Review of compliance

Grace Manor Care Limited Grace Manor Care Centre	
Region:	South East
Location address:	348 Grange Road Gillingham Kent ME7 2UD
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	Grace Manor Care Centre is a care home providing accommodation, personal and nursing care for up to 60 people. The home is a listed building which has been extended. The home has been divided into three units, of which one is a separate and supports people with dementia.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Grace Manor Care Centre was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 10 - Safety and suitability of premises
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 17 - Complaints

How we carried out this review

We reviewed all the information we hold about this provider, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Some people told us that they liked living at Grace Manor. They said that it had taken them a while to settle in, but that they were now happy living at the home. A relative told us that they had no problems with the home.

People told us that visitors were always welcome.

People told us that they were not aware that they had a plan of care and said that they had not been involved in writing one.

People told us that there were not enough care staff available during the day to support their needs. They said a lack of staffing resulted in: not being able to have a bath when

they wanted one; staff being in a rush and not being able to spend time talking to them; and having to wait a long time for staff to be available to take them to the toilet.

People told us that some staff were not gentle with them when they supported them in their care.

People told us that the activities which were provided were good but there weren't enough of them.

Some people told us that they had a choice of food and drinks whilst other people said that there was not a good choice.

People who had made complaints to the home were not all satisfied with the way that the home had responded.

People told us that their rooms were kept clean, but that they could do with more cleaners so that their rooms were cleaned thoroughly each day.

People told us that they did not like using the communal areas as they were busy and noisy. They said that there were no chairs for visitors.

Some of the people in the home were not able to tell us their views as they had dementia or limited verbal communication. We used a formal way to observe these people. This is called the 'Short Observational Framework for Inspection' (SOFI). This involved observing up to five people for up to an hour. We did this in two areas of the home and recorded their experiences at regular intervals. This included their state of well being, how they interacted with care staff and how they occupied themselves. The findings of our observations are included in this report.

What we found about the standards we reviewed and how well Grace Manor Care Centre was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who lived in the home did not always have their privacy, dignity and independence respected due to the inconsistent practices of the care staff team.
Overall, we found that improvements were needed for this essential standard.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Most people who lived in the home had not given formal consent to their care and treatment as they had not signed their plan of care. Some people who lived in the home were not asked for their consent when care staff supported them in their daily care and treatment.
Overall, we found that improvements were needed for this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People were withdrawn and bored. Individuals were not receiving the level of care and support they required. Even when a care need had been identified and recorded, care staff did not deliver the care and support the people needed..
Overall, we found that improvements were needed for this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

People were potentially at risk of poor nutrition because there were an inconsistent approach in supporting people to receive adequate drinks and food. Some people did not receive a range of food choices. People were not supported in a dignified way when they required care staff to support them to eat. Mealtimes were not respected and people's dinning experience was frequently disrupted.
Overall, we found that improvements were needed for this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People were not always protected from abuse, as not all staff had received training. There were not effective strategies in place for managing people's challenging behaviours or people's valuables and possessions. .
Overall, we found that improvements were needed for this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People who lived in the home were not fully protected by the infection control practices of the home.
Overall, we found that improvements were needed for this essential standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Not all people who lived in the home had their medication given to them when they needed them. Arrangements were not in place to monitor and assess medicines which came into the home.
Overall, we found that improvements were needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The design and layout of the premises did not meet the needs of the all the people who lived in the home. There were not adequate arrangements in place to make sure that the home remained safe and well maintained.
Overall, we found that improvements were needed for this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People who lived in the home were not protected by the home's recruitment and selection

practices.
Overall, we found that improvements were needed for this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People were not supported by sufficient numbers of staff to meet all their health and welfare needs.
Overall, we found that improvements were needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People's health and welfare needs were not always met due to staff not being supported to acquire the specialist skills and knowledge that they needed to perform their roles.
Overall, we found that improvements were needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People did not benefit from their views being taken into account or acted upon. There were not effective systems in place to identify, monitor and improve the quality of the service.
Overall, we found that improvements were needed for this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

Not all people who lived in the home were confident that their comments were listened to and acted upon. Systems were in place to deal with complaints, but it could not be demonstrated that they were always resolved to the satisfaction of the complainant.
Overall, we found that improvements were needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Some people told us that they liked living at Grace Manor. They said that they were able to get up and go to bed when they wanted.

