Wellburn Care Homes Limited

Grimston Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 March 2016 and was unannounced.

Grimston Court is a care home, which is registered to provide personal care and support for up to 47 people, some of whom have dementia. At the time of our inspection the home had five vacancies. The home is spread across three floors, with spacious communal lounges and a dining room on the ground floor. The home is located in large grounds on the outskirts of York.

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home was being managed by the deputy manager, until a new registered manager is appointed.

During our inspection we found that whilst the registered provider completed assessments to identify risks to people, these were not always consistently reviewed, and there were some gaps in falls risk assessment paperwork. The provider was aware that there had been some gaps in reviewing risk assessments and care plans over the last six months and was taking action to address this. We made a recommendation about this in our report.

We saw two examples where bed rail assessments and equipment checks had not been regularly completed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for four members of staff and found that recruitment practices were not robust, because appropriate checks were not always consistently completed before staff started work. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people using the service, as well as staff and relatives, thought there were sufficient staff to meet people's needs. The registered provider had recruited a number of new staff recently and had been using some regular agency staff to ensure safe staffing levels were maintained.

We found there were systems in place to ensure people received their medication safely. There were also systems in place to help staff identify and respond to any signs of abuse, to protect people using the service from harm.

Staff received an induction and training in order to carry out their roles effectively. Most of the training was completed using training DVDs. We found that the majority of staff were up to date with all training

considered essential by the registered provider. We found that where specific training was required, such as catheter care, this was not always provided by specialists in in that area. The registered provider agreed to look at sourcing some specialist training in this area.

We found that the home sought consent to provide care in line with legislation and guidance. Care files contained an assessment of the person's mental capacity and people had signed to record their agreement to the care, where they had capacity to do so. Care files recorded where someone had a Lasting Power of Attorney (LPoA) or were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation.

We observed a mealtime at the home and spoke with people about the support provided to meet people's nutritional needs. People using the service were generally complimentary about the food. We observed that the food served looked hot and appetising and that people were offered a choice of food and drinks. The registered provider used an assessment tool to identify people who may be at risk of malnutrition and care plans were in place regarding people's nutritional needs.

People using the service told us that staff were very kind and caring. We observed positive and friendly interactions between staff and people using the service. Relatives of people using the service were also very complimentary about how caring and attentive the staff were, and told us that "The main thing for them [staff] is the people living there, and making them happy".

People using the service told us they were treated with dignity and respect, and staff were able describe to us how they promoted people's dignity and independence. The registered provider completed care plans, and these contained some person centred information and preferences. Staff were able to tell us about people's needs and preferences.

The home employed an activities coordinator and people had opportunity to participate in a range of activities. We observed people enjoying some of these activities on the day of our visit.

People using the service were aware of how they could raise a complaint if they had one, and said they would feel comfortable doing so. Relatives we spoke with also said they would feel comfortable raising any concerns with the management or care staff, and felt confident they would be listened to.

There were quality assurance systems in place to monitor the quality of service. Relatives we spoke with were unanimous in their praise of the service and felt their relatives were very well cared for.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always effectively managed, because not all equipment was regularly checked and some risk assessment documentation had not been completed.

Recruitment processes were not robust because appropriate checks were not consistently completed before staff started work.

There were systems in place to identify and respond to signs of abuse to keep people using the service safe.

There were sufficient numbers of staff to meet people's needs.

Systems were in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received an induction and training in order to carry out their roles, and could request any additional training or support if they needed it.

Consent to care was sought in line with legislation and guidance. Mental capacity assessments were recorded.

People were supported appropriately with their nutritional needs. They were also supported to maintain good health and access health care services.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and they had positive relationships with the staff who supported them.

People using the service were involved in decisions about their

care and felt that their views were acted on.

People we spoke with felt that care staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Peoples' needs were assessed and care plans were in place to enable staff to provide personalised care. The registered provider was taking action to ensure care plan documentation was being reviewed in a more timely manner.

People were provided with support to take part in social activities.

