Somerset Care Limited

Grovelands

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 27, 28 and 31 October 2014 and was unannounced. Grovelands provides accommodation and personal care for up to 60 older people, specialising in care for people with dementia. There were 57 people living there when we visited. This provider is required to recruit a registered manager for this type of service. There was a registered manager in post. 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 and associated Regulations about how the service is run.

We inspected the home in January 2014 and June 2014. In January 2014 we had concerns about how people were cared for, how they were protected from abuse, how many staff they had available and the quality of record keeping to ensure safe and appropriate care. We asked the provider to take action to about these areas. At our last inspection, in June 2014, we continued to have concerns about how people were protected from abuse and we took enforcement action to ensure the provider made changes. We had continued concerns about record keeping, how people were cared for especially around mealtimes, and staffing levels. At our June 2014 inspection we also identified additional concerns around how quality was assured in the home. We asked the

Summary of findings

provider to take action about these areas and they sent us a plan detailing that they would have addressed them by the end of August 2014. At this inspection we found that improvements had been made in all these areas but the concerns about record keeping and how quality was assured had not been improved enough. This meant there were continued breaches of regulations.

At this unannounced inspection we found improvements in how people were cared for, how people were protected from abuse and staffing levels.

Grovelands is a purpose built service and is divided into two main parts. There is a residential care provision on one side of the home and a specialist residential care (SRC) provision on the other side of the home. This provides care for people with complex dementia needs and is commissioned directly by the Somerset Partnership who provide a dedicated nurse to work with the provider.

The majority of concerns found at this inspection were found within the SRC. The service was not safe for people living in this part of the home because they were not protected from infection as this part of the home was not kept clean.

Staff within the SRC were not monitoring where people were in the building and did not have training in responding to physical aggression. The people in this part of the home had dementia and could not keep themselves safe and this put them at risk.

People's capacity to consent to their care and treatment was assessed and people's representatives were involved in 'best interest decisions' but some best interest decisions had not been recorded and some had not taken place.

The management team undertook monitoring and audits to check on the quality of the service people received. This was only partially effective and concerns around reporting and cleanliness identified during our inspection had not been picked up by these checks.

People were supported to access health professionals although monitoring necessary for supporting health was not always maintained effectively.

People had the support they needed to eat and drink safely. Meal times were social and relaxed events and people were supported to make choices throughout.

People told us that staff were kind and we observed that the staff were aware of people's preferences and respected their privacy and dignity. People and or their relatives were also involved in decisions about the support they received and their independence was respected and promoted.

People and their relatives felt heard by the registered manager and staff. They were confident that concerns were listened to. Relatives and staff were confident in the management of the home and believed that the senior team were making necessary changes.

People in the residential part of the building were safe because there were enough staff and their environment was kept clean.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to: quality not being monitored effectively; records not being accurate; the home not being clean and putting people at risk of infection and people's care not being provided within the framework of the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe for people living in the specialist residential care (SRC) part of the home because they were not protected from the risk of infection because this part of the home was not kept clean.

Staff in the SRC were not managing all identified risks because they were not always monitoring people appropriately.

People in the residential part of the building were safe because there were enough staff and their environment was kept clean.

Is the service effective?

Inadequate

The service was not effective. We identified concerns with the training of staff working in the SRC in relation to their skills in supporting people whose behaviour was challenging at times.

Some staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's capacity to consent to their care and treatment was assessed and people's representatives were involved in 'best interest decisions'. Some best interest decisions were not evidenced.

People were supported to access health professionals although the monitoring necessary for supporting health was not always maintained effectively.

People had the support they needed to eat and drink safely. Meal times were social and relaxed events and people were supported to make choices throughout.

Is the service caring?

Good

The service was caring. The people and their relatives told us that staff were kind and caring.

People and or their relatives were involved in decisions about the support they received and their independence was respected and promoted.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was responsive but gaps and inaccuracies in care plans put people at risk of not getting the right care.