People explained that staff helped them to wash in their own bathrooms to maintain their privacy.

People told us that they were not aware that they had a plan of care and said that they had not been involved in writing one.

Other evidence
We observed that whilst some care staff respected the dignity and privacy of people who lived in the home and gave them choices, other care staff did not.

We saw that some care staff respected and involved people, who lived in the home in that they: knocked on people's bedroom doors and waited for a reply before entering; closed the door when they attended to people's personal care; addressed people who lived in the home by their own name; spoke gently to people and explained what they were going to do before they performed a task with them; and shared a joke with people who lived in the home in a fun and appropriate way.

We also saw that some care staff did not respect and involve the people who lived in the home in that they: put a sling around one person to use the hoist, without first having asked them if they wanted to move or explained to them what they were going to do; put disposable aprons on some people who lived in the home, without asking them if they wanted to wear them, or explaining what they were going to do; put on a person's jumper and knocked their glasses so that they had to be readjusted, without having explained what they were going to do or having made an apology for this accident; addressed some people generally as 'darling' and 'sweetheart' rather than by their individual names; ignored one person who verbally asked for some music to be put on; ignored two people who could not verbally communicate, but who looked distressed from their facial expressions.

When the home surveyed people who used the service, some people responded that staff shouted at them and that they were rude. There was no evidence that the home had taken any action to address these concerns.

In one person's plan of care it was written, "to respect him (the person who lived in the home) and his choice in spite of his condition". This showed that the care staff who wrote this plan of care had little understanding of how to respect a person as they focused on this person's disability, rather than their individual needs. .

Our judgement
People who lived in the home did not always have their privacy, dignity and independence respected due to the inconsistent practices of the care staff team. Overall, we found that improvements were needed for this essential standard.

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
We did not obtain any information from the people who lived in the home about this outcome.

Other evidence
Most people who lived in the home had not been involved in writing their plans of care which contained information about their individual needs and choices. Care staff told us that they needed to get people to sign their new care plans. We saw a list on the wall in one of the units, detailing that only three out of ten people had signed their plan of care to confirm that they agreed with it.

Consent had not been sought from the people or their relative or advocate when they had been assessed as needing bed rails for their own safety. Nor had consent been sought when taking photos of any wounds that people may have developed in order to track the care that they received.

As mentioned in Outcome 1, people's consent was not always sought when staff attended to people's care needs.

We found that some plans of care had been developed using the principles of the Mental Capacity Act. In this plans it had not been assumed that because a person had

a disability, that they could not make any decisions These plans of care identified the day to day decisions that people could make, such as what to eat and what to wear. However, other plans of care did not contain this important information.

We saw that a deprivation of liberty check had been carried out for one person who it was assessed did not have the capacity to agree to be moved to Grace Manor.

Our judgement
Most people who lived in the home had not given formal consent to their care and treatment as they had not signed their plan of care. Some people who lived in the home were not asked for their consent when care staff supported them in their daily care and treatment.
Overall, we found that improvements were needed for this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One person told us, "It took me about six weeks to settle in here, but it's ok now. I feel settled and secure." Another person told us, "It's ok in here. I am happy staying in my room".

People told us that visitors were always welcome.

People told us that they were only able to have a bath once a week. One person thought that this was, "disgusting". They said that when they had asked to have a bath more often, care staff had responded that they did not have the time as other people needed baths too.

People told us that they had to wait a long time to go to the toilet.

One person told us, "The staff are mostly friendly and kind, but some are quite rough with me; I am not happy about it". Another person told us, "The girls are mostly very kind, but some of them pull me about".

When one person was using the hoist, staff asked if they were all right and the person replied, "I'm trusting you love", showing that they felt safe in their care.

One person told us that there was, "no quality of care". They explained that they asked for a specific member of care staff to attend to their relative as they felt that other staff on duty would not be able to help appropriately.

People told us that the activities which were provided were good but there were not'not enough of them. People told us that they enjoyed singing, visits from PAT dogs, bingo, quizzes, and arts and crafts and visits to the local shopping centre and garden centre.

One person said they wanted to go to the entertainment, but did not like it that they had to sit in their wheelchair for the whole time.

One person told us, "What is there to do all day? There's nothing".

Other evidence
We spent time in different parts of the home and looked at how people were being cared for.

Some people who lived in the home called out for care staff to assist them, as they were not able to use a call bell. We asked care staff what support one of these people required. They replied that the person was having a, 'bad day'. However, this person was left for long periods calling out without any one going to their assistance.

