Care Quality Commission

HC-One Oval Limited

Grey Ferrers Care Home

Inspection report

5 Priestley Road, Off Blackmore Drive
Braunstone
Leicester
Leicestershire
LE3 1LF

Tel: 01162470999

Date of inspection visit:
20 March 2018
21 March 2018
22 March 2018

Date of publication:
23 May 2018

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

Grey Ferrers Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Grey Ferrers Care Home accommodates 120 people across four separate units, each of which has separate adapted facilities. One of the three units provides palliative and end of live care and the other three units specialises in providing care to people living with dementia, mental health care and physical disabilities. At the time of our inspection there were 97 people were using the service.

The last inspection took place in December 2015 when the provider for this location was Bupa Care Homes (CFH Care) Limited.

This was the first inspection of the service since the legal entity changed on 31 January 2017. This inspection took place between 20 and 22 March 2018 and was unannounced.

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

We found improvements were needed to the premises, décor and cleanliness. Infection control procedures were not always followed to ensure people's health and wellbeing was protected. Despite the regular checks and audits on the premises and action plans developed there remained a number of outstanding actions to improve the environment. Staff trained were trained in health and safety, infection control procedures and regular cleaning was carried out but that had not assured people were protected from avoidable risks.

The provider's governance systems and processes had not been fully implemented. The new care plans were being introduced and implemented from March 2018. We found inconsistencies in the management and the quality of care people received across the four unit. Regular audits and checks were carried out but the improvements were not made in timely manner.

A range of risk assessments were completed to ensure measures to support people to stay were put in place and reviewed regularly. Care plans provided staff with sufficient guidance to follow but the records relating to how staff monitored people's health was not always clear.

People received their medicines as prescribed and systems were in place that ensured any discrepancies found were promptly addressed. Records were not always kept of regular monitoring or checks carried out, for example to check that the medicines administered via a transdermal patch was still in place. When these issues were raised with the respective unit managers they assured us they would review and update the care

plans.

People had a choice of meals, drinks and snack available. People told us that they mostly enjoyed their meals although at some people had to wait to be supported or were not provided with their meal or food of their choice. The cook was aware of people's dietary requirements and planned menus that were nutritious and balanced. People did not always experience a positive dining experience.

People's privacy and dignity was not always respected by staff. We observed instances when people's dignity had been compromised and shared our observations with the unit managers. The following day we saw staff's approach and practices had improved whereby people's dignity had been maintained. Despite the improvements we saw on the following day it highlighted that staff's practices were not being observed and managed. Staff promoted and respected people's diverse backgrounds and lifestyle choices. People's care records were kept securely and staff maintained people's confidentiality.

People did not always receive care and support that was personalised and responsive. People's care plans reflected the care and support people needed and included their preferences, hobbies, interest and their religious and spiritual needs. However, staff were not always consistent in their approach in how people were cared for. Care plans were reviewed regularly. Information was made available in accessible formats to help people understand the care and support agreed.

People had developed positive trusting relationships with the staff team. Staff mostly treated people with kindness and spent time getting to know them.

People were supported to stay safe. Staff were trained in safeguarding and other relevant safety procedures to ensure people were safe and protected from avoidable harm and abuse. Staff knew how to report potential risks to people's safety.

There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service.

Staff were recruited safely. There were sufficient numbers of staff and skills mix of staff available to support people. Staffing levels were based on the needs of people using the service and reviewed regularly to ensure there were enough staff available to meet people's needs.

We found staff training and training records were not kept up to date due to the change of provider. Some staff told us that in addition to the essential training for their role they wanted more specialists training such as dementia care to enable them to provide effective care.

Following our inspection visit the registered manager confirmed that a new training programme for all staff was due to start in May 2018. Nurses were booked to attend specific health care training to ensure their knowledge and practice to meet people health needs. Systems were in place to ensure staff received regular support and supervision to carry out their job.

People were involved and made decisions about all aspects of their care. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Despite staff's understanding of the Mental Capacity Act, 2005 (MCA) being varied and they did gain people's consent before providing personal care.

People's diverse needs were met by the adaptation, design and layout of the premises. People could access

all areas of the service including the garden areas.

Staff supported people to access support from healthcare professionals, and supported them to maintain a healthy lifestyle. The service worked with other organisations to ensure that people received coordinated and person-centred care and support.

People using the service were encouraged to provide feedback about the service. People, their relatives and staff had opportunities to develop the service through regular meetings. The provider worked in partnership with other health and social care professionals to ensure people received appropriate care.

There was a variety of activities and social events which people participated in. People maintained contact with those important to them and were therefore not isolated from those people closest to them. Family and friends were welcomed to visit.

People and relatives all spoke positively about the staff team, management and the quality of care.
People knew how to raise a concern or make a complaint and the provider had effective systems to manage any complaints they received.

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.

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 consistently effective.

Staff had received induction and training to carry out their role but the training was not kept up to date. Some staff felt they needed more specialist training to enable them to provide effective care.

People's needs were assessed to ensure staff were able to provided effective care. People's consent was sought before staff provided care. People made daily choices and decisions. People's rights and liberties were protected in line with the Mental Capacity Act 2005.

People's dietary needs were mostly met but further improvements were needed to ensure people received the support they needed to eat their meals and experienced a positive dining experience.

Staff liaised with health care professionals to ensure people's health needs were met. Prompt action was taken when people were unwell.