People enjoyed a range of activities.

People and their relatives were confident that their concerns were taken seriously.

Summary of findings

Is the service well-led?

The service was led by a registered manager and senior staff who were respected and liked by people and their relatives.

Staff, relatives and professionals believed the service was improving.

People were not fully protected by the quality assurance systems the registered manager and senior staff used to ensure the quality of care provision. At this inspection we found that monitoring and audits had not found problems with cleaning and record keeping.

Requires Improvement

Grovelands

Detailed findings

Background to this inspection

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

This inspection took place on the 27, 28 and 31 October 2014 and was unannounced.

The inspection team consisted of two inspectors. Both inspectors visited the home on the three days of the inspection.

During our inspection we spoke with 12 people and the representatives of five different people. We looked at the care records relating to 12 people and the medicines records of six people. We spoke with two senior staff members, a cleaner, the cook, two senior care staff, four care staff and the registered manager. We observed care and support in communal areas. We also looked at records that related to how the home was managed.

During the visit to the home we spoke with a visiting specialist nurse. We spoke with two social care professionals and commissioners after the visits to the home to obtain their views about it.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed information we held about the home, we did not have the Provider Information Return (PIR) available as the home had not been asked to provide this information at the time of our inspection. The PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from other information we held about the service including notifications of incidents that the provider had sent us since the last inspection, and the action plan that the provider had sent us after their previous inspection. We also discussed these areas with the registered manager and staff during our inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, on the 16 and 23 June 2014, we had concerns about how the service kept people safe from harm and abuse and staffing levels. There had been breaches of Regulations 9, 11 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action. At this inspection we found that improvements had been made in ensuring that allegations of abuse were reported appropriately and that people who may cause harm to others were monitored more closely. We also found that risks to people's well-being were assessed and managed so they were at a reduced risk of harm. Staffing levels had been increased and people were monitored more closely to ensure their safety and were able to participate in more activities. We identified some concerns around staffing and monitoring, within the specialist residential care part pf the home, but these no longer constituted breaches of the regulations.

We found that records were not adequate to keep people safe at our last inspection. This meant there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we asked the provider to take action. At this inspection found that the records remained inadequate to ensure that people received appropriate and safe care and this constituted a continued breach of this regulation.

Although improvements had been made since our last inspection, people living in the specialist residential care (SRC) part of the home were not safe because they were not protected from the risks of infection and staff were not always monitoring people adequately. These concerns did not apply to the residential part of the building.

We found issues with hygiene on all three days of our inspection. These included faeces on the floor and hand rails in communal areas and on door handles and toilet seats within people's private bedroom areas. We saw that people were drinking from shared cups within this part of the building. We discussed these concerns with the registered manager, senior staff and cleaning staff. They told us that there were check lists for staff to follow but that no formal audit took place of the cleaning or infection control measures. Staff in the home had not taken action to ensure people were provided with a clean environment to live in and this put people within the SRC at risk of harm. During our inspection a senior member of staff held a meeting with cleaning staff to begin to address these concerns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff in the SRC were busy and we observed that they moved from task to task. The representatives of two people told us that staffing had improved in this part of the home since our last inspection and staff comments supported this assertion. However, we observed that one person whose care plan detailed that their interactions with other people should be monitored was not always monitored by staff. During our observations we did not see this have a negative impact on anyone living in the SRC but their care plan indicated that this lack of supervision could put people at risk. We saw that people walked up and down the corridor sometimes going into other people's bedrooms without staff observation. Due to the nature of the needs of people living in this part of the home this meant that identified risks may not be being managed.