We looked at the plan of care for another person who spent long periods of time calling for assistance. The plan stated that when this person called out, care staff should allow the person to express themselves. We observed that in practice this did not always happen. In the morning we heard this person calling and found them on the floor. We had to look for the care staff on duty and ask them to come to this person's assistance, as this person was not able to get up by themselves. Care staff said that they could not always attend to this person's needs as they had other people who needed support. They said that this was upsetting to them.

Later on, we saw that care staff sat with this person and gave them one to one attention. As a result, this person chatted and appeared calm and at ease.

We looked at some other people's plans of care to see if people were receiving the care and support that they were assessed as needing. These plans contained nursing assessments and guidance for staff on how to support people with their personal and healthcare needs, including personal hygiene, continence, nutrition, mobility, eating and drinking, tissue viability and daily activities. We saw that generally these records were reviewed on a monthly basis. However, there were exceptions to this, which are detailed below.

There was inconsistency in the completion of daily notes. Some had specific information about the person's mood, and what they had done but others were vague, with comments like, "no problems," and "checked regularly". Therefore, it could not be certain if these people's needs had been met.

We found that in general that wound assessments undertaken by the registered nurses provided clear instructions for the nurses to follow. Monthly evaluations had been made of any changes to the wound, together with photographs to evidence any changes. We found one exception to this practice where the actions to be taken by nurses was not clear and there had not been a recent evaluation of the care and treatment being given.

Some risks identified in the care planning process, had been identified, together with

the action that staff or others needed to take to minimise the risks. For example, for people who were at risk of pressure sores, due to spending long periods of time in one position, it was stated in their plan of care that they needed to be moved on a regular basis. Some plans gave a specified timescale, such as every two hours, so this could be put into practice. However, in one plan of care it stated that the person needed to be moved, 'regularly. It was therefore not clear how often it had been assessed that this person needed to be moved to minimise the risk of them developing poor pressure areas.

For people whom it had been assessed as needing to be moved every two hours, we could not find any evidence that this was being done. We looked at the daily records of one person and found that 'regular turns' had been recorded. Staff said that positional charts which recorded when the person was moved should be used, but no evidence was found or produced to support this.

Records confirmed that nurses made regular observations of people's temperature, pulse and blood pressure. However, we found that for one person these checks had not been carried out monthly since April 2011. There was no reason recorded why these regular health checks had stopped being carried out.

For people who were at risk of constipation, their daily bowel movements had been recorded. However, some records had many gaps in them of up to five days. It was not clear from looking in these people's daily notes, whether these records had not been completed over a number of days, or whether the person had a problem that had not been addressed.

A record was kept of the personal care that each person received on a daily basis. However, these records had not been completed to ensure that each person had the personal care that they had been assessed as needing. For example, for one person it had been recorded that over a sixteen day period they had had one bath, and twelve body washes. No personal care had been recorded for a three day period. Therefore, it was not clear if this person had received any personal care during this time. For one person, whose care plan instructed that they needed a hair wash twice a week, the bathing records showed that over a sixteen day period they had only had their hair washed three times.

There were a number of people that lived in the home who had limited verbal communication. For one person, their plan of care had assessed that alternative ways of communicating were needed. It advised that a communication book be used so that they could make their needs known. We did not see staff use this communication book on the day that we visited the home.

Plans of care showed that people had been referred to other healthcare services such as the optician, specialist diabetic service, out-patients clinics at the hospital, the tissue viability nurse for wound care, speech and language therapist and physiotherapy. Reports in plans of care also showed there were regular visits from the GP.

The home's brochure stated that there was a, 'Full lifestyle programme based on individual and person-centered care'. It stated that there were, "Full-time lifestyle coordinators" and that, "tactile ornaments" and "rummage baskets" were available. It concluded that, "Clients are spoilt for choice with the range of activities on offer". We

did not find evidence to support these statements on the day of our visit to the home.

There was one activities coordinator who was available for four hours each day, from 11am to 3pm. They were responsible for providing activities for all 60 people who lived in the home. This person was also responsible for supporting people with their lunch and going to the toilet. We saw that by the time people had had their lunch and had gone to the toilet, there was only about one hour of meaningful group activity each day. It also meant that they did not have sufficient time to spend one to one time with a large number of people who preferred to stay in their own rooms.