Is the service effective?

Requires Improvement

The service was not consistently caring.

People were not consistently treated with respect and their dignity was not always maintained. Staff knew people they cared for well and mostly communicated with them in a respectful manner. People were cared for staff who were kind and mostly compassionate.

People were encouraged to make decisions about how their care was provided.

People's privacy was maintained and their personal information was kept confidential.

Is the service caring?

Requires Improvement

The service was not consistently responsive.

Further improvements were needed to ensure people received the support they needed and that staff were responsive and consistent in their approach and provide support in line with people's wishes.

People's needs were assessed before they came to stay at the home and were kept under review to ensure their individual needs could be met.

People were encouraged to take part in activities and social events. People's religious and spiritual needs were met.

People could raise a concern about their care. Complaints procedure and information about advocacy services was available in accessible formats.

Is the service responsive?

Requires Improvement

The service was responsive.

People's needs were assessed before they came to stay at the home and were kept under review to ensure their individual needs could be met.
People were supported by staff who knew people well and were mostly responsive to their needs and requests.

People were encouraged to take part in activities and social events. People's religious and spiritual needs were met.

People could raise a concern about their care. Complaints procedure and information about advocacy services was available in accessible formats.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's governance system to assess and monitor the quality of service was not fully implemented. There were inconsistencies in the quality of care people experienced across the four units. Despite the provider's investment into the service further improvements were needed to ensure people received a quality service and systems were put in place to ensure the improvements would be sustained.

The registered manager provided leadership and understood their role and responsibilities. The inconsistencies in the leadership of each unit meant that staf were effectively observed and managed. A staff training programme was planned and

transfer of systems, processes and care planning records was still ongoing.

People and staff had opportunities to make comments about the service and to develop the service.

The registered manager provided leadership and understood their role and responsibilities. The leadership of each unit was not consistent to ensure staff were effectively observed and managed. A staff training programme was planned and transfer of systems, processes and care planning records was still ongoing.

People and staff had opportunities to influence and develop the service.

Care Quality Commission

Grey Ferrers Care Home

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 March 2018 and was unannounced. The inspection team consisted of three inspectors, a Specialist Professional Advisor and two Experts by Experience. The Specialist Professional Advisor had experience of working and caring for people within health care and managed care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Experts by Experience had personal experience of caring for someone who uses this type of care service.

We returned on 21 and 22 March 2018 to complete the inspection and this was announced

We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed all the information we held about the service. This included concerns received about the service and notifications we had received from the provider. A notification is information about important events and the provider is required to send us this by law. We reviewed the provider's statement of purpose. A statement of purpose is a document that describes the facilities and services, what people can expect to receive and the provider's philosophy of care; visions and values.

We contacted commissioners for health and social care, responsible for funding some of the people that use the service and health care professionals involved in the care of people living at Grey Ferrers Care Home and asked for their views. We contacted Healthwatch Leicester City, an independent consumer champion for people who use health and social care services. We used this information to inform our inspection judgements.

We spoke with nine people who used the service and 13 family members who were visiting their relative. We used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service. We made direct observations at meal times and staff's interaction with people who used the service.

We spoke with three health and social care professionals. We spoke with 29 staff. They included four unit managers, four nurses, a senior care staff, seven care staff, three hostesses, three activities coordinators, a house-keeping staff member, finance staff, the cook and a maintenance staff member. We spoke with the registered manager and the Area Quality Director visiting the service at the time of our inspection visit.

We reviewed the care records of 10 people and 24 people's medicines and care records. We looked at the recruitment records for five staff and staff training information. We looked at a range of documents including meeting minutes, audits and complaints and records relating to how the provider monitored the quality of the service being provided.

Requires Improvement

Is the service safe?

Our findings

We found the premises were not always safe and well maintained. The heating in one unit had broken overnight and the building was cold. People were sat in the lounge with a blanket to stay warm. People were given warm drinks whilst this was being managed by the provider's head office team.

All the radiators within the service; communal areas and bedrooms were not covered. That meant people's safety was put at risk where they had the ability to reach or touch radiators. For some people who potentially lacked awareness were at a greater risk of scolding. A maintenance staff member told us that the radiator temperatures were controlled centrally and we saw them manually adjusting the temperature dial on the side of the radiator. This meant anyone else could also do this.

We found the radiators and mirrors in the bathrooms and toilets were rusty. Hand washing taps in the medicine room was damaged and did not have elbow handles for safe hand hygiene. The décor in the communal areas looked tired; door frames and skirting boards were damaged caused by equipment such as wheelchairs. The quiet room in one unit was used to store unwanted items such as a desk, bedroom lamp and television left on the floor.

This was a breach of breach of Regulation 15 (1)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the premises were not always safe, kept clean and people's health and safety was put at risk because the environmental risks had not been managed.

Despite the regular cleaning we saw dust and food left around the edges of the lounge floor in two units. The carpet in the lounge of one unit was heavily stained in parts and at the entrance to the kitchenette. A number of store rooms were full of equipment such as wheelchairs that were no longer needed and waiting to be collected by the suppliers. That meant there was not enough space to adequately clean the room. A linen room was slightly malodours and the cupboard with activity equipment was dirty. A hoist was kept in a walk in shower room. Although staff could access the hoist easily there was no assurance that the hoist would be regularly cleaned. We shared our concerns about the premises and environmental risks to people's safety with the respective unit managers and the registered manager.