We observed the SRC during the time when people were getting up in the morning. With a full staff compliment of five carers a senior carer and the registered manager spending time responding to someone who was distressed everyone had their needs met promptly. Staff were able to spend time with people when they were involved in organised activities and meal times were unhurried and staff were available throughout. Staff had mixed views as to whether there were enough staff deployed in SCR to meet the needs of people living there. Two staff told us they did not have time to spend time with people but four staff working told us there were enough staff working to meet people's needs. They made comments such as: "We manage very well.", "They don't have to wait long." and, "I am comfortable that people's needs are met." One of these staff members identified that sometimes they only have three carers working in this area, which is less than the commissioners' expectation of a minimum of four carers for the SRC, and another member of staff told us that people's needs had increased but staffing levels had not matched this. They described this as having an impact on the time they could spend with people. The rota showed that the higher staffing level agreed for this part of the home of five carers and a senior carer were achieved on half of the shifts we looked at. The minimum level of four

Is the service safe?

carers and a senior carer were achieved for the remainder. We asked about this and were told that the senior staff member undertook personal care when there were only four carers available. The provider had developed a dependency tool that helped the registered manager identify appropriate staffing. This was based on physical needs and did not refer to mental health needs. As a result the dementia care needs of the people living in the SCR were not fully acknowledged by the tool and it produced a staffing level very similar to that for the residential area where people were more independent and risks were substantially lower. This suggested the tool may not be appropriate for the home.

We spoke with the registered manager about staffing levels and they told us that when people had additional needs funding was sought so that agency staff could be used to provide them with one to one support. They described a time that this had happened and provided evidence of this additional support. Within the residential care part of the building people told us the staff always had time to attend to them and we saw that this was the case.

Staff described the support individuals needed with their care consistently and respectfully. They were mostly able to tell us about the risks people's behaviour may present or how health conditions impact on their safety. Whilst staff were mostly aware of current risks, the records did not reflect this knowledge and were not always clear about the support people needed to stay safe. This put people at risk of receiving inappropriate or unsafe care. For example, one person's care records held conflicting assessments of the risks a person faced around weight loss. The guidance around these risks was also contradictory. Records held about managing aggression were not suitable. Care plans included personalised information to enable staff to help people calm when they became anxious. However, there was a lack of recorded detail regarding how staff should respond if people did not calm and their agitation escalated. We spoke with staff about this and found they were not clear about how they should respond to some behaviours. For example there was not clear guidance about what staff should do if people were physically aggressive towards them or other people living in SRC. We read eleven incidents involving physical aggression that happened during October 2014 that included staff being grabbed and hit and other people being slapped. Staff were also not clear what level of monitoring was required for one person whose care plan outlined they should be monitored. One member of staff said, "We keep an eye out for where they are" but acknowledged that they did not make any clear agreements about who was doing this. The care plan did not detail how this monitoring should be undertaken. Another person who lived in the residential part of the building had been identified as requiring monitoring for similar reasons and their care pland described this in a clear and structured way that respected their dignity and kept people safe. Within SCR there was a risk that people would not receive safe and appropriate care because the records related to risk management were not adequate. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe in the home. One person described how they knew they were checked on and this made them secure and happy. During our observations we saw that people who couldn't tell us how they felt were relaxed in each other's company and in the presence of staff. All staff were clear of their role in responding to allegations of abuse. They told us that they had received training and were confident that concerns were acted upon. All incidents we saw recorded had been referred to the appropriate agencies.

People did not receive their medicines in personalised way which would optimise its benefit. Some people were given their morning medicines at 0600 because they lived on the downstairs floor of the SCR rather than because it was the best time to take these medicines. We saw a person being given a medicine that should be taken with or after food before their lunch. We asked the staff member about this and they told us they did medicines before lunch. We saw that one person who was taking a medicine to help them remain calm had been prescribed this to take when they needed it. There was no information about what the staff should look for to decide if the person needed to take this medicine and the records showed they had taken it at maximum dose for the six days prior to our inspection. The medicines in the SCR were overseen by a visiting specialist nurse who reviewed their usage as part of a wider healthcare team. We spoke with them about this person's medicine and they told us they had reviewed its use that day.