The service had a system in place to listen and learn from people's experiences and to respond to complaints and concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post, which is a condition of the provider's registration.

The deputy manager was accessible to staff and people who used the service, and provided staff with the support they needed to deliver the service.

The service had quality assurance systems in place and were able to measure and review the delivery of care.

Grimston Court

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 29 March 2016 and was unannounced. The inspection was carried out by two Adult Social Care Inspectors.

Prior to the inspection we had received some information of concern about the service, so we brought forward our scheduled inspection. Before the inspection we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback about the home from City of York Council's contracts and commissioning team, and they did not have any concerns about Grimston Court at the time of our visit.

As part of this inspection we spoke with four people who used the service, three care staff, an activities coordinator, the deputy manager, a visiting healthcare professional and three relatives of people using the service. We looked at four people's care records, four care worker recruitment, induction and training files and a selection of records used to monitor the quality of the service. We also carried out a tour of the premises and observed throughout the day how people were being supported within the home.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included "I feel safe here", "I never feel unsafe and I am regularly checked during the night" and "The whole environment feels safe". A relative we with spoke with told us "I definitely think my relative is safe; I have no concerns about that". Another told us "I can sit back in absolute comfort knowing that they are well looked after".

The registered provider completed assessments to identify potential risks to people using the service and care staff. We reviewed the care files of four people living at the home and saw that there was a range of risk assessments in place, such as risk assessments for manual handling, falls, pressure care and nutrition. The registered provider used the Malnutrition Universal Screening Tool (MUST), which is a tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes guidelines which can be used to develop a care plan. The risk assessments we saw were up to date at the time of our inspection, although we did note that there had been gaps over the previous six months where the risk assessments had not always been reviewed monthly as per the registered provider's policy. This included gaps in reviewing falls risk assessments. One MUST assessment had also been incorrectly calculated. The deputy manager told us that they were aware that there had been some gaps in the monthly reviews and that they already had an action plan in place to address this. We saw a copy of this action plan.

The registered provider had a system for recording and responding to accidents and incidents, in order to keep staff and people using the service safe. We saw records of accidents and incidents that had occurred since the start of the year. Most of these incidents were relatively minor with no injuries sustained, but there had been three incidents where significant injuries were sustained. We reviewed the care files of three people who had sustained injuries, and found that there were risk assessments in place for these people in relation to falls. People did not have specific falls care plans, but information about their mobility needs and falls risk was reflected in their moving and handling care plans. Moving and handling risk assessments and care plans were in place for all these individuals. We saw two examples where the person's falls risk assessment had not been reviewed promptly after a fall. It is good practice, and was the registered provider's policy, to review a person's falls risk assessment and care plan after a significant incident or fall, so that it was always up to date and reflective of the person's current risk level and needs.

The registered provider had issued a new policy on prevention and management of falls in February 2016. This stated that for anyone scoring medium or high risk on the falls risk assessment, there should be an additional programme document completed in order to generate a care plan. Three of the care files we looked at indicated the person was at medium risk but the registered provider had not completed the additional documentation required to generate the care plan.

We recommend the provider acts promptly to ensure all risks are regularly assessed and managed in line with best practice.

The registered provider conducted an analysis of accidents and incidents every month. This was used to monitor any patterns in relation to accidents and falls, in order to reduce the risk of reoccurrence. The

analysis also recorded what action had been taken in the event of accidents or falls.

Prior to the inspection we had received a concern about moving and handling practices at the home. We observed safe moving and handling practices throughout the day and saw that people were supported to mobilise independently around the home. Staff were able to describe to us how they supported people using hoisting equipment and they told us that no one was allowed to use hoisting equipment unless they had been trained. A relative told us that they visited the home regularly and had never observed any concerns regarding how the staff supported people to mobilise around the home. They said staff were always gentle and encouraging. On the day of our inspection we did note two occasions when a person's walking frame was not located near to them when they needed it, so staff had to look for the frame before the person could mobilise.