The activity records that we looked at showed that people received very minimal stimulation. Most entries for people stated that they watched television. Staff told us that in reality people in some parts of the home did not watch TV although this was recorded in their daily notes. At other times the records had been left blank. We saw that in one record staff had been recording 'sleep' as a person's main activity.

We observed that people who sat in the lounges started to close their eyes when there was no activity going on around them. We concluded this because, when a person came into the room and started talking, these people opened their eyes to see what was going on. They had actually been dozing and were not asleep.

We observed that in a forty five minute period some people's body language showed that they were withdrawn and they had no stimulation or contact with staff for this whole period of time.

Our judgement
People were withdrawn and bored. Individuals were not receiving the level of care and support they required. Even when a care need had been identified and recorded, care staff did not deliver the care and support the people needed..
Overall, we found that improvements were needed for this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People told us that they had a choice of food and drinks. One person told us, "The food is good. There is always a choice, and the chef will do different things if I don't want what is on the menu".

One person told us that whether they got a good choice of food depended on what member of staff was working in the kitchen. This was because one member of staff rotated the same choices each week.

Other evidence
Nutritional assessments had been completed to identify people who were at risk of poor food and fluid intake. The records that we looked at showed how much a person ate and how much fluid they drank each day. However, one person asked a member of care staff why their relative had not received enough fluids, according to their fluid chart. A member of the care staff replied that this person had received the right amount of fluids, but that their records had not been completed correctly. This person was not satisfied with response that they were given. Also, on all the fluid and food charts, the amounts recorded had not been added up and evaluated. Therefore, it could not be certain that people had received sufficient fluids and food that they needed each day to keep them in good health.

People were weighed on a regular basis to monitor their weight. One person's plan of care showed that they had lost a significant amount of weight earlier in the year. Monthly reviews of this person's plan of care showed that care staff had taken action to contact the dietician and to give food supplements. However, as mentioned above, we

found no evidence that information about people's food intake was assessed on a daily basis and used to take immediate steps to increase their food intake until the time of their monthly review.

We saw that one person who had diabetes had been referred to the specialist diabetic service. Their blood glucose levels were being monitored three times per day to make sure that they remained at the correct level.

We saw that some care staff stood over people, to give them drinks or to help them to eat, rather than sitting down next to them. This was not dignified for the person concerned and was an

The kitchen was located in Haven unit. During meal times we saw that there was a constant stream of staff coming in and out of the dining room to get meals for the other people who lived in the home. This meant that people had their mealtimes disrupted.

We saw that when two people were given their meal, there was a delay in them being given their cutlery, which meant that their dinner was getting cold.

There were not enough dining chairs and tables to accommodate all the people who lived in the home. This meant that some people had to eat in their own rooms or in the lounge. Some people preferred to eat in their own room, but this provision did not offer people a choice of where they could eat.

Our judgement
People were potentially at risk of poor nutrition because there were an inconsistent approach in supporting people to receive adequate drinks and food. Some people did not receive a range of food choices. People were not supported in a dignified way when they required care staff to support them to eat. Mealtimes were not respected and people's dinning experience was frequently disrupted.
Overall, we found that improvements were needed for this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
One person told us that they did not feel safe and wanted more security in the home.

Other evidence
We spoke to staff about their understanding of safeguarding and protecting people who lived in the home. They said that they would report any concerns to the nurse on duty or the home manager. They were not fully aware of the home's whistle blowing procedures, but knew to contact another appropriate agency if the home did not take any action to address their concerns.

We looked at training information and found that not all staff had been given training in the prevention of abuse for vulnerable adults or in how to diffuse challenging situations.

As detailed in outcome 4, we saw that when people had been identified as displaying challenging behaviours, such as calling out, there was no comprehensive behaviour management plan to provide staff with information on how to manager these behaviours and keep them and other people safe.

There were not comprehensive risk assessments in place for people who had voiced concerns about the safety of their possessions and valuables. One such plan of care stated that, 'money should not be kept in their room', and that,'the person should be more observant about who goes in and out of their room'.

The home had not always reported significant events to us that affected people's health and welfare to us. This included allegations of abuse and incidents which have necessitated the involvement of the police. During the visit the home manager demonstrated that he was aware of his duties and responsibilities.