We looked at medicines records for five people and saw that there were no gaps in the records although during a medicines round we saw that the staff member signed that

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Is the service safe?

the medicine had been taken before giving them to the person. This is not good practice because it can lead to inaccurate recording although during our observation everyone took the medicines we saw signed. We also saw a person being asked how much pain relief they wanted and this being provided as requested. We looked at the medicines that were stored safely in four people's rooms and found discrepancies in the record number of two of them. The registered manager explained this may be due to a change in the delivery system and was a recording error. This meant it was not possible to check if people had received their medicines as prescribed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

At our last inspection, on the 16 and 23 June 2014, we had concerns about the way people were supported to eat and drink at mealtimes. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action and at this inspection we found improvements had been made and people were being supported effectively at mealtimes.

At our inspection in June 2014 we also found that records were not adequate to effectively monitor people's health and well-being. This meant there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we asked the provider to take action. At this inspection found that the records remained inadequate to ensure that people received appropriate and safe care and this constituted a continued breach of this regulation.

The service was not effective because people and staff were not protected by effective use of the Mental Capacity Act 2005 and records did not enable the effective monitoring of people's health.

Staff were not knowledgeable about the Mental Capacity Act 2005. Some staff had been undertaken Mental Capacity Act training, although three staff we spoke with had not. We spoke with the registered manager about this who showed us that this training was scheduled shortly after our inspection. Staff were able to describe how they encouraged people to make the decisions they could make on a day to day basis but did not have an awareness of capacity is assessed or how best interest decisions should be made. Senior staff in the home were knowledgeable about the Mental Capacity Act 2005. Records showed that peoples' ability to make decisions had been assessed. They showed the steps which had been taken to make sure people who knew the person and their circumstances well had been consulted to ensure decisions were made in their best interests. Whilst these principles of the Mental Capacity Act 2005 were followed for clearly restrictive practice such as locked doors used to keep people safe, there was no record available to show that general care plans had been agreed in this way. Some people who lived in the home had dementia and were not able to make important decisions about their care and we saw records that indicated that some of these people sometimes refused care. There were no best interest decisions made around how staff should respond to personal care refusals.

We also saw that in some cases when people became distressed staff interventions were recorded that included physical intervention. For example one record described a person who was upset being "assisted away". There was a risk that staff interventions in these situations would be defined by the Mental Capacity Act 2005 as a restraint. We spoke with staff who told us that they did sometimes physically prompt people to move to safer, calmer spaces in ways they had learned in manual handling training. There were no best interest decisions available about these interventions and practice was neither recognised nor monitored within the framework of the Mental Capacity Act 2005. This meant that staff were not acting within the legal framework provided by the Mental Capacity Act 2005 for this care to be delivered. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People in the home required some restrictions to be in place to keep them safe and for them to remain living in the home. The home had been granted the right by the local authority to deprive some people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS). The staff in the home were complying with the conditions of these authorisations, because the care people received reflected them. However not all staff were aware which people had DoLS in place. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards can only be used when there is no other way of supporting a person safely. The provider kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were protected.

We observed the midday meal being served in all four dining areas of the. Meal times were well organised and people were provided with a relaxed and social experience with choice offered throughout. People received the support they needed quietly in ways that supported their dignity. We saw a person with dementia sometimes put their cutlery into their drink. Each time they did this staff quietly changed their drink explaining they might want another one without drawing any negative attention to the

Is the service effective?