We saw records of health and safety and environmental checks, including the gas safety certificate, electrical certificate, fire alarm tests, emergency lighting, fire blanket and fire extinguisher checks, six monthly fire safety checks, and hoisting equipment checks. The registered provider also had a contract in place for pest control checks. This showed that equipment and systems in place to protect people from the risk of harm were well-maintained.

Personal emergency evacuation plans (PEEPs) were in place for people who lived at the home. PEEPS are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use.

We looked at care files for two people who used bedrails. Bedrails can be used, when appropriate, to reduce the risk of people accidentally falling or rolling out of bed. There are, however, risks associated with the use of bed rails, such as entrapment of limbs and the risk of people climbing over the bedrail. Bedrails can also be used as an inappropriate form of restraint. It is therefore important that the use of bedrails is thoroughly risk assessed prior to use, and consideration given to whether they are the most appropriate method of ensuring someone's safety. Equipment must also be regularly checked.

In the first care file we reviewed the person had not signed the bedrail consent form, giving their consent to the use of the bedrail. We saw that a bedrail assessment form had been completed. The assessment asked various questions, such as; Has the resident fallen out of bed? Has the resident requested bed rails? Do you assess the bedrails would improve safety? All these questions were answered 'No'. The final two questions were both unanswered; Are bedrails indicated? Is there a safer alternative? It was therefore not clear why this person had been provided with bedrails. We saw that a bed rail maintenance assessment form and a bed rail risk assessment form, both stating they should be reviewed weekly, had only been completed on 8 December 2015 and 24 March 2016.

In the second care file we reviewed the person had not signed the consent form, giving their consent to the use of the bedrail. The questions were all completed and the form indicated that bedrails were required. However, the bed rail maintenance form and bed rail risk assessment form were both blank, indicating that the bed rails had not been routinely checked since the person had started using bed rails in November 2015.

This was a breach of Regulation 12(2)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for four members of staff. We saw that an application form had been completed that recorded the names of two referees and a declaration from the applicant that they did not have a criminal conviction. We saw that employment references had been obtained and that some people

had Disclosure and Barring Service (DBS) first checks in place before they commenced work. DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that some references were addressed as "To whom it may concern" which indicated they may have been provided by the applicant rather than requested by the home. However, we noted that telephone calls had been made to referees to check that the references received by the home were authentic.
Staff told us they had had not been able to work at the home until all of their safety checks were in place. However, we noted that one person had commenced work before their full DBS check had been received, and two people had started work before their DBS first and full DBS checks had been received. There were risk assessments in place that recorded, "Risk assessed: working before DBS has arrived. Risk: working unsupervised – abuse to residents and staff. Theft from staff and residents. Risk management: to be shadowed whilst working until full DBS has arrived and been received. All staff to support and supervise". Although it may be acceptable to allow staff to work under these conditions in an emergency, it appeared that this was standard practice at Grimston Court, as three of the four staff whose records we checked had been employed in this way. The arrangements to evidence that new employees did not work unsupervised needed to be more robust. Although we saw evidence on staff rotas that some of these new employees were working supernumerary, this was not the case for every new employee.

Interview questions and answers were retained with staff records for future reference, but we noted that documents to confirm the person's identity were not retained and there was no evidence that some new employees were given a job description. This would have ensured that staff were aware of what was expected of them.

This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New employees had signed a document to record that they had received a copy of the staff handbook.

Staff worked 12 hour shifts and standard staffing levels were two senior care workers and six care workers during the day (although this was sometimes reduced to five care workers) plus one care worker from 5.00 – 10.00 pm (known as the twilight shift). The deputy manager acknowledged that they sometimes had difficulty covering the twilight shift. There was one senior care worker and three care workers on duty during the night. The deputy manager told us that they were currently recruiting more staff and they would then have four care workers on duty during the night. They were also recruiting staff to cover the twilight shift.

