Gracewell Healthcare Limited

Gracewell of Church Crookham

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

This inspection took place on 11, 13 and 14 December 2018 and was unannounced.

Gracewell of Church Crookham is a 'care home'. People in care homes receive accommodation and nursing or personal care, as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Gracewell of Church Crookham is registered to provide accommodation for up to 60 people, including people living with a cognitive impairment. At the time of our inspection there were 45 people living in the home. The home is organised in four household units on two floors; Vogue, Poolside, Tweseldown and Galley Hill. Each of these units is staffed independently and has its own lounge and dining areas. This provided people with a sense of homeliness, while providing additional facilities, such as a cinema and 'Bistro'. Each household was designed to and furnished to meet the needs of the people living in them.

The home did not have 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. At the time of inspection, the there was a general manager responsible for the daily running of the home. They were being supported by a deputy manager and the provider's operations director.

The service had not been consistently well-led or well-managed since our last inspection. The provider had failed to operate processes effectively to ensure the service complied with legal requirements. Relatives and staff had consistently raised concerns, which had not been effectively addressed by the provider.

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

People had not always experienced care that made them feel safe and protected from avoidable harm and discrimination. When concerns had been raised, thorough investigations had not always been carried out, in partnership with local safeguarding bodies.

Risks had not always been assessed, monitored and managed effectively. Interventions had not always been put in place to mitigate or reduce identified risks. This meant that people had been exposed to the further risk of experiencing unsafe care. Care records demonstrated that staff had not always followed the provider's policy and procedure in relation to the recording and management of falls.

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them internally and externally. However, the provider had identified that such incidents had not always been reported effectively. The provider had developed an action plan to address these issues.

People's prescribed medicines had not always been managed safely, which had led to several medicine errors. People had not always received their prescribed pain relief as required.

People had not always been supported to have access to healthcare services and receive on going healthcare support when required. The provider had addressed the need to improve and provide appropriate responses to people's changing needs within their service recovery plan and their back to basics approach.

The provider had failed to effectively engage with community nursing team forums. Nursing professionals had been concerned that previous management teams had not been open and transparent or demonstrated a proactive approach to delivering effective care based on best practice.

The general manager had completed a review of all authorisations in relation to the Deprivation of Liberty Safeguards and identified that a further 12 applications were required. These applications have been submitted and await authorisation. The general manager had established a tracking system to ensure all future applications are submitted expeditiously.

People had not always experienced personalised care that was flexible and responsive to their individual needs and preferences. People had not consistently been supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.

Care records did not always effectively demonstrate responsive assessment and monitoring of people's needs, for example; evidence of repositioning had not always been effectively recorded in relation to people's pressure ulcers, which had healed. People's preferences and choices for their end of life care were not consistently recorded, communicated and kept under review.

Relatives of people who had limited verbal communication reported a mixed experience in relation to the care their loved ones had received. Three such relatives told us that staff were consistently kind and caring. Seven relatives conversely told us their loved one's had experienced poor continuity and consistency of care from some staff, who were not caring or compassionate.

People and their relatives concerns and complaints had not been consistently listened and responded to. This meant the provider had missed opportunities to improve the quality of care people received. Prior to our inspection the provider had engaged with people and their relatives and had arranged forums to seek feedback regarding concerns and complaints. The provider had appointed a new management team, including the general manager and new operations director. The provider's recovery action plan detailed measures being undertaken to ensure all complaints were dealt with in accordance with their policy and used as an opportunity to drive improvement in the service.

At the time of our inspection the provider had deployed sufficient, suitably qualified staff to meet people's assessed needs. People, relatives and staff consistently made positive comments about recent measures introduced by the general manager to provide continuity and consistency of staffing within the different households. These new measures had had a significant impact on staff morale and people's confidence and well-being.

Staff had experienced a comprehensive induction and did not work unsupervised until they were confident to do so and the general manager had assessed them to be competent. Staff had completed the provider's required training, which ensured they had been enabled to develop and maintain the skills necessary to deliver effective care and support. Staff were supported by the provider with their continued professional

development and to maintain qualifications relevant to their role. Staff were receiving on- going training and guidance from an area coordinator to embed best practice in relation to supporting people who experienced living with dementia.

The home had been designed to promote the independence and safety of people who live with dementia, which helped them to manage disorientation and confusion.