Audits and checks carried out on the premises this year had identified similar issues regarding repairs, cleanliness, infection control risks and unsafe storage of equipment. Following our inspection visit the provider confirmed that issues identified from the internal audits were included in the home's improvement plan, which they monitored.

Staff had received training in how to prevent and control infection. Staff told us and our observations showed they had adequate supplies of and used the disposable gloves and aprons to help prevent infection. However, during lunch we saw staff wearing disposable aprons but gloves were not always worn. This indicated that the staff member did not fully understand the potential risks posed to people's health.

This was a breach of breach of Regulation 12 2(h) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 because the infection control procedures were not followed.

Records showed servicing was carried out on the electrics, gas and fire systems and equipment such as the hoists were safe to use. Infection control measures were in place. For example, supply of disposal gloves and aprons, soap dispensers fitted in bathrooms and toilet, which also had photographs showing good hand hygiene techniques. The service had a five star food hygiene rating.

There were policies and procedures for the promotion of people's safety in place. These included advocacy services, a policy on safeguarding people from abuse and managing people's finance. We saw all transactions were documented and regularly checked to ensure people's money was safe.

A business continuity plan provided the management team with a plan to follow to enable them to continue to deliver a consistent service should such unforeseen emergency occur. These measures supported people's safety. Individual emergency evacuation plans were in place that described the support, equipment and medicines needed for each person in the event of an emergency situation.

People told us they felt safe at the service and with the staff who supported them. A person said, "The surroundings make me feel safe. It's a nice place and secure. I've had no falls." Another said, "Definitely been safe. Staff are around day and night. No one has been rough or cross with me." Relatives told us that their family members were safe. One relative said, "I have no concerns about things going missing." Another relative told us that they managed their family member's finances and settled payment for chiropodist and hairdressing services.

The provider's safeguarding procedure was in place. Staff told us and records confirmed that they had received safeguarding training. Staff knew how to recognise abuse and they would report any concerns about people's safety to the unit manager. A nurse told us "Management definitely take all concerns seriously; they would rather you raised concerns even it if turns out to be nothing." Another staff member said, "I have done safeguarding training. People are vulnerable and I would report if I saw anything that worried me. I would always speak up." Records showed when safeguarding notifications had been made these had been appropriately investigated.

People were being cared for safely and without restrictions. One person said, "I get up when I want to. No one bothers me on what time I want to get up." Another person who was nursed in bed said, "Someone pops in to check I'm alright." A relative said, "We have discussed the care plan. [My relative] has a wheelchair, bedside mat alarm and a walking frame for safety. The staff give feedback on how [my relative] is." Another relative told us that their family member's personal hygiene needs were met and were always dressed in clothing of their choice.

Assessments had been undertaken to identify any risks associated to people's safety, which included risk of falling, moving round, choking and developing a pressure ulcer. They took account of people's diverse needs, rights and choices without placing undue restrictions and significant history of incidents such as falls.

Care plans mostly gave staff clear instructions as to how to support people safely. For example, advice from health care professionals and a photographic sequence guiding staff in where to position the pressure relieving cushions reduce any discomfort or preventing the risk of developing a pressure sore.

In another person's care plan the key safety risks identified was that they could be misunderstood and their choices not met. But there was no information documented to enable staff to support the person appropriately. Where people received their nutrition and medicines via a feeding tube a chart in place

showed the feeding regime and cleaning. For people with a catheter a chart showed that the catheter was regularly flushed. The charts did not show that daily checks were carried out to detect early signs of infection or other health problems. These issues were raised with the respective unit managers and they assured us the care plan would be updated and charts would be amended to include daily checks.

Staff were able to describe how they supported people to stay safe and where required used assistive technology to promote safety. For example, a person at risk of falling had a sensor mat placed in their room which would alert staff when the person was moving around and hourly safety checks were carried out. Care records for this person confirmed that hourly checks had been carried out and measures in place to manage the risks were reviewed regularly.

Staff recruitment processes ensured staff were suitable for their role. Staff files contained evidence that the necessary employment checks such as police checks, references and nurse's professional registration had been completed before they commenced work at the service.

Most people told us that there were enough staff available to support them when needed. One person said, "If anything is wrong with you then they come quick." A relative said, "I can find staff if needed."

Most staff felt the staffing levels were adequate and acknowledged that. One staff member "There are not really enough staff. I am here constantly. This morning I had help. If I am on my own I can't go in the kitchen to get people's drinks or toast as there has to be someone in the lounge at all times [to ensure people were safe and supervised]." They told us that a member of staff remained in the lounge at all times to ensure people were safe. The staff member went into the kitchenette to make drinks and toast when another staff member remained in the lounge.

Other staff said "This is one of the best places I have worked; there is a good team of staff on this unit; we make sure we cover if anyone is off;" and "[Registered manager] worked a couple of shifts when we had the heavy snow because the nurses couldn't get in."

Throughout our visit we saw staff responded to people's needs and requests in a timely way. Each unit had a hostess who supported people in the main lounge / dining area with drinks, snacks and meals. This helped to ensure people were safe whilst the nurses and care staff supported people in their rooms.

The registered manager told us staffing levels had been agreed based on the needs of people using the service. The staff rota showed that the staffing levels and skills mix was maintained across all four units. These were reviewed regularly and when required regular bank staff were used to cover unplanned absences.