We checked staff rotas and saw that there were occasionally five members of staff on duty instead of six. Staff told us that every effort was made to cover shifts but that this was difficult when staff telephoned at short notice. However, staff said that they worked as a team and people always received the care they needed. One member of staff told us, "If we are short staffed, staff pull together and residents are a priority". The deputy manager told us they were currently using one agency worker per day to help make sure the home was fully staffed. They used the same agency and requested the same agency workers to provide consistency for the people who lived at the home.

Ancillary staff were employed in addition to care workers; this included an activities coordinator, chefs, housekeepers, domestic assistants, kitchen assistants and laundry assistants. This meant that care staff could concentrate on providing personal care and support to the people who lived at the home.

Most people who lived at the home told us there were enough staff to support them with their day to day

needs, although they told us more staff would be beneficial. Comments included, "Sometimes could do with more staff", "Plenty of staff" and "Staff are usually quick at answering the buzzer but take a bit longer if they are short staffed". Relatives we spoke with told us "The home is well staffed; one of the best things about it. There are more than enough" and "In general they have enough staff. At times there seem to have been slightly less, but this is usually only when some staff have left and they are recruiting new ones. But generally it's fine and they have enough staff". Another told us "I think there are enough staff. There have been some changes recently, but there have always been a good mix of senior staff and more junior staff".

The registered provider had a medication policy in place and senior staff that had responsibility for administering medication had received training on medication management. We observed staff supporting people appropriately with their medication and recording on Medication Administration Record (MAR) charts that they had given people their medication. Medication was stored in a locked trolley and there was a treatment room for the home. The treatment room contained an appropriate controlled drugs cabinet. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs.

We looked at the MAR charts for three people who used the service, and found that these were appropriately completed. We checked the stock balance for a selection of medications. It was not possible to accurately check the stock balance for one medicine, because the amount of medicine received by the home had not been appropriately recorded on the MAR chart. The other stock balances we checked were correct. We also noted that the opening date had not been written on a bottle of eye drops that had a limited shelf life once opened. The deputy manager said they would issue a reminder to staff about this. Care files contained a medication care plan, with key information in relation to the person's medication needs.

The deputy manager completed medication audits monthly, including spot checks on medication stock levels. We also noted minutes of senior staff meetings, where issues in relation to medication were discussed.

This showed that there were systems in place to ensure people received their medication safely.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Safeguarding adults training was provided to all staff. Staff we spoke with could identify the types of abuse that could occur and were able to describe what action they would take if they had any concerns. Staff commented "I would know if something was wrong with someone – it comes from knowing someone. Staff are always alert and any poor practice would be recognised". Another told us "Staff are very good at reporting any concerns".

There was a safeguarding file to record details of safeguarding referrals and investigations. We saw this was empty and the deputy manager confirmed that this was because there had been no safeguarding referrals in the last year. We did see an example in one care file where the registered provider had sought advice from the local authority safeguarding team about whether they should make a safeguarding referral regarding a situation.

This showed there were systems in place to respond to safeguarding concerns and keep people safe.

Good

Is the service effective?

Our findings

People who lived at the home and visitors told us they felt that staff had the skills they needed to carry out their roles. People who lived at the home told us, "Staff are marvellous; they work their 'butts' off", "Most staff have the right kind of skills but some are very young and still learning. The middle aged ones are better" and "Staff have the right skills – absolutely". Relatives commented positively about the skills and experience of staff. They told us "They are attentive and on the ball" and "Their experience was invaluable in helping my relative settle when they first moved in to the home. My relative took a while to settle but staff came up with various suggestions to help, as they had lots of experience, and their ideas worked really well".

The deputy manager told us that they used a DVD system to train staff. Staff were allocated two training sessions per month; these were assessed by senior staff. An email was sent to the organisation's head office when staff had successfully completed each session, and they were then issued with a certificate. Staff had individual training files in place and their certificates were stored in the file.

We saw details of the training sessions in the yearly training plan; staff were expected to complete training on first aid and food hygiene in October 2015, health and safety and moving and handling in November 2015, infection control and medication in December 2015, dementia and Deprivation of Liberty Safeguards (DoLS) in January 2016, and safeguarding adults from abuse and equality and diversity in February 2016. The deputy manager told us that any non-achievement was highlighted on the matrix in purple ink (we saw this on the day of the inspection) and a notice was placed on the notice board listing the names of staff who needed to complete this training.