person. We observed that people received the help they needed to eat safely. Staff understood the potential risks people faced with eating and were able to describe the sorts of food and support they needed consistently. However, we found inaccuracies and omissions in the related records. For example: we found discrepancies between records held in the kitchen and those on people's care plans regarding what food they could eat safely; two people who needed support to eat and drink safely did not have relevant care plans and one person's care plan had not been updated to detail that they required a pureed diet. There was a risk that people would receive unsafe or inappropriate care because the records held about them were inaccurate. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People were supported to access healthcare professionals. We were told by people living in the residential care part of the home that they received the care they needed to support their health. When referring to how the staff supported them with their health care needs, one person told us, "You know you can call on them." Another person told us, "If we've got problems, we go to the staff and they sort it out for us." Within the SRC we saw evidence of health professionals visiting and GP's being contacted when people's health changed. However, we also found that monitoring records were not maintained and we found an example of a gap in bowel monitoring for a period seven days without prompting a response from the staff team. This was raised by an inspector and led to a GP being called to assess the person. The GP found that the person was not likely to have not had a bowel movement for this length of time however the records were not adequate to highlight the possible risk to the person's well-being. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not all have the skills and knowledge they needed to undertake their roles safely and effectively. Within the SRC staff identified that five people could become physically aggressive towards staff or other people. We spoke with staff about managing aggression and they told us they used distraction and they had manual handling training if they needed to reassure and guide people. They told us they had not received specialist training in how to keep themselves safe or how to intervene safely if people were being hurt. We spoke with the registered manager who acknowledged this and assured us it would be addressed. They identified a course that some staff were about to attend but acknowledged that this might not fully address this learning need.

In the residential care part of the home staff had the knowledge and skills they needed to meet the needs. They told us they felt confident about their skills and had received training relevant to their roles. Staff told us that they received regular training and could talk to both colleagues and senior staff for support. We looked at the training records held for three staff. The records showed that they were either undergoing or had undergone an induction programme. They also received and undertook additional support and training through supervision, team meetings and various forms of on going training. As a result they had the skills necessary for their role. We looked at the training records that the registered manager used to plan training and saw that plans were in place to ensure that gaps identified in training such as the Mental Capacity Act 2005 training were addressed promptly.

Good

Is the service caring?

Our findings

The service was caring. Interactions between staff and people were warm and positive. We saw touch used effectively to support communication with people for whom dementia had impacted on their ability to process words. Staff described people with respect and understood details of their lives before they had moved into the home. One member of staff told us, "It's their home. You have to make it the best for them." Another person told us that the staff are, "Family, they are not workers as far as I am concerned." They continued that, "There is nowhere I would rather be."

For people who could not use words to communicate, we saw that details about their preferences were used to personalise the way their care was delivered. For example, within SRC detailed information was recorded about things people liked and that could be used to distract or calm them if they were anxious or agitated. This personal knowledge applied with kindness further helped staff to develop positive caring relationships. This was being built upon at the time of our inspection. A senior member of staff working within the SRC told us they had recently contacted people's representatives to ask for additional information about people's past lives and things that mattered to them such as personal music preferences. This information would be used to support communication with people with dementia.

Family members commented on the kindness of the staff and in some instances gave examples of how they felt staff went above and beyond expectations to ensure their relative felt cared for. One relative told us, "Caring – oh without a doubt, absolutely. The staff are tender. They are really, really caring."

People felt that their views were taken into account in relation to how they were supported individually. One person told us about how they decide day to day decisions such as when they get up and go to bed. They explained that their views were acted upon. We saw people being offered choices about food and activities throughout our inspection. Relatives told us that they were consulted over their relatives care. One relative said, "They always speak with me." Another said they were kept informed about the choices their relative made.

Visitors were made welcome within the home; we saw people received visitors at different times. One person explained how their relatives felt visiting the home, saying that, "They're always made welcome."

People were encouraged to be as independent as they chose to be. We heard from some people, within the residential part of the home, that they went out regularly and one person described making their own medical appointments. Within SRC we noted that people were supported to maintain daily living skills. For example during meal times both the environment and unobtrusive staff support enabled people to eat and drink independently and with dignity.