People told us they received their medicines at the right time. One person said, "[Nurse] always gives me the tablets alright. I sometimes get paracetamol [to manage pain]." We observed two nurses supporting people with their medicines. A nurse was heard saying, "Still got a tablet on your tongue? Make sure you swallow it, would you like more drink?" Another nurse said "Hello, [person's name], I need to do your test on your finger." The person obliged as knew it was to test their sugar levels. We observed staff in all four units supported people with their medicines in a safe way. Relatives had no concerns about their family member's medicines.

Staff had access to information about safe management of medicines. These included the provider's medicines policies, procedures and National Institute for Health and Care Excellence (NICE) guidance.

The medicines in all four units were stored securely and within the manufacturers recommended safe temperature range. The medicines administration records (MAR) all contained photographs of the person to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. The MARs we checked confirmed that people received their prescribed medicines. When people refused to take their medicines after several attempts, the reason was recorded on the reverse.

Documentation was available to support staff to give people their medicines according to their preferences. A number of people were prescribed medicines to be administered 'when required' such as pain relief. The MARs described how to assess pain where the person was living with dementia and had difficulty to tell staff and described specific behaviours staff should be aware of.

A number of people were prescribed medicine via a transdermal patch which is applied on the body. A rotation chart showed where the patch had been applied and by alternating the site it prevents possible irritations. We found no record of the daily checks carried out to ensure the patch was still in place or removal of the previous patch to avoid the risk of overdosing. Records showed people's blood sugar levels and blood pressure was monitored. However, no information was found about the typical blood pressure range for a person, or the signs or actions to take in the event of significant change. When we raised these issues with the relevant unit managers they assured us action would be taken.

Arrangements were in place supported by a self-medicating policy and assessments to ensure people were able to safely manage their own medicines. Regular reviews and checks were carried out to ensure people continued to take their medicines safely.

There was a system for recording medicines received and disposals to ensure staff knew what medicine was in the service at any one time. Any discrepancies were identified and rectified quickly. Incidents where medicine stock had ran out or supply problem staff had contacted the GP surgery and pharmacy to ensure medicines were received quickly. This contributed to a safer medicines management system.

An internal system was in place to ensure lessons were learnt and improvements made when incidents or accidents occurred and safeguarding concerns were reported. These events including near misses, were analysed so that the registered manager could establish why they had occurred and take actions to reduce the likelihood of the same thing happening. The registered manager told us that any lessons learned from incidents were shared with staff through supervision and staff meetings. For example, soft slings were available for people identified at risk of fragile bones and their moving and handling risk assessment was reviewed to ensure suitable slings were used to protect them from avoidable harm.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff had the knowledge and skills needed to support them. One person said, "I think they are very good. They know how to do the job." A relative said, "Most of the staff are skilled and trained." We observed staff supported people to move and used equipment correctly.

Staff all confirmed that they had received induction and training for their role which covered topics such as health and safety and person centred care but felt they would benefit from more training in dementia awareness, Parkinson's and behaviours that challenge services. One staff member said, "I did all the basic training. I did training with SLT [Speech and Language Therapist]. I am now feeling more confident and more aware. If someone is coughing I will refer [to a nurse] and am aware of swallowing [risks] and things we can do to improve this." Another staff member felt they were able to put into practice the learning from the dementia training. We saw that other staff were aware of this person's behaviour and guided them to the toilet when needed.

The staff training programme was based on current legislation and best practice guidance, but the training record was not up to date. For example, there were no dates recorded to show when staff had completed training in infection control, manual handling and safeguarding whilst for others the same training topics were last completed ranged from the year 2011 to 2017.

Nursing staff were aware of National Institute for Clinical Excellence [NICE] guidelines in clinical care, such as medicines and health conditions. They told us they followed best practice through reading up to date research. Nurses' competency updates were managed through NMC and revalidation processes. This helped to ensure nurses had the up to date knowledge and competency required to support people with their health needs.

The registered manager told us that staff training and records were not up to date due to the change of provider. They did assure us that the provider had planned training for the nurses in catheter care, PEG (feeding tube) and venepuncture care.

Following our inspection visit the registered manager confirmed the new training programme would be available to all staff from May 2018. Some training has started in moving and handling and wound care.

Staff were encouraged to complete nationally recognised qualifications in health and social care. Nurses were supported to maintain their professional registration. Staff practices and their competencies had been assessed and any issues were discussed at supervisions and annual appraisals. This gave staff the opportunity to discuss their work and identify any training and development needs.

People's needs were assessed by a representative of the funding authority before they moved into Grey Ferrers Care Home. The registered manager or the unit manager carried out a further assessment by meeting with the person, their family member where appropriate and gathered information from the relevant health care professionals such as dietitian and GP. People's capacity to make decisions about their

care and their preferences, religious, cultural and dietary needs were recorded. Care plans were developed from the assessments and provided staff with guidance to follow to ensure people's needs were met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments were completed and best interest decisions documented when people were unable to make some decisions for themselves. Assessments were based on the individual and the specific decision. Appropriate referrals were made to the local supervisory body. Where people had a DoLS authorisation in place and the conditions on authorisations were mostly being met. For example, the staff rota was planned so that where possible a member of staff who could communicate in the same language as the person with a DoLS was able to support them. The registered manager told us the recruitment of staff with the specific language skills was ongoing to meet the DoLS conditions. Records demonstrated that authorisations were kept under review and new applications made in a timely manner. This helped to ensure that any restrictions on a person's liberty were being lawfully applied.