People were supported to have a balanced diet that promoted healthy eating and the necessary nutrition and hydration. Staff were aware of those individuals who had been identified to be at risk of choking and the support they required to mitigate these risks, which we observed staff delivering in practice.

We observed that staff consistently treated people with kindness in their day-to-day care. Staff knew and respected the people they cared for, including their preferences, personal histories, backgrounds and potential.

The quality of people's care had improved since the arrival of the general manager who had implemented a staffing system, where staff only worked in a specific household. People consistently told us they now experienced good continuity and consistency of care from staff who knew them and their needs well.

The operations director and general manager had developed a credible recovery strategy to deliver high-quality care and support, which achieved good outcomes for people. The general manager and deputy manager were highly visible within the home and provided clear and direct leadership, which inspired staff. Without exception staff told us they now felt respected, valued and supported by the management team.

The general manager had begun to collaborate effectively with key organisations and agencies to support care provision, service development and joined-up care, for example; community nursing and local authority safeguarding teams.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had not always been protected from avoidable harm. Detailed investigations into safeguarding incidents had not always been undertaken.

Measures had not consistently been put in place to protect people from identified risks to their safety.

People's prescribed medicines had not always been managed safely.

Recent measures to provide continuity and consistency of staffing had had a significant impact on staff morale and people's confidence and well-being. The provider needed time to show these improvements had been sustained.

Is the service effective?

Requires Improvement

The service was not always effective.

People had not always been supported to have access to healthcare services and receive on going healthcare support.

Applications in relation to Deprivation of Liberty Safeguards which had not always been completed expeditiously, had now been submitted.

People were supported to have a balanced diet that promoted healthy eating and the necessary nutrition and hydration.

Is the service caring?

Requires Improvement

The service was not always caring.

People had not always been treated with kindness and

compassion in their day-to-day care and support.

People had not always experienced care which respected their privacy and promoted their dignity and independence.

Since the appointment of the general manager the quality, continuity and consistency of care people experienced had improved.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not always experienced care that was flexible and responsive to their individual needs and preferences.

People had not consistently been supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.

People's concerns and complaints had not been consistently listened and responded to.

People's preferences and choices for their end of life care were not consistently recorded, communicated and kept under review.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to operate processes effectively to ensure compliance with legal requirements.

Governance and performance management had not been consistently reliable and effective.

The general manager and deputy manager were highly visible within the home and provided clear and direct leadership, which inspired staff.

The operations director and general manager had developed a credible recovery strategy to return the service to compliance with legal requirements.

Gracewell of Church Crookham

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014. A service provider is the legal organisation responsible for carrying on the adult social care services we regulate.

This unannounced, comprehensive inspection of Gracewell of Church Crookham was carried out by two out by two inspectors on 11, 13 and 14 December 2018. The inspection was prompted in part by notification of incidents following people using the service sustaining harm. While we did not look at the circumstances of these specific incidents, which may be subject to criminal investigation, we did look at associated risks. The inspection was also prompted by concerns raised by relatives and supporting health and social care professionals, regarding the quality of care experienced by people living in the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law. We also reviewed information contained within the provider's website.

During our inspection we spoke with 11 people living at the home, some of whom had limited verbal communication, 11 relatives and six health and social care professionals. We used a range of different methods to help us understand the experiences of people using the service who were not always able to tell us about their experience. These included observations and pathway tracking. Pathway tracking is a process which enables us to look in detail at the care received by an individual in the home. We pathway tracked the care of four people.

We observed care and support being delivered in communal areas of the home. We spoke with the general manager, deputy manager, the director of operations, and 24 staff, including six nurses and all department heads.

We looked at care plans and associated records for ten people using the service, staff duty records, eight staff recruitment, supervision and training files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The service was last inspected on 15 November 2016, when it was found to be Good.

Requires Improvement

Is the service safe?

Our findings

People had not always been protected from avoidable harm. The provider had processes and practices in place to safeguard people from abuse, which had not always been effectively followed by registered managers. Detailed investigations into peoples and staff concerns, safeguarding incidents or accidents, had not always been undertaken. For example, investigations into safeguarding incidents had not always been completed to ensure lessons were learned and action plans implemented to prevent future occurrences. The failure by the provider to consistently investigate effectively and immediately upon becoming aware of, any allegation or evidence of such abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The general manager was appointed on 5 November 2018 and had completed a comprehensive review of all safeguarding incidents to ensure they were now subject to thorough investigation and had been notified to the relevant authorities. During our inspection the general manager had completed retrospective notifications in relation to incidents identified.