Our judgement
People were not always protected from abuse, as not all staff had received training. There were not effective strategies in place for managing people's challenging behaviours or people's valuables and possessions. .
Overall, we found that improvements were needed for this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People told us that their rooms were kept clean, but that, "there are not always enough cleaners to do a proper job each day".

Other evidence
The home manager said that he was aware of the 'Code of Practice on the prevention and control of infections', which detailed good practice in this area. The home had appointed a lead nurse who was responsible for infection control in the home. However, we found that no audits had been undertaken to ensure that this code of good practice was being put into action. This shortfall is addressed under outcome 16.

We saw that disposable gloves, hand wash and paper towels were available in bathrooms. Some bathrooms had items of equipment such as walking frames, hoists and slings stored in them, which meant that they could pose an infection control hazard.

There was a smell of urine in some areas of the home. There was a very strong smell of urine in the sluice room from an open bag of soiled continence pads, which had not been stored correctly.

We saw that care staff were habitually leaving food on the upstairs windowsills for long periods of time. This posed the risk of a person who lived in the home eating the food, as it had been left standing all day and so was potentially not fit to eat.

The cleaning staff said that they, "Did the best they could in the time that they had". One cleaner did not know how the programme of cleaning worked for each room to ensure that each room had a thorough clean each week.

Our judgement
People who lived in the home were not fully protected by the infection control practices of the home.
Overall, we found that improvements were needed for this essential standard.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not obtain any information from the people who used the service about this outcome.

Other evidence
The home used a monitored dosage system for most medication. We looked at the records for administering medicines and found that most of them had been accurately signed and completed. However, we found a few gaps in these records so it was not clear whether on these occasions people had received their medication as prescribed by their GP.

One person's medicine had been allowed to go out of stock for four days, so that this person did not receive their prescribed medicine for this time period. This is of particular concern as at a pharmacy inspection in July this year the same issue was raised, but the home had still not taken action to address it.

There was no evidence of any audits being done to check the amounts of "as necessary" (PRN) medication being used and held by the home.

National guidance about medication that was available for nurses, was dated 2009 which did not reflect current good practice.

Plans of care showed that GP's had been contacted when nursing staff had a query

about medicines that people were receiving.

We looked at stock cupboards which showed that medication was rotated and not overstocked. We saw that clinical rooms were quite cluttered.

Our judgement
Not all people who lived in the home had their medication given to them when they needed them. Arrangements were not in place to monitor and assess medicines which came into the home.
Overall, we found that improvements were needed for this essential standard.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
People told us that they did not like using the communal areas as they were busy and noisy.

People told us that there were no chairs for visitors.

Other evidence
The home was divided into three areas. There was a separate unit for people with dementia, called 'Haven' and two general nursing areas with accommodation upstairs and downstairs, called 'Abbey' and 'Randall'.

People who lived in Haven had their own lounge and dining room. However, people who lived in the other two parts of the home only had one lounge and dining room to share between approximately 45 people. There were not enough chairs in this lounge or dining room to accommodate all the people who lived in the home. Some people chose to use the lounge and dining room in Haven. But this area of the home was specifically for people with dementia and people who did not have dementia had few people whom they could talk to.

The kitchen was located in the Haven unit. Therefore, staff were constantly coming in and out of the unit to get food and refreshments for people who lived in other parts of the home. Staff said that some people who lived in the home enjoyed the constant staff interaction that this offered. But other people preferred fewer disturbances and it meant that people's meals were interrupted.

We walked around the main areas of the home. We saw that new flooring had been laid in some areas. However, there were other areas in the home, including people's bedrooms, where the flooring was worn out and had not been replaced. We saw that flooring was not flat, but rumpled and that it could present a tripping hazard. Some carpets were dirty and stained in corridors and people's rooms. We saw that paintwork in many corridors and on skirting boards and doors was scuffed.

The window frames of some rooms were flaking on the outside. It was not possible to tell if these window frames required more paint to protect them, or whether there was a more serious problem due to the wood rotting.

We saw that the garden displayed beautiful flowers and had a number of different areas where people could sit.

We saw two other things that presented a hazard to people who lived in the home. The first was in an upstairs bathroom where we saw two urine bottles filled with bright green chemicals. Anyone who lived in the home, who had dementia, could have picked these up and drank the contents. Secondly, a vacuum cleaner had been left in one of the corridors, which presented a health and safety hazard.

We did not see colour coding for different areas of the home to help people with dementia to navigate themselves around the home.