Records showed another person with a DoLS was supported by a 'paid person's representative' (PPR). The PPR monitors the implementation of the DoLS; we found a record of their visits had been made and that PPR's had not identified any concerns in relation to the implementation of the DoLS by staff. That showed MCA principles were met.

The registered manager showed an understanding of DoLS. This was not the case of the staff who we spoke with as not all staff had received MCA training. Despite this people told us that they made daily decisions about their care and staff encouraged and supported them in the least restrictive way possible. We saw people chose where and how they spent their time and moved around freely. One person said, "[Staff] all always ask you first." We heard staff sought consent by saying, "Can I help you with that" and assisted when the person agreed. A relative who was actively involved in their relative's care said, "They will discuss with me before making any decisions about [my relative] care." Records confirmed the relative had legal authority to be involved in best interest decisions made about their family member's care.

People's needs were met by the design and adaptations within the service which meant they were not restricted. All units were on one level and clear pathways meant people could move between units easily. People had been encouraged to personalise their bedrooms and had brought in personal items from their own home when they had moved in which had helped them in feeling settled. There was accessible garden space for people to use in good weather, and people had space for privacy when they wanted it.

The menu choices for each day were displayed in each unit. One unit had the wrong menu displayed which was changed immediately when it was pointed out to the unit manager. There were snacks and drinks available throughout the day and we saw the hostess staff serving drinks and a snack regularly.

We observed instances in three of the four units that showed people dietary needs was not always met and some people had to wait to be supported to eat which meant their meal was cold. When a person told the

member of staff they wanted to have bacon for breakfast they were served a bowl of fruit. Another person's care records indicated that they did not eat meat. Although the hostess in that unit was aware of this other staff were not and were served the lamb hotpot to the person. We saw a third person had not been supported adequately and spilt their tea on their clothing but was not offered another drink. A fourth person had a meal placed in front of them but they were unable to eat it. A staff member returned after 20 minutes to support the person to eat a cold meal. Our observations were shared with the relevant unit managers to address.

Staff served the meals individually and portions sizes suited people's appetites. Drinks were replenished and second helpings were offered. Some people used special cutlery and beakers so they continued to eat and drink independently. Staff provided sensitive care and support to people during the lunchtime meal, encouraging people to eat and offering support where required.

People told us they enjoyed the food and felt the quality and choices available was good. Their comments included "The food is very good. I don't eat a lot. You get what you want. There's plenty to drink" "I get plenty to eat and enough tea and orange juice. I'd give it 9/10" and "Food is good if it's not too cold." Relatives told us, "[Staff] asked what [my relative] likes to eat. She loves chips. Her weight has been kept here" and "[My relative] tends to graze throughout the day so staff are always giving her something to eat if she's not eaten at lunch time." We saw the person was encouraged to eat a piece of cake with their cup of tea.

The chef told us they were provided with information about people's dietary requirement such as food tolerances, cultural diets and food texture such as pureed food. This information was updated each time a new person moved to the service or when people's dietary needs changed. They told us each unit was fully stocked to prepare breakfast, drinks and snacks. Lunch was the main meal and alternatives were available should people want something different to eat.

People were supported to maintain a healthy balanced diet and were weighed weekly where appropriate. Where people had experienced difficulties with swallowing, referrals to a dietician and speech and language therapist (SLT) had been made. Advice from SLT had been incorporated into people's nutritional care plans, which specified the food type and texture required.

Staff worked together within the service and with healthcare professionals to provide effective care. Any change in people's health was recognised by staff and referrals were made to the appropriate healthcare professionals. Records showed that staff sought advice promptly when people's health deteriorated and followed instructions when given. Our findings supported the feedback we received from health care professionals during and after the inspection visit.

People were supported to access health care support and attend routine health check appointment. Records showed that staff had contacted people's GP when they felt the person's health had not improved. One person said, "The doctor comes to see me. The nurse is doing the [dressing] on my feet. My hospital appointments are made for me by the home and a member of staff will take me by car." A relative told us, "When [my relative] was poorly the staff kept us informed of what they were doing. We didn't think [they] would make it but glad [they] are still here."

Requires Improvement

Is the service caring?

Our findings

We found people's experiences of receiving a caring service was inconsistent. We did observe instances in two units that showed people's dignity was not always maintained. A staff member brought another person to the lounge only wearing one slipper. When the activity coordinator arrived 20 minutes later they noticed and found the slipper and put it back on. We alerted a staff member in the lounge that someone was coughing and had spilt the drink onto their clothing and gave them a napkin. The staff member made no attempt to ensure the person was comfortable; they did not offer them another drink nor assisted them to change their clothing. We saw staff moved another person using a hoist but had not placed a blanket over their legs to maintain their dignity. We saw a staff member moved a person seated in a wheelchair without permission. The person could not verbally express how they were feeling but looked startled as to why they were being moved.

We shared this with the unit manager and they assured action would be taken. The following day we saw staff were more vigilant and acted promptly to ensure people's dignity was maintained. Despite the improvements it showed that the unit managers had not been observing practice to ensure that staff were caring and promoted people's dignity at all times.

We saw staff spoke politely to people; they knocked on bedroom doors before entering and checked with people whether they were happy for them to enter. The staff we spoke with could describe how they would preserve people's dignity during personal care such as covering exposed parts of the body when washing people so not all of the body was exposed. One member of staff commented, "I love looking after people, I treat them as my own family members. I always close the door and don't talk about things in front of others." These were examples of a caring attitude.