Since our last inspection in November 2016, people's care and treatment had not always been provided in a safe way. Assessments had been completed which identified risks and hazards to people's safety. However, measures had not consistently been put in place to reduce and evaluate the remaining risk. For example, pressure area management and positive behaviour management plans had not always been completed, when risks had been identified. This meant there was a risk that new staff or agency staff may not know how to manage the behaviour. If a consistent approach was not followed by staff this had the potential to escalate people's behaviour.

Care records demonstrated that staff had not always followed the provider's policy and procedure in relation to the recording and management of falls. However, falls management was now subject to daily review and analysis by the deputy manager and a standing agenda item at the daily head of departments meeting.

People's prescribed medicines had not always been managed safely, which had led to several medicine errors. For example, staff had failed to order one person's prescribed pain relief, which had led to them remaining in bed. The person's family were not informed until four days later. Staff told another family that their loved one was feeling anxious and upset because they had not received their prescribed medicines for two days, due to an ordering error. We spoke with one family member who was concerned that medicines were not always administered as prescribed, for example; with food or at the appropriate time. One person who lived with Parkinson's disease had been administered their medicine very late one morning. Family members were concerned that the lateness of this administration was a contributory factor in their loved one experiencing a fall due to being unsteady on their feet. These concerns were not investigated by the provider. The provider's quality assurance processes had identified that improvements were required to improve the safe management of medicines.

At the time of inspection, an external health professional with safe management of medicines expertise was

reviewing the provider's policies, procedures and staff practice, to identify areas to improve the safety of medicines management within the service.

The provider's policy only authorised designated nurses to administer medicines. However, we observed that Gracewell nurses and agency nurses did not always follow the same administration practice. For example, Gracewell nurses dispensed medicines from the relevant medicine treatment rooms, whilst agency nurses took trolleys to people's rooms. Nurses did not wear tabards to dissuade people, visitors and staff from distracting them, whilst concentrating on medicine administration. We observed care assistants disturb nurses engaged administering medicines, with none essential conversations. These interruptions increased the risk of administration or recording errors occurring

The provider's failure to do all that was reasonably practicable to mitigate identified risks to people and to ensure the proper and safe management of people's medicines, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff without exception told us the service had been thrown into turmoil when a previous registered manager and deputy manager had left the home in September 2017, followed by the departure of a large number of experienced staff. People, relatives and staff told us there had been a significant reduction in the continuity and consistency of care provided since that time, due to a lack of regular staff.

People and their relatives consistently told us they had not felt safe living in the home since the winter of 2017, due to a lack of suitable staff. Staff, people and relatives told us that the high level of agency staff deployed, meant that people had experienced care from staff who did not know them or their needs. People, relatives and staff told us that at busy times in the morning and evening people often had to wait to receive their personal care.

At the time of our inspection we observed the provider had deployed sufficient, suitably qualified staff to meet people's assessed needs. The general manager completed a daily analysis of people's dependency and adjusted staffing levels to meet increased need. The management team completed a daily analysis of response times to ensure people's needs were being met promptly.

People, relatives and staff consistently made positive comments about recent measures introduced by the general manager to provide continuity and consistency of staffing within the different households. These new measures had had a significant impact on staff morale and people's confidence and well-being. Rotas and daily allocations demonstrated that the provider had reduced the service dependency on the use of agency staff.

Recruitment of further staff was subject to the provider's service recovery action plan, which had been implemented in November 2018. The provider needed time to demonstrate the improvements in relation to staffing levels had become embedded and were sustainable.

The provider had arrangements for ensuring that the premises were kept clean and hygienic so that people were protected from the risks associated with infections. Staff had completed the provider's required training in relation to infection control. During a recent outbreak, we reviewed records which demonstrated that the management team had effectively implemented the provider's infection control policy and procedures.

However, some relatives had raised concerns that some waste products requiring immediate disposal had

been left in their loved one's bathrooms.

Staff had completed relevant training and clearly understood the importance of food safety when preparing, handling and serving food.

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them internally and externally. However, the provider had identified that such incidents had not always been reported effectively. As part of the service recovery plan the provider was implementing a back to basics training programme to ensure all staff understood the importance of sharing information so that lessons could be learned from mistakes and when things had gone wrong. The provider needed time to demonstrate this initiative had been effective and was sustained.