The home's action plan stated that an additional dining room should be available on the first floor, but did not give a timescale for completion. The plan did not address any of the other issues detailed above.

Our judgement
The design and layout of the premises did not meet the needs of the all the people who lived in the home. There were not adequate arrangements in place to make sure that the home remained safe and well maintained.
Overall, we found that improvements were needed for this essential standard.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are moderate concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not obtain any information from the people who used the service about this outcome.

Other evidence
The home's brochure stated that, "Staff are carefully screened with extensive referencing and police criminal records checks". We looked through four staff records and did not find this to be an accurate reflection of the practice in the home.

Police criminal record checks had been carried out on all staff that we checked. However, only one out of the four files we looked at contained two appropriate references in line with the home's policy for staff recruitment and legislation. One file contained two references from the same employer. The second file contained a file note that only one reference had been obtained, but no action had been taken to address this, although the person had been employed at the home since February this year. The third file contained two references from 2002 and 2008, but no reference from their last employment which was working with vulnerable adults. Regulation 21 schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) states that where a person has been employed with vulnerable adults and that employment has ended, satisfactory verification should be obtained as to the reason why.

Our judgement
People who lived in the home were not protected by the home's recruitment and selection practices.

Overall, we found that improvements were needed for this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person told us, "The carers come in day and night, and are there when I call for them."

People told us that there were not enough staff to attend to their needs. These comments included:
"Things have gone downhill over the past few months because there has not been enough staff….the girls have been really struggling for some months".

"There are a lot of agency staff here because staff are so stretched"….they (agency staff) do not always know what they are doing".

"If I could wave a magic wand I would ask for more staff as the girls here are struggling".

"When I ring the bell to go to the toilet there is not always enough staff to come and get me quick enough".

"Staff are trying their best but that they are often rushed and they do not have a lot of time to chat with me".

The staff are quite friendly, but seem to be in a hurry.
People said that they had spoken to the manager about needing more staff but that nothing had been done.

Other evidence
We saw that staff were busy in all parts of the home throughout the day. In outcome 4 we evidenced that there were not enough staff in the home to meet the needs of the people who lived there. People who called out for help did not get the support that they needed. Staff said that they wanted to help people, but had to ignore them as they had other people to support at the same time. Staff were rushed and did not take the time to sit down and support people to eat. People's records of health and welfare were not all up to date to evidence that their assessed needs were met. People had very little stimulation or one to one staff contact. Staff ignored some people's calls for attention as they were busy with other tasks.

Staff told us that 'staffing was a problem' and that they had told the manager about this and attempts had been made to get in floating agency the week that we visited.

The home manager told us that there were currently two nurse vacancies and a few care staff on long term sick. He said that they had recruited some bank staff and therefore did not anticipate any further long term use of agency staff.

The home's action plan stated that a review of staffing levels in the home had been carried out prior to our visit. This resulted in one additional care staff being allocated to one of the units in the home. This assessment stated that additional staff, "is not required from a care point of view and is not supported by current funding".. This did not reflect the care practices that we saw on the day that we visited, or the comments made by staff and people who lived in the home.

Our judgement
People were not supported by sufficient numbers of staff to meet all their health and welfare needs.
Overall, we found that improvements were needed for this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
One person said, "It depends on what staff you get as to whether you get good care here. ….There are really good staff here…. I would ask for these staff if I needed any help or had any concerns".

Other evidence
The home's brochure stated that, "We believe highly trained and well managed staff are the secret to providing quality and safe care….We are specialists in dementia care". We looked at staff training records and did not find this to an accurate reflection of the practice in the home.

We saw that most staff were up to date with training on how to move and handle people safely, understanding health and safety and how to minimise infections. As identified in outcome 7, not all staff had received training in the prevention of abuse.

The home had a specialist dementia unit and cared for many other people who had dementia. However only 12 out of 71 staff had received training in this area, as detailed on the home's staff training records.

We could not evidence from staff files that all new staff had received a comprehensive induction before they started to work at the home.

The home's action plan identified that there had not been systems in place in the home to identify when care staff required specific training for their roles. This plan stated that training needs were going to be reviewed on a monthly basis. However, a list of what

training was needed and the timescale in which it would be delivered to care staff had not been established.

We did not see any evidence to show that staff were supervised on a regular basis. Staff said that staff meetings did take place, but that there had not been one for the last five or six months.