People were complimentary about the staff and felt they had a good relationship with them. One person said, "They speak nicely and care. Staff are polite, caring and come quickly if I call them." Relatives told us that they felt staff were caring in their approach and kind to the relative. One relative said, "They are compassionate and caring; [we] feel happy with [my relative] care." Another said, "Pleasant, capable staff. I would like to praise the nursing staff. The staff are stable here [named unit]."

There was a warm, friendly atmosphere across all four units. We observed lots of positive interaction between staff and people who lived in the home. We saw when a staff member complimented a person who had had their hair done, the person smile and kissed the staff member's hand. Staff communicated with people effectively and used different styles of communication. For example, communication was enhanced with touch; staff knelt down so they were at the same eye level with people who were seated and staff altered the tone of their voice appropriately. These were instances of caring attitude.

People looked happy and relaxed and we observed positive relationships between other people, staff and visitors. One person said, "The staff always like to chat with me and help me." Staff respected people's individuality and responded to people by their chosen name. From our conversations with staff it was clear they knew people well and had built positive caring relationships with them. This supported the feedback

we received from health care professionals who felt staff treated people with 'kindness and compassion'.

People were involved in making decisions about how they wanted their care and support provided.
One person knew what information was recorded in their care plan and said, "Staff explain to me the care they give me." If people were unable to make decisions for themselves and had no relatives to support them, the registered manager was aware of advocacy organisations that they could contact to support people. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Staff were trained in the promotion of and respecting people's dignity and privacy. People were dressed in clothing of their choice and co-ordinated. Some ladies wore jewellery and had their nails painted. That showed staff recognised that people's appearance promoted their wellbeing.

People said staff supported them to make their own decisions about their daily lives. We saw staff assist people when they moved around and guided them to wherever they were going. When someone tried to stand up a staff member responded; they assisted the person to stand up using their walking frame and provided clear directions as they walked. People were provided with suitable cutlery and plate guards that enabled them to eat. These examples showed that staff supported people to remain as independent as practicable.

There was an equality and diversity policy in place and staff received training on this. Staff were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. A staff member described how they used key words and objects such as a towel and shower gel when supporting a person with their personal care needs whose first language was not English. They added that another member of staff had taught them a few key words so that they could address the person in a respectful manner.

Visitors were welcomed throughout the day and were offered drinks. Visitors interacted with other people who used the service and staff. People were able to speak with their relatives in private if they wanted to. Health care professionals confirmed that they had observed staff maintained people's privacy and dignity and stayed with the person if requested to do so during any treatment or consultation.

People's care plans referred to their needs in a dignified and respectful manner. People's care records and personal information were kept securely and the provider had a confidentiality policy which was followed. Staff had access to records and only shared information on a need to know basis. Handover of information and meetings took place in private. That meant compliance with the provider's confidentiality policy and the Data Protection Act.

Requires Improvement

Is the service responsive?

Our findings

We found people's experience of receiving responsive care and support was inconsistent. We observed instances that showed people did not always receive care and support that was responsive or person centred. We saw staff were not always attentive or aware of their own approach. For example, a staff member brought a person seated in their wheelchair to the lounge and positioned them against the back wall of the lounge without any communication with the person. They were unable to communicate and sat looking to get the attention of a staff member for over an hour. They were not offered a drink as the staff member focused on the small group of people who were engaged in conversations. This was pointed out to the unit manager and on the following day the person was seated with other people in the lounge, and was more engaged.

During lunch staff assisted people in one area of the lounge / dining room, which meant they were not able to see or respond to people seated elsewhere. We saw a visitor replenish someone's drink as staff were busy serving meals. If staff were spread around the lounge / dining room they would be able to respond sooner. We observed people attempted to stand up without the use of their walking frame which not within reach. We intervened by asking the person to be seated and asked a staff member to help the person. We shared our findings with the unit manager and registered manager. The following day we saw staff were spread around the lounge and responded when people needed support.

Meal time experiences were generally pleasant with music playing in the background. The ambience was interrupted with the double doors closing with a loud bang each time staff entered or left the lounge. We raised this with the registered manager and on the following day staff were mindful and ensured the doors closed gently. The registered manager told us that maintenance staff would install soft closing fittings to all the doors in the communal areas.

People told us that staff were mostly responsive and supported them when needed. One person said, "[Staff] look after me; you press the buzzer and they are there; they are good." A relative said, "Staff let us know when [my relative] isn't well and what they have done; like call the doctor."

People received care and support based on their assessed needs. They had care plans which detailed the care and support they needed; this ensured that staff had the information they needed to provide consistent support. If a person's needs had changed the care plan was updated to reflect this. This meant the care provided was responsive to people's needs.

Staff and nurse told us that they felt communication and team work across all four units was good. A senior carer said, "If we have to, then we use regular bank staff who know how to look after our residents. Handovers are informative. I usually say hello to everyone and make sure those who need to, are sitting on pressure cushions (to avoid developing pressure sores)." We saw staff made sure people were positioned comfortably in their beds. A nurse said, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right." That meant people were assured that staff would provide the care and support they needed.