Requires Improvement

Is the service effective?

Our findings

People had not always been supported to have access to healthcare services and receive on going healthcare support. For example, one person who was living with dementia, had previously undergone treatment for skin cancer and required to have changes to their scalp monitored closely. Family members noticed significant changes to their loved one's scalp which had not been identified by staff or other visiting health professionals. Treatment in relation to the changes was then provided. However, relatives told us they were concerned, not only because of the failure to identify the changes by staff, but also the breakdown in communication between the provider and relevant healthcare professionals.

During a family visit one person complained their feet were hurting. Further examination revealed they had not had their toe nails cut for 11 weeks. Family members arranged for a chiropodist to attend the service to provide the relevant care and alleviate their loved one's pain. Due to a lack of communication this visit coincided with an infection outbreak at the service.

The provider had failed to engage with community nursing team forums, for example; clinics in relation to tissue viability and palliative care. Nursing professionals had been concerned that previous management teams had not been open and transparent or demonstrated a proactive approach to delivering effective care based on best practice. However, community nursing professionals told us they had noticed a significant change in the welcoming attitude of staff. The general manager and new operations director were working hard to develop positive relationships with other agencies to deliver effective care, support and treatment. The provider had addressed the need to improve and provide appropriate responses to people's changing needs within their service recovery plan and their back to basics approach. The provider required more time to demonstrate these measures had been effective.

Staff told us they had experienced a comprehensive induction and did not work unsupervised until they were confident to do so and the general manager had assessed them to be competent. Staff told us they had completed the provider's required training, which records confirmed. This ensured they had been enabled to develop and maintain the skills necessary to deliver effective care and support. Nurses told us that they were supported by the provider with their continued professional development and to maintain qualifications relevant to their role.

The provider had enabled further staff training to meet the specific needs of the people they supported, for example; Staff were receiving on- going training and guidance from an area coordinator to embed best practice in relation to supporting people who experienced living with dementia. The provider's area coordinator was to remain at the home to ensure best practice had become embedded. The provider required more time to demonstrate that the best practice guidance in relation to supporting people with dementia had been effective and was sustained in practice by staff.

The provider had established a system of supervision, appraisal and support. However, staff consistently told us that since our last inspection they had not experienced effective supervision and support to carry out their roles and responsibilities. Staff told us the general manager was approachable and gave them the

opportunity to communicate any problems and suggest ways in which the service could improve. The provider's quality assurance processes had identified that 64 per cent of staff had not received a recent supervision in accordance with their policy. The general manager was in the process of scheduling supervisions at the time of inspection. The provider required more time to demonstrate that supervisions were completed effectively, in accordance with their policy, and that identified improvements were sustained.

People were supported to have a balanced diet that promoted healthy eating and the necessary nutrition and hydration. However, people and relatives had consistently complained about quality of the food provided, which did not meet the standards described in the provider's promotional material. People and their families commonly reported that the focus on food preparation had been on quantity, not quality. As a result, the home's head chef had received support from the provider's nutrition lead to review menus and practice. At the time of inspection, people told us that there had been a marked improvement in recent months in the quality of the food provided. The provider required time to demonstrate that improvements made had become embedded and were sustained.

Staff involved in the preparation and service of food had completed the required training to do so, for example; staff knew which people required specific diets to maintain their health and how to meet their individual nutritional and hydration needs. Records confirmed that food safety measures were undertaken, for example; the temperature of food prepared was checked and cleaning schedules were completed daily.

When staff supported people with their meals, we observed caring, attentive staff discreetly offering and providing support, where required to keep people safe and maintain their dignity. Staff were aware of those individuals who had been identified to be at risk of choking and the support they required to mitigate these risks, which we observed staff delivering in practice. People were offered a choice of meals from the menu and the chef prepared demonstration plates to be shown to support people with their choice.

Some relatives had raised concerns about the support their loved one's received in relation to remaining well hydrated, for example; ensuring drinks were always within the reach of those people who had difficulty mobilising or who were visually impaired. During our inspection we observed that people who were being supported in their rooms, had drinks which were easily within their reach and view. These were frequently replenished. People were effectively supported to remain hydrated. Throughout the home there were ample nutrition and hydration stations. These were well stocked and enabled people to help themselves to drinks, fruit and snacks, whenever they wished between meals.