Our judgement
People's health and welfare needs were not always met due to staff not being supported to acquire the specialist skills and knowledge that they needed to perform their roles.
Overall, we found that improvements were needed for this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not obtain any information from the people who used the service about this outcome.

Other evidence
We looked at the systems that the home had in place to monitor and ensure that it was providing a quality service. The home had a system in place to audit areas in the home such as the kitchen, care plans, medication, laundry, accidents, and infections and wound care. We saw that most of these audits had not been kept up to date. For example, wound care audits had not been completed weekly since June 2011. Infections audits had not been completed monthly since May 2011.

The home had carried out yearly satisfaction survey for people living in the home, and their relatives. The positive comments included:
"The staff are pleasant"; "The staff are very good". "The home is ok, not too bad"; "The home is alright"; "There are friendly staff, and light and pleasant surroundings"; and "I love the fish and chips".
The negative comments included:
"Some staff shout at me"; "At night times I feel neglected"; "I don't feel people are listening to me"; " Not a lot of people talk to me"; "Sometimes staff are rude", and "I have to wait a long time to go to the toilet".

The results of the survey had not been analysed and no action had been taken to address any shortfalls that had been identified.

The evidence included throughout this report demonstrates that the process used by the registered provider to monitor the quality of the service provide fails to identify areas for improvement. Also that little or no action is taken to respond appropriately.

Our judgement
People did not benefit from their views being taken into account or acted upon. There were not effective systems in place to identify, monitor and improve the quality of the service.
Overall, we found that improvements were needed for this essential standard.

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are moderate concerns with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
One relative told us that they had, "no problems with the home".

One person told us that they were not happy with the way that the home had dealt with a compliant that they had made.

Other evidence
Staff told us that they knew who to report any concerns made to them by a person who lived in the home or their relative. We did not see any information prominently displayed in the home that told people how they should make a complaint.

We saw that the home kept details of complaints, but this record did not contain details of all the complaints that people had told us about.

The home kept details of a number of verbal complaints as well as written complaints,. The action that needed to be taken to address the complaint had been recorded, but not whether this action had taken place. For example, where someone had complained that some of their clothes had gone missing, the action was to label their clothes and for their key worker to check their inventory from time to time. It was not clear whether their clothes had been labelled nor what the timescale was of how frequently these checks should take place.

Our judgement
Not all people who lived in the home were confident that their comments were listened

to and acted upon. Systems were in place to deal with complaints, but it could not be demonstrated that they were always resolved to the satisfaction of the complainant. Overall, we found that improvements were needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People who lived in the home did not always have their privacy, dignity and independence respected due to the inconsistent practices of the care staff team.	
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: Most people who lived in the home had not given formal consent to their care and treatment as they had not signed their plan of care. Some people who lived in the home were not asked for their consent when care staff supported them in their daily care and treatment.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People were withdrawn and bored. Individuals were not receiving the level of care and support they required. Even when a care need had been identified and recorded,	

	care staff did not deliver the care and support the people needed..	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were potentially at risk of poor nutrition because there were an inconsistent approach in supporting people to receive adequate drinks and food. Some people did not receive a range of food choices. People were not supported in a dignified way when they required care staff to support them to eat. Mealtimes were not respected and people's dinning experience was frequently disrupted.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People were not always protected from abuse, as not all staff had received training. There were not effective strategies in place for managing people's challenging behaviours or people's valuables and possessions. .	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: People who lived in the home were not fully protected by the infection control practices of the home.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines

	How the regulation is not being met: Not all people who lived in the home had their medication given to them when they needed them. Arrangements were not in place to monitor and assess medicines which came into the home.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The design and layout of the premises did not meet the needs of the all the people who lived in the home. There were not adequate arrangements in place to make sure that the home remained safe and well maintained.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: People who lived in the home were not protected by the home's recruitment and selection practices.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People were not supported by sufficient numbers of staff to meet all their health and welfare needs.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People's health and welfare needs were not always met due to staff not being supported	

	to acquire the specialist skills and knowledge that they needed to perform their roles.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People did not benefit from their views being taken into account or acted upon. There were not effective systems in place to identify, monitor and improve the quality of the service.	
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 17: Complaints
	How the regulation is not being met: Not all people who lived in the home were confident that their comments were listened to and acted upon. Systems were in place to deal with complaints, but it could not be demonstrated that they were always resolved to the satisfaction of the complainant.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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