People and their relatives told us that they had sometimes been involved in developing and reviewing the care plan. One person said, "My [family member] deals with all that stuff. What I can say is that I'm happy with the care I get." Relatives we spoke with knew about their family member's care plan and had been involved in review of their care and wishes regarding their end of life care.

Care records had information about people's past lives, spiritual needs, hobbies and interests that ensured staff had an understanding of people's life history and what was most important to them. This enabled staff to interact with people in a meaningful way. Any changes in people's care and their care plans was communicated to staff, which ensured staff, remained up to date with people's care needs.

The registered manager told us that the information in people's care records would be transferred to the provider's new care planning documentation starting from May 2018. Records confirmed that people's risk assessments and care plans continued to be reviewed regularly and took account of daily monitoring records such as food intake and re-positioned charts. For example, one person's pressure sore had healed as a result of staff being responsive, they had followed the instructions provided by tissue viability nurse and kept accurate records of visual checks and care provided. We looked at accident records. We found where people had falls and been injured, nursing staff had responded to people's medical needs. This assured people staff were responsive to their needs.

People told us that staff understood how to support them. One relative said, "Every day they have activities for [my relative] who's 94yrs, it helps, it's stimulating and better than just sitting here. She's in a soft chair with wheelchair; it's amazing and comfortable; they hoist her into it and into bed. The staff are amazing they can't do enough, her pureed meals are amazing and she loves her meals." Another relative said, "In my view [my relative] is well looked after. I have a laugh with her and [my relative] likes [staff name], one of the nurses."

People told us that there was a range of activities they took part which included film shows, bingo, and outings. One person said, "I like doing lots of things. I do colouring. The activity woman is very good. We have songs here. I get on with our residents and chat with them." A relative told us that that when the weather was good staff often took their family member to the garden and the local shops.

People's spiritual needs were mostly met. A local faith minister and priest visited regularly and people were supported to practice their religious beliefs.

During our visit we saw people doing arts and crafts and puzzles. When one person asked to listen to a Vera Lyne CD, a staff member played it and the person and others enjoyed singing along. The activity coordinator spent time talking with people and used picture books to stimulate conversations about different places and special events in people's lives.

Entertainment had been planned in the afternoon in the afternoon on the first day of our inspection visit. A dementia café was set up in the main reception foyer to the service. People from all four units who wanted to, and some relatives went to dementia café. We saw people, their relatives and staff all enjoying singing "You are my sunshine…..". People looked happy; laughter and conversations could be heard and we saw people were making new friends. People were enjoying themselves even though the receptionist was not able to answer telephone calls and attend to visitors to the service.

The activity coordinator told us that they spent time with people who were nursed in bed. They spent time reading newspaper articles, talked about topics that was of interest to the person and gave hand massages and painted nails.

A policy and information about how to support people at the end of their lives, bereavement and counselling was available to staff, people who used the service and their relatives. The nurses and some of the staff had received training in end of life care was undertaken. Staff had supported people at the end of their life to have a comfortable, dignified and pain-free death. Where possible people were able to remain at the home and not be admitted to hospital. Advance care plans were in place to support people's decisions and a capacity assessment with regards to their end of life care. Nurses confirmed that they liaised with other agencies such as palliative care nurse to support people with their final wishes.

The provider understood their responsibility to comply with the Accessible Information Standard (AIS). The AIS is a framework making it a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider ensured people had access to the information they needed in a way they could understand it, to comply with the AIS. Staff we spoke with knew people well and knew how each person communicated.

People were encouraged to raise any concerns or complaints and knew who to speak to if they had any complaints. A relative said, "The staff are very good at sorting things out if you tell them, so there's been no need to go to the manager." A staff member said, "I would try to deal with anything minor straightaway but if I couldn't then I would let the nurse or the unit manager know."

There was a clear complaints policy and procedure in place, complaints received had been dealt with appropriately and were logged and monitored. Advocacy support was available to people if they needed support to make decisions, complain or if they felt they were being discriminated against under the Equality Act, when making care and support choices. An advocate speaks up on behalf of a person, who may need support to make their views and wishes known.

Records showed two complaints received had been appropriately investigated and action taken. This showed us the service was open and transparent in handling complaints, which was used to improve the quality of care and service people received.

Requires Improvement

Is the service well-led?

Our findings

We found some inconsistencies in the quality of care and support people experienced across the four units. The effectiveness how each unit was managed contributed to this. For example, staff practices were not always observed to ensure people received the care and support hey needed that maintained their dignity at all times. We saw instances that showed staff were focused on tasks and not always responsive to people's needs and requests.

The provider's governance system had not been fully implemented as the new audit paperwork, electronic systems and processes were not in place. Despite this we saw regular audits and checks in all aspects of the service were still carried out using the existing documentation. We looked at a sample of audits for premises, catering, medicines and care records. We noted some safety issues had been identified in relation to the premises, which supported our findings in relation to the risks to people's safety. Action plans were in place to address areas of improvements identified and monitored by the registered manager. It was acknowledged that there was some delay in addressing issues regarding the environment and décor and that plans were in place.

We saw that the management team held adhoc meetings known as 'flash meetings' to address any issues of staff poor practice and observations. For example, a flash meeting was held to remind a staff member of the risks when using a wheelchair without footplates. Staff member's competency and practices had been observed to ensure the training had been effective.

People's care records had not been transferred to the new care planning documentation for HC-One. Despite this people's care needs were reviewed regularly and care files were randomly audited by the unit manager. This helped to ensure the relevant information was in place, kept up to date and reflective of people's needs. Following our inspection visit the registered manager confirmed the process to review and transfer people's information to the new care planning documentation had begun.