People's individual needs were met by the design and decoration of the service. The home had been designed to promote the independence and safety of people who live with dementia, which helped to mitigate symptoms like disorientation and confusion. There were tactile wall hangings and objects, dressing up areas, and reminiscence and reflection areas created to stimulate people's memories. People, staff and external professionals praised the maintenance manager who promptly monitored and resolved health and safety issues relating to the home, for example; compliance with fire safety regulations.

People were involved in decisions about the decoration of their personal rooms, which met their personal and cultural needs and preferences. Where required, the premises had been adapted to meet people's needs and to accommodate individual specialised supportive equipment.

The registered manager had ensured people's ability to make decisions was assessed in line with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making specific 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 people lack mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We observed staff seeking consent from people using simple questions and giving them time to respond. Staff supported people to make as many decisions as possible. Staff had consulted with relatives and healthcare professionals and had documented decisions taken, including why they were in the person's best interests. For example, decisions had been made on behalf of people who would prefer to remain at the home to continue their care if their health deteriorated.

Records showed that staff had completed training in relation to the MCA. However, this training had not enabled all staff with a clear understanding of the basic principles. Staff often confused questions relating to MCA with the deprivation of liberty safeguards.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection applications had been made in relation to 18 people, five of which had granted and 13 which were awaiting authorisation.

Shortly before our inspection the general manager had completed a review of all authorisations and identified that a further 12 applications were required. These applications have been submitted and await authorisation. The general manager has now created a tracking system to ensure all relevant applications are submitted and tracked expeditiously. The provider needs time to demonstrate that improvements made are effective and have become embedded and sustained.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed staff consistently treated people with kindness in their day-to-day care. Staff knew and respected the people they cared for, including their preferences, personal histories, backgrounds and potential.

Staff showed concern for people's well-being in a caring and meaningful way. We observed and heard staff providing reassuring information and explanations to people, whilst delivering their care. When people were being supported, staff engaged in day-to-day conversation with people which put them at ease, whilst also providing a commentary about what they were doing to reassure them.

When supporting people to move, staff were patient and unhurried, encouraging people to take their time and not to rush. When people required support to move in communal areas using safety equipment, staff maintained and promoted people's dignity.

We observed staff respond in a compassionate and timely way when people experienced physical pain, discomfort or emotional distress. When people were disorientated, we observed staff spoke caringly about their loved ones and important events from their lives to reassure them. We observed staff promote respectful and empathetic behaviour within the staff group, for example; by regularly volunteering to support colleagues without being asked.

We observed staff discreetly support people to rearrange their dress, to maintain their personal dignity when required. Staff always knocked and asked for permission before entering people's rooms. Staff gave examples of how they supported people in a dignified way with their personal care, for example; by ensuring doors were closed and curtains were drawn.

People consistently told us that the quality of their care had improved since the arrival of the general manager who had now returned to a staffing system, where staff only worked in a specific household. People consistently told us they now experienced good continuity and consistency of care from staff who knew them and their needs well. Two people told us that staff promoted their independence and supported them to do as much as they could for themselves, which improved their confidence and self-esteem.

One person told us, "Things are back on track. The carers are wonderful and seem to have more time now. The night staff are excellent, very caring and always have time to talk to you when you can't sleep. [Named staff member] massages my back, ah the bliss, it is so comforting."

However, relatives of people who had limited verbal communication reported a mixed experience. Three such relatives told us that staff were consistently kind and caring. Seven relatives conversely told us their loved one's had experienced poor continuity and consistency of care from some staff who were not caring or compassionate.

Relatives who told us that their family members had repeatedly experienced a lack of care and compassion

told us the provider had consistently made them feel that their concerns and their loved one did not matter to them. These concerns included not treating people with dignity and respect whilst providing personal care, not considering people's preferred gender of care staff, and not affording people with limited verbal communication the opportunity to use the toilet frequently.

Concerns from two family members had been raised that on several occasions their relatives hearing aids and glasses had been misplaced, lost or not given to them, which had an adverse impact on their ability to communicate.

One relative had raised concerns that their loved one was not being treated with respect by some staff because they were unable to speak for themselves and sometimes could display behaviour that may challenge others. They told us they were "appalled" that their loved one's dignity was not being respected because they had previously taken great pride in their appearance and now were often found to be unkempt, unshaven, wearing dirty clothes and did not have clean teeth and nails.

One relative told us their family member had been embarrassed by a member of care staff shouting down the corridor that they needed help with a "hygiene emergency".