An updated training record was sent to us the day after our inspection. This identified the training that was considered to be essential by the home, and included nutrition and diet, person-centred care, end of life care, safeguarding adults from abuse, dementia awareness, health and safety, first aid and moving and handling. Medication was listed as essential training but the deputy manager confirmed that this was only for senior staff who had responsibility for the administration of medication. The training record showed that most staff had completed essential training, although some training was overdue. This was highlighted on the training record. The deputy manager explained that one person had recently returned from maternity leave and some staff recorded on the training record were new, so most staff had undertaken essential training.

A concern had been raised with us prior to the inspection regarding catheter care at the home. We looked at the care records for one person who had a catheter and found that an up to date continence and catheter care support plan was in place. We spoke to a visiting healthcare professional who was involved in providing support to individuals at the home with catheters. They did not have any concerns about the care staff were providing in this area. We noted that guidance for care staff regarding catheter care was provided by senior care staff at the home, rather than by formal specialist catheter care training. We talked to the deputy manager about this, who agreed that specialist training would be beneficial. We were aware that the home sought guidance the day after our inspection about accessing specialist catheter training.

The deputy manager told us that some staff had achieved a National Vocational Qualification (NVQ) and that some new members of staff had 'signed up' to undertake the Diploma in Health and Social Care. The deputy manager was undertaking an award at Level 5.

Staff who we spoke with confirmed that they had completed a thorough induction programme and that they were happy with on-going training that was provided for them. One felt that the training DVDs were appropriate for them as a more experienced worker, but that additional face to face training would be beneficial for new staff.

We checked induction training records in the care files for new employees. This was more like orientation to the home but included the topics of cleanliness, health and safety and care planning. Staff also told us that they shadowed experienced care workers as part of their induction training; this was before they worked unsupervised. The induction checklist recorded further training that had been identified for the person concerned; this usually consisted of in-house training, Skills for Care induction, Deprivation of Liberty Safeguards (DoLS) and further training. However, the deputy manager told us that new staff now completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. This showed us the service had an effective induction programme to support and develop new staff.

When new staff had stated on their application form that they had completed training at previous work places, they were required to provide copies of training certificates. If they could not provide certificates, they were considered to require this training.

The staff who we spoke with told us they were well supported by the supervision systems in the home. They said they had supervision with a manager and they were able to discuss their concerns at these meetings. We saw the supervision record for one new member of staff. This recorded, "[Name] is new to the role. They understand whistle blowing, abuse and health and safety e.g. preventing danger or potential risks. To continue with training DVD's and to carry on training in role".

We talked to the deputy manager about staff communication. They told us they previously used a 'pass the baton' system to handover information from shift to shift. They had recently changed this system; they used a form that recorded the name of each person who lived at the home and this incorporated a professional visit log. The form would record, for example, "[Name] saw support worker today". Staff would then record the details of this contact in the daily record. We noted that each person's daily record form included a summary of the key points of their care plan as a reminder for staff.

A daily handover report was also being used. This recorded the name of the staff member responsible for the handover meeting, the names of each member of staff on duty, and any tasks that needed to be carried out by staff. In addition to this, the form recorded any falls or accidents that had occurred and any appointments with health care professionals or at the hospital. The staff on shift were required to sign the handover report to evidence they had read it.

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

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

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There were eight people living at the home subject to a DoLS authorisation at the time of our inspection, and the home had submitted an application for a further two people. This showed that the registered provider was taking appropriate action to ensure that legal authorisation was sought for people to be deprived of their liberty where this was in their best interests.

Care files contained an assessment of the person's mental capacity. We also saw evidence that care plans were signed by the people using the service, to consent to the care plan, where they had the capacity to do so. Where people had a Lasting Power of Attorney (LPoA) this was clearly recorded in the person's care file, and staff were aware of this. An LPoA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances).