Staff did not speak about people's care needs in ways that could be overheard by others and we saw that people's care was provided privately. There was one exception when people were weighed in a communal area and their weight discussed with them in front of others. We discussed this with a senior member of staff who acknowledged that this was not appropriate and assured us that they would ensure it would not reoccur.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, on the 16 and 23 June 2014, we had concerns about inaccurate care plans putting people at risk of inappropriate or unsafe care. There was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action. At this inspection some parts of people's care plans contained more personalised detail. However, the records remained inadequate to ensure that people received appropriate and safe care and this constituted a continued breach of this regulation.

The care plans included people's social history, likes, dislikes, social, cultural and religious preferences and staff were knowledgeable about the personal likes and dislikes of people we discussed with them. Plans were reviewed regularly, involving professional support and input where required. However there were gaps and inconsistencies in nine of the 12 care plans we looked at. This included care plans related to eating and drinking, continence care and support with behavioural concerns. There was also information missing from the documentation that would accompany a person if needed to go into hospital. For example details about how someone needed to be supported with continence were not included in one person's form. There was a risk that personal care and support would not be consistent due to the lack of detail held in some care records. This meant that people might not receive care in the best way to meet their individual needs. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff also shared information through records and at handovers. The daily records were computerised and staff acknowledged that their skills in this system were developing. However, care staff told us that they shared information verbally and this meant they knew people's current needs. This was verified by staff's ability to describe the care and support needs of people with complex health issues including the way they provided personal care and the health professional involvement people received. The care people received was, therefore, responsive. We spoke with people and their relatives about the care they received. We heard that the staff were responsive to people's needs. One person said, "They know what you need without too much probing." Two relatives told us they were involved in agreeing their respective relative's care plans and two others told us they felt involved and consulted on how their relative's needs were met. One relative said, "They always let me know what is happening and ask what I think."

People had access to activities they enjoyed. Relatives commented that this had improved substantially in recent months. One relative told us, "Every day there is something good going on." A member of staff who organised activities described how they focused on both individual and group activities, increasingly trying to meet the needs of the people who were harder to engage in activity. We saw people enjoying a music session and doing table top activities. Entertainment was also brought into the home and on the last day of our inspection a singer performed to a lounge packed with people from both parts of the home.

People were supported to maintain relationships with those that mattered to them. Relatives were welcome in the home and those we spoke with told us that this was always the case. People used online video chatting to communicate with friends and relatives who could not visit. One room in the residential home was being converted into a computer room to support the use of technology to help more people stay connected.

Within the SRC a senior member of staff had begun to make environmental changes that responded to people's dementia care needs. Lighting had been changed reflecting research around the impact of daylight on people with dementia. This research suggested that daylight lighting would help reduce the pacing agitated behaviours that are common in people with dementia as daylight begins to fade. An area had also been created that people could come and sit in and listen to music. This area had been created at the end of a corridor that people had previously walked along to a doorway that they tried to get through. This walk to an exit had now been replaced by a new focus to this area providing people with a purpose when they arrived. We saw people relaxed in armchairs in this area.

We spoke with a specialist nurse who worked within the SRC. They told us it was their role to oversee care needs in this part of the home. They told us that the staff had become more responsive to people's changing needs and they believed more proactive action was being taken by the staff team as people's needs changed. They described that the home were specifically more proactive in response to

Requires Improvement

Is the service responsive?

the appropriate management of behaviours that challenged the service. They identified that this meant that their role as specialist nurse had become more monitoring rather than drawing up care plans.

Suggestions and comments made during residents meetings were acted on. One person told us, “They are always willing to listen.” Suggestions for the whole home that had been acted upon included comments about the garden that had led to a weekend gardening session to get bulbs planted. Staff had come in to help with this when they were not working.

Relative’s told us they felt listened to and that complaints led to improvements being made. One relative told us: “I am confident they take me seriously.” People also told us that they were confident that their concerns were acted upon. One person told us, “They’re always willing to listen.” Another person said, “If we’ve got problems, we go to the staff and they sort it out for us.”