Another relative told us that GP consultations were taking place in public areas within the home, which did not respect people's privacy.

Another family member told us they visited the home on one occasion at 11.30 am and found their loved one struggling to put socks on, a task that they were unable to perform, because they had received no assistance to dress.

Some relatives told us the standard of care had deteriorated since people's keyworkers were moved to different areas within the home, which had diluted the consistency of care provided. Relatives of those people who had experienced poor care told us they had raised the issues with the provider but no action had been taken.

Prior to our inspection the provider had engaged with relatives regarding these concerns and had created an action plan to drive the required improvements. The general manager told us they were now aware of the concerns that had been raised and had reinstated the keyworker system. At the time of inspection designated staff had been appointed as individual keyworkers. The general manager told us the 'back to basics training programme' would also incorporate the keyworker system. The overall aim of key working is to ensure the provision of holistic care and support to meet the individuals' needs.

At the time of inspection, the general manager had begun to implement an action plan to ensure people always experienced kind and compassionate care and support. The provider required more time to evaluate the new keyworker system and confirm that required improvements had been made and sustained.

Requires Improvement

Is the service responsive?

Our findings

People mainly told us they had received personalised care that met their needs. One person told us, "The ship has now got a good captain [general manager] and stability is coming back. The carers are wonderful to me and always there for me. They treat me like their own." One person's relative told us, "The carers and nurses know [their loved one] really well are very quick to let me know if they are worried or things aren't quite right."

However, relatives of people who had limited verbal communication told us their family members had not always experienced care that was flexible and responsive to their individual needs and preferences.

Two families had raised concerns that their loved ones who lived with dementia had remained in bed during the summer heatwave on very hot days, without air conditioning or windows open for breeze. When questioned staff said the individuals had chosen to remain in bed. Families understood that staff had listened to people's choice but were disappointed that staff did not appear to have encouraged their loved ones to enjoy the weather.

Three relatives had raised concerns that when they visited the home unexpectedly, they frequently found their family member was still in bed and had not been supported to get dressed or with their morning personal care. The provider had begun to address these concerns by posting their area coordinator who had specialist knowledge, into the household supporting people with a diagnosis of dementia. They were observing practice and providing hands on guidance. The general manager had also arranged further 'back to basics' training for all staff to reinforce the importance of providing personalised care.

Some relatives of people living with dementia had chosen the home with their family members love of gardening in mind. Two relatives told us their choice had been based on the assurance that the home had an active gardening club and sensory garden. Relatives told us they had repeatedly requested the provider to support initiatives to improve the garden for everyone who lived in the home. Relatives told us that promises made by the provider had not come to fruition.

People had not consistently been supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. Relatives consistently told us that there had been a lack of external visits organised in the last 12 months and that prearranged activities publicised on the activities programme often did not take place. Some relatives raised concerns that published activities such as 'Sunday Sundae', where people chose ice cream to eat, should not be considered as an activity and demonstrated the provider's current ethos in relation to activities. The general manager had listened to these concerns and had recently appointed a new activities coordinator to develop the activities programme.

Relatives of people living with dementia told us they felt staff had not worked closely with them, to ensure they were fully involved in their loved one's care planning. These relatives told us the care and support provided did not always reflect their family member's wishes, and staff did not always understand how to

promote people's independence and maximise the opportunity to do things of their choice.

Records demonstrated that staff had completed the provider's dementia awareness training. However due to concerns raised the provider had commenced an action plan to develop further and improve all staff awareness and practice in relation to supporting people who lived with dementia. Two suitable care staff had been selected by the provider's area coordinator and were receiving training to become home's Dementia Champions. Whilst measures had been implemented to provide more responsive care to people living with dementia, the provider required more time to be able to demonstrate the improvements had been effective, and best practice had become embedded.

As well as a comprehensive care plan, people also had a more concise Individual Service Plan (ISP). Care plans and ISP's were personalised and contained information such as the person's life history, family connections, preferences around their personal care routines, likes and dislikes, hobbies and interests. Care plans contained details of any spiritual or cultural needs people had and how staff needed to adjust meet them. Other needs covered included, nutrition and hydration, dressing, mobility, communication, tissue viability, oral care and end of life wishes.

People living with dementia had assessments relating to memory, cognition, mood, interactions and behavioural tendencies. Where people had a specific medical need, then individual care plans were completed. For example, plans in relation to diabetes and catheter care.

