appeared busy and were working hard to support people to engage in group and one to one activities and they based themselves in The Granary. The manager told us the activity coordinator vacancy was being advertised and it was apparent this void was impacting on the engagement and social activity of the people living in the home. For example, at times we observed people sitting in lounges in front of the television with limited interaction from staff.

There was a weekly activity programme in place that included group activities in a communal area called the 'atrium'. We saw people and their relatives joining in with the tea dance and singing together activity. We observed the activity coordinators engaging people in informal activities such as starting the chorus of an old time song and encouraging people to finish the sentence. People appeared to enjoy engaging in this activity. We also observed people receiving hand massage and making seasonal decorations for a display in

the home.

On Crofters Lodge there was one planned weekly activity. Some people had one to one time with the Occupational Therapist; some people went out into the community. The Occupational Therapist told us that they were reviewing the activity program with a view to expanding it; this included making the environment more dementia friendly. Staff supported people to access spiritual support, if required staff took people to local places of worship or arranged for ministers to visit the home.

Relatives said they would feel comfortable about making a complaint if they needed to. Relatives were aware of the complaints policy and were confident if they did raise any concerns they would be dealt with by staff and the manager. Staff confirmed that they would refer any complaints to their manager. One relative said, "We usually speak to the carers. If there was a problem, myself or more likely my daughter would call [name of manager]." When asked how comfortable they would be in raising a concern or complaint one relative told us, "Very." Other comments included, "Not very comfortable but I would" and "I wouldn't have a problem."

Staff told us they gave people and their relative's information on how to complain and would contact an advocate to assist a person if required. An advocate is an independent person that can support someone to express their wishes or views. There had been 21 complaints in the past year and these had been responded to and actioned in line with the provider's policy.

Relatives told us they were invited to attend relatives meetings every two months to express any views or concerns about the service. One relative said, "We attend relatives meetings often we [the relatives] have similar issues." Another commented, "There are relatives meetings every couple of months." The relatives went on to say when they did raise concerns these were dealt with appropriately. We looked at the relative meeting minutes and saw they covered areas such as the managers posts, staffing vacancies, food, cleanliness, laundry, the care staff were providing and accessing the communal garden. Following the meeting an action plan was devised and where required an action point was noted with the person responsible for completing it. We saw most of the action points from the August 2016 relatives meeting had been marked as completed.

The provider sent out surveys annually to obtain feedback from relatives. The operations manager told us the surveys for the current year had not been sent out in 2016 due to change in administration staff. They confirmed these had been sent to relatives during our inspection.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led.

There were a range of audits in place that were completed by the manager, senior managers and the providers' quality management team. The audits identified some of the concerns we raised during our inspection and had action points in place, such as care plans needing to be updated and staff supervision not being consistently held. However, there were areas of concerns we raised that had not been identified. These concerns related mainly to Crofters Lodge, being a hospital for people being detained under the Mental Health Act 1983 and their non-compliance with the Act. There were no new policies associated with the updated MHA code of practice, which the government introduced in April 2015. The provider had an Environmental Ligatures assessment policy. However, the managers had not followed the policy. For example, managers had not completed a ligature risk audit. This meant people were at risk because they were not being supported in line with current legislation and the home was not following the provider's own policy in order to keep people safe. When we spoke with the managers they told us about the needs of the people living at Crofters Lodge and it was identified the risk of ligatures within the current group of people was low.

Relatives raised concerns about the number of managers that had been in post. One relative told us "None of the managers stay, they introduce the manager at the relative's meeting and by the next meeting they are gone." There had been various changes in management in this service since the last inspection due to unforeseen circumstances with the current manager being the fourth one in post in the past year.

Staff also commented on the different managers that had been in post. One staff member said "Each manager comes in with different ideas, paper work changes. You just get your head around a care plan and they change it." Another commented "The managers change a lot, I don't know why." Staff morale was varied. Some staff felt positive about working for The Granary Care Centre, others did not. Not all the staff we spoke with felt appreciated by their managers. One staff member said "We don't get any thanks from managers". Some staff felt there was noticeable divide within the staff team. Staff raised concerns that they felt some staff were prioritised over them when it came to booking annual leave.

Some staff told us they did not have regular meetings and were not able to contribute to the service or offer suggestions for improving people's care. Staff said there were limited opportunities for leadership development. Staff we spoke with did not know the values and vision of Crofters Lodge. They were not clear on the aims and objectives, particularly around promotion of independence and autonomy. However, staff did tell us they wanted to do the best for the people they supported.

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

The provider had not always notified us of significant events which had occurred in line with their legal responsibilities. We had been notified of some events. However, following our inspection we looked at the

provider's safeguarding records and found incidents where alleged abuse had occurred between people who used the service. Whilst these incidents had been investigated internally by the provider and reported to the local safeguarding authority, we found 24 incidents had not been reported to us. This meant we had not been able to review the incident and ensure the correct action was taken to ensure people were safe.