Breakdowns in communication were identified by three relatives as an occasional difficulty but these were described within a context of being able to address this with the registered manager or senior staff who had responded appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, on the 16 and 23 June 2014, we found continued breaches following our inspection on 22 January 2014. These continued breaches related to the people not receiving appropriate safe care, not being protected from abuse, records being inadequate to ensure safe and appropriate care and that there were not enough staff to meet people's needs. At our inspection in June 2014 we also found that the provider did not have an effective system in place to monitor quality. There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we asked the provider to take action. At this inspection found that whilst improvements had been made to the quality assurance systems in the home they had not found the concerns identified by this inspection. This meant there was a continued breach of this regulation.

The service was being led through a period of improvement. People, relatives, staff and health and social care professionals all told us they had confidence in the leadership skills of the manager and senior staff team to achieve the change necessary. However, we found that the service did not reflect the characteristics of a well led service despite the improvements that had been made. The registered manager had a comprehensive action plan following the last inspection and it was evident they were working their way through this. An example was the way people were supported at meal times. We saw that staff had received guidance around good practice, information about positive support was available to them during meals and there had been spot checks undertaken to discuss individual practice. The result had been an improvement in the meal time experiences of people living in the home.

We found serious concerns about the standards of cleaning and infection control in the SRC and this was not being monitored formally by the registered manager. We found omissions and inaccuracies in nine out of 12 care plans we looked at and daily recording was not adequate to effectively monitor people's well-being. This had not been identified by the audit process that the manager used to assess the quality of care records. The registered manager was monitoring incidents and accidents that happened in the home. However, there was no emphasis on staff support and training needs as a part of this and as a result a gap in staff confidence and skills in responding to aggression had not fully identified or adequately addressed. Checks on medicines had not identified the concerns found during our inspection. The governance and audit systems were not effective in ensuring people received high quality care. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The people, relatives and staff we spoke with were positive about the registered manager and senior staff. One relative told us, "I have absolute respect for all of them." Another said, "They have a nice manner and they will come through and keep it running well." This was echoed by people who told us the registered manager and senior staff were easy to speak with. Staff told us, "Everyone is comfortable around the manager." The registered manager was often visible out and about and we observed they had a kind and friendly manner when interacting with people. Staff, relatives and people were confident in the abilities of the registered manager and the senior staff to ensure that care quality was improved and maintained. One staff member told us, "They are very good at what they do."

The theme that ran through the comments of the staff and relatives was that the senior staff and registered manager were approachable and that improvements had been made. For example they all described increased staffing, more activities and an increased sense that they were informed and involved. One member of staff told us, "Recently it has got a lot better." The majority of staff felt listened to, one member of staff said, "They take it on board." when describing how staff are encouraged to make suggestions at staff meetings. Staff also made points about not always hearing back the outcome to suggestions they had made and that it was not easy to know if they could talk with the manager and senior staff if the office door was shut. Senior staff explained that it was a large home and they did need to close the door to ensure confidential work was completed.

People and their families felt their views were listened to about events in the home and we saw evidence that they were kept informed about these, including the outcome of inspections .Staff meetings and meetings with relatives and residents were documented and showed that everyone was afforded the opportunity to raise concerns and offer suggestions. This meant that the challenges facing the home were understood and people staff and relatives.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment There were not always suitable arrangements in place for determining mental capacity, obtaining consent or establishing a person's best interests in line with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People were not protected from the risk of exposure to healthcare associated infection because the home was not clean and there was not an appropriate system designed to assess the risk of, prevent, detect or control the spread of healthcare associated infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected from the risks associated with unsafe use and management of medicines.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them because records did not contain appropriate information.

The enforcement action we took:
We served a warning notice and told the provider to take action by 4 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not protected because there was not an effective system in place to monitor service quality and identify and manage risk.

The enforcement action we took:
We served a warning notice and told the provider to take action by 4 March 2015.