It was noted that some plans lacked detail, or contained conflicting, out of date or repetitive information. Care records did not always effectively demonstrate responsive assessment and monitoring of people's needs, for example; evidence of repositioning had not always been effectively recorded in relation to people's pressure ulcers, which had healed. The general manager and nursing quality assurance lead had already identified improvements required in relation to wound management and the deputy manager had begun to review all care plans to update them. The provider needed time to demonstrate that required improvements had been made and were sustained.

People and their relatives concerns and complaints had not been consistently listened and responded to. This meant the provider had missed opportunities to improve the quality of care people received. We reviewed the provider's complaints system. This demonstrated that the provider had not consistently addressed concerns raised in a responsive manner and in accordance with their own complaints policy and procedures.

Prior to our inspection the provider had engaged with people and their relatives and had arranged forums to seek feedback regarding concerns and complaints. The provider had appointed a new management team, including the general manager and new operations director. The provider's recovery action plan detailed measures being undertaken to ensure all complaints were dealt with in accordance with their policy and used as an opportunity to drive improvement in the service. The provider required more time to demonstrate that the complaints and concerns system was operated effectively and required improvements had been sustained.

People's preferences and choices for their end of life care were not consistently recorded communicated and kept under review. At the time of inspection, the general manager and deputy manager were reviewing all care plans to improve the information contained within these sections. The provider required time to demonstrate these improvements had been effective and were sustained.

Three relatives told us their loved ones had experienced caring and compassionate support at the end of

their life, to have a comfortable, dignified and pain free death. These relatives praised staff for the kindness and consideration extended to their family members at a distressing time. Another family had been disappointed with the level of knowledge and support provided by a previous registered manager in relation to the processes involved when a person passes away in a care home.

Requires Improvement

Is the service well-led?

Our findings

The service had not been consistently well-led or well-managed. Since our last inspection in November 2016, the service had experienced poor recruitment and retention of staff, numerous complaints from people who used the service and their families, and extensive staff disaffection.

Since our last inspection in November 2016, there had been two registered managers and a series of interim managers. One registered manager left the service in September 2017, shortly followed by their deputy manager and fifteen experienced care staff. The service has been recruiting to fill these vacancies since. The last registered manager left the service on 5 November 2018 and was immediately replaced by the general manager, who had initially been brought in to support the registered manager to improve the service. The general manager had commenced the process to become the registered manager.

During our inspection we identified the provider had failed to operate processes effectively to ensure compliance with legal requirements. The provider had failed to consistently investigate allegations or evidence of abuse, which was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; The provider had failed to do all that was reasonably practicable to mitigate identified risks to people and to ensure the proper and safe management of people's medicines, which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's failure to ensure compliance with legal requirements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Governance and performance management had not been consistently reliable and effective. Whilst an action plan was now in place, people, relatives and staff had consistently raised concerns which had not been addressed by the provider. The provider required to improve their response to concerns and complaints, to drive continuous improvement in the service. The provider also required to improve their response to meet people's changing needs.

The operations director and general manager had developed a credible recovery strategy to deliver high-quality care and support, which achieved good outcomes for people. The general manager and deputy manager were highly visible within the home and provided clear and direct leadership, which inspired staff. Without exception staff told us they now felt respected, valued and supported by the management team. Staff consistently told us that their voices were now heard and acted on. Staff had been encouraged to become involved in developing the service by considering and proposing new ways of working. People consistently told us the general manager was very approachable and always available, if they worried or concerned about anything. People and staff consistently told us the general manager was compassionate and dedicated to the people living in the home and her staff.

The provider had now invested resources to develop staff and drive improvement in relation to supporting people living with dementia, for example; the area coordinator will be based in the home until best practice has become embedded and sustained.

The service had not worked effectively in partnership with key organisations, including the local authority, safeguarding teams and multidisciplinary teams, to support care provision, service development and joined-up care. However, health and social care professionals consistently told us the general manager had embraced opportunities to work collaboratively with them.

The general manager understood their regulatory responsibilities. For example, the general manager had promptly notified the CQC and other authorities as required, in relation to important events or serious incidents that took place at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to mitigate identified risks to people and to ensure the proper and safe management of people's medicines,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to consistently investigate effectively and immediately upon becoming aware of, any allegation or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate processes effectively to ensure compliance with legal requirements.