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

Following our inspection the operations manager told us they would ensure we were notified of all incidents of abuse and alleged abuse in line with their legal responsibility. We saw incidents and accidents were analysed monthly to identify any trends or themes. We saw in response to the analysis action was taken for example; following a person falling they were referred to the falls team and care plans were updated.

Despite the issues reflected in this report relating to the changes in managers, high use of agency staff and busy shifts, some staff told us they felt positive about working at The Granary. They felt they generally worked well as a team and all spoke positively about the people they supported. Staff comments included "I love working here and the residents" and "The best thing here is the residents."

All of the managers we spoke with acknowledged there was a lot of work to do in the home however they felt they had made some progress and their plans to improve the service could be achieved. The managers were in the process of creating a 'project plan' for the whole of The Granary Care Centre identifying the improvements required and action needed to meet these.

The current manager had been in post for a month and they spoke enthusiastically about their plans and vision for the service. They told us the support they received from their managers was "Brilliant." The manager told us their vision was "For The Granary Care Centre to be a centre of excellence for dementia care." They told us they were aware there was an amount of work needed in order to improve the service and that they were aware collaboration with the staff team was required. They also said they "Wanted everyone living at The Granary Care Centre to be looked after like they were at home, for people to smile and create a connection with staff." The manager told us they had used team meetings to share their vision with staff. One staff member told us the vision for The Granary was "To help people feel like they are not in a care home" and another said it was "For everyone to have person centred care, we want to create a nice homely atmosphere." This meant the staff working in The Granary shared the manager's vision for the service.

The manager was also a registered nurse and they told us they kept their skills and knowledge up to date by maintaining their nurse's registration. They also told us they attended local provider forums and found these meeting useful to network and share ideas with managers from other organisations.

The manager told us they had a commitment to promoting an open door policy where staff could approach them with concerns. One staff member told us "We see the manager all the time and can go to them with any problems." The manager told us they walked the floors three times a day to keep themselves up to date and aware of any specific concerns relating to people such as illness. They also told us they spent time observing staff and giving them feedback to support their development and promote best practice. The project manager told us they based themselves on the second floor each day so they could be available to the staff and help out where required. Staff confirmed the project manager helped out at busy times such as lunchtime. Observation of staff performance was also completed as part of the providers monthly audit.

The operations manager and director of residential and nursing services told us between them they had spent five days a week at The Granary Care Centre since February 2016. This had been to provide senior management support to the team. The operations manager told us they provided support to the manager

and they would be assisting them in improving the staff morale and staff and manager relationships. They also told us regular staff meetings had been scheduled for the team.

We saw minutes from a staff meeting held in April 2016 when the manager was in the clinical deputy manager role. During the meeting staff raised that they did not feel supported and the manager responded by assuring them they were approachable and there for the people living at The Granary Care Centre and the staff. Approachability of senior staff and manager was also raised and staff were also reassured that they should go to senior staff and managers if they have any concerns. The meeting was also used to discuss the high turnover of managers and how the experienced senior management team were brought in during February 2016 to provide stability. Other items discussed included incident reporting, record keeping, training needs and key worker responsibilities. The home also held senior team and head of department meetings. Head of department meetings were used to discuss and communicate messages to the different departments in the home such as the kitchen and domestic staff. We noted there had been a staff meeting held in September 2016 however the minutes from this meeting were not available at the time of the inspection.

The home had recently appointed the providers dementia lead to work in the home for four days each week. They told us they planned to work with staff on the second floor to support them to provide person centred dementia care. They had plans to work alongside staff completing observations and offering feedback in order to support the team to work with people in line with best practice. They also told us they would be focusing on team building as part of the plan.

The dementia lead explained how they had recently attended two dementia conferences and they used these to keep themselves up to date with best practice and bring ideas back to the home. They explained how they were looking at what makes a home have an outstanding rating with CQC and factors that could improve the environment to make it more dementia friendly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying us of all incidents of abuse or alleged abuse in relation to service users. Regulation 18 (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care did not always reflect their preferences. Regulation 9 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate supervision to enable them to carry out their duties. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because safe procedures were not in place for the administration of some medicines. People detained under the Mental Health Act 1983 were not being protected against the risks associated with unsafe care and treatment. There were not always suitably experienced staff available to provide care and treatment to service users. Regulation 12 (1) (2) (a) (b) (c) (g) (h)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 24 February 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the safety and quality of the service. The provider did not have effective systems in place to monitor and mitigate risks relating to the safety and welfare of service users. Secure, accurate and contemporaneous records were not kept in respect of each service user. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 24 February 2017.