Staff demonstrated an understanding of the importance of gaining consent before providing care to someone. On the day of the inspection we saw that staff asked people if they needed assistance before supporting them. This showed us that staff sought consent to provide care in line with legislation and guidance.

We observed a mealtime at the home and spoke to care staff, relatives and people who used the service about the food at the home and support provided with nutritional needs. Staff had a good knowledge of people's individual dietary needs and food preferences. Staff told us, and we observed, that staff showed each person the two hot food options available for lunch. This technique of showing people the food options at the time food is available, which staff referred to as 'show and tell', is particularly useful for some people living with dementia, who may not be able to understand or retain the information about food options if the choices are presented too far in advance. Staff knew which people were able to retain the information and make a decision in advance, and staff told us that they asked these people their menu choices in advance.

The food served looked hot and appetising. We saw staff members encouraging people to eat and offering a choice of drinks. Some residents used coloured and adapted crockery, where this was appropriate for their needs. There was one main dining room in the home, used by the majority of people. In addition, there was a 'therapy table' in another room which we were told was used at mealtimes by a number of people who needed more one to one support with their meals and drinks. Additional support was provided for these people away from the distraction of the larger dining room. We saw one staff member providing assistance with eating to two people at once in this dining room, which was not best practice.

We observed staff offering people who used the service drinks and snacks between mealtimes. We also saw one person being given a smoothie drink, which was part of their care plan. People using the service told us "The food is lovely" and "Staff come early in the morning to explain the menu and ask for my choices. I get a choice at tea-time as well". The person explained that they took their meals in their own room, as this was their preference. They also felt that staff encouraged people to have lots to drink, including fruit juice. They said the food was "Good and well-balanced". Another person told us "The food is average, but I am a bit picky. There are two choices for each meal, and a pudding". A relative told us "The meals seem really nice. Myself and family have had a couple of meals when we've been there and they were really good". Another

told us "The food is great. Their lunches and dinners are first class".

Peoples' care files contained a care plan regarding nutrition, and we found that these care plans contained information about peoples' preferences. People's weight was also regularly monitored. We noted that people's monthly weight recordings were not always consistently transferred into their individual care file, in order to update their malnutrition universal screening tool (MUST). However, the deputy manager used a monthly audit tool to monitor any changes in weight of people using the service. This was also used to record any actions taken as a result of weight loss.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as the district nursing team, physiotherapists and GPs. A visiting healthcare professional that we spoke with commented positively about the service and told us the home acted on advice they gave them. A person using the service told us "I see the optician and the chiropodist". Another said "I've recently seen an optician; they come to Grimston Court" and "I can ask them to ring the GP and they would definitely do it for me. The GP comes regularly though; once a week". Relatives we spoke with commented positively about the support provided to maintain good health and access healthcare services. One told us "My relative has had a number of chest infections recently and I talked to the staff about getting her chest scanned. They sorted it out straightaway".

We looked around the premises during our inspection, including the communal areas, the hairdressing room, laundry, treatment room and some bedrooms. We found that the home was clean and free from malodours. It was spacious and generally well maintained. The deputy manager advised us that there was a programme of redecoration planned, but they did not have a planned start date for this work at the time of our inspection. They told us that they intended to consider dementia friendly environment principles and signage in future redecoration plans. This is important because it can help people with dementia to orientate themselves. The property had a conservatory which overlooked large gardens and the deputy manager also advised us that there was work planned to the gardens, so that they could be safely accessed by people without support from staff, where appropriate.

Good

Is the service caring?

Our findings

People using the service told us "The staff really care" and "They are very kind and thoughtful staff – all of them". Another told us "The staff are kind and treat us with respect". They continued, "You get to know them, so they are familiar". They did comment that some of the agency staff that the home were currently using did not know them as well. A further person said "The staff are real friends; they look after me well. They are very affectionate". This, and other comments made, showed us that people felt comfortable with staff and that staff had built positive caring relationships with the people