The Area Quality Director described the systems and processes in place to oversee the service and their role in supporting the registered manager. They assured us that the provider was investing in the service to ensure transition was being managed effectively, and sufficient resources were available to drive improvements in areas such as staff training and refurbishment plans. For example they monitored the progress of the action plans from the bi-monthly internal audit visits and reviewed any new risks, incidents, complaints and safeguarding concerns. Following our inspection visit the registered manager confirmed the service had access to a mini bus and outings were being planned for the year.

We saw that staff did not wear a name badge that identified their role. That meant people and visitors may not always know who they should approach for specific things. For example, if someone needed pain relief medicine or a relative wanted to discuss their family member's health concerns. The registered manager told us that new name badges and uniforms had been ordered. They added that once all uniforms were received the changeover would take place on a set date which would avoid any unnecessary confusion for people who used the service.

We concluded that the inconsistencies found across the four units were due to a lack of oversight and the provider's governance system not fully embedded.

This was a breach of breach of Regulation 17(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the governance system to monitor the quality of care people received and the management of the service was not used effectively.

The registered manager understood their role and responsibilities with regards to legislations relevant to social care and the reporting of incidents to CQC. They were aware of the legal requirement to display the registration certificate and rating from this inspection.

The registered manager spoke positively about the support they had received from the Area Quality Director for the new provider who was present during our visit. They acknowledged that training had been planned for staff in completing the provider's paperwork and until such time the service continued to use some documentation from the previous provider. Key information such as policies, procedure, complaints procedure and information about Grey Ferrers Care Home, was related to HC-One Oval Limited.

The registered manager and the staff team understood the provider's vision and values to provide quality care. We saw the service had received cards, compliments and letters of thanks from people and relatives about the quality of care people received and staff team's approach. One comment read, "We can't thank you enough for the care you have provided my [relative], you are all truly exceptional." This showed people felt Grey Ferrers Care Home provided quality care.

The registered manager continued to maintain their knowledge and skills and accessed relevant clinical training and worked alongside the staff team. This enabled them to provide effective leadership and ensured the service continued to operate effectively during the transition of paperwork, processes and systems. They said, "I've supported my staff team during this transition; the residents and their relatives. We've held meetings and met with people and staff individually to re-assure them and answered any questions that they had."

We received positive comments about the registered manager from people who used the service, relatives, staff and health care professionals. Their comments included "Its run properly. It's alright. I'm happy here" "[Registered manager] is approachable, nothing is too much trouble" and "[Registered manager] is a qualified nurse so I have clinical supervision with him."

Unit managers told us they felt supported to manage their respective units and had confidence in the registered manager to guide them when dealing with complex care needs or staffing issues.
When we asked about the changes, a staff member said, "The changes have been positive. These are down to [registered manager]. I like to think we support him."

People's views about the quality of care they received was sought through care review meetings and residents meetings. Each unit held their own residents meetings. A sample of the residents meeting minutes showed that people were informed about the change of provider and assured it would not impact on the care they received; feedback on the menu choices and updates on new furniture and the refurbishment plans for the unit. People had commented that they were happy with the care and had no concerns. This demonstrated that people's views were listened to and acted upon, ensuring people had a voice.

The registered manager conducted daily 'walk rounds' across all units and spoke with the key staff in the kitchen, house-keeping and maintenance. That meant they were visible to all and encouraged people who

used the service, visitors and staff to speak with them and raise any concerns if needed. New tablecloths and bedlinen had been purchased as a result of their observations. These examples showed issues were promptly addressed and the effectiveness of the registered manager.

People told us and we saw staff worked well together as a team. The staff team felt they were well supported to look after people. A system was in place that ensured staff accessed regular training and supervision and appraisals where they could discuss their work and identify training needs. The registered manager told us that they provided person centred support to staff and when required adapted training to meet staff's learning needs.

Regular staff meetings were held. The meeting minutes confirmed that staff received updates; had the opportunity to raise concerns, share ideas around good practice and learn together from any outcomes to investigations or complaints.

The registered manager told us that the provider encouraged new ideas to drive improvements. Staff, people who used the service, visitors and health and social care professionals could use the 'blue marshmallows' balls sited around the service or the provider's website to make suggestions and share ideas to improve the service.

The registered manager spoke about their vision for the service. They included developing lead roles for staff in areas such as continence care and falls and championing the care for people living with dementia and palliative care. They spoke passionately about creating an environment that enhances the lives of people living with dementia which they had suggested using the blue marshmallow. Following our visit they confirmed that they and the unit managers were due to attend a dementia conference and the further dementia training was planned for the staff team.

The registered manager and staff team continued to work in partnership with other agencies in an open, honest and transparent way to ensure people received joined up care. Healthcare professionals we spoke with during our inspection visit and feedback we received showed that staff followed instructions and advice which had had a positive impact on people' quality of life. One health care professional told us that the improvement in communication and care was reaching a 'higher standard' in one unit.

Feedback we received from health care professionals and commissioners who monitored and evaluated the service was generally positive. They told us that the service was well managed and people mostly received quality care and support.

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 People's health was not protected because infection control procedures were not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected from risks to their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance system was not fully implemented and not used effectively to address inconsistencies in the management and the quality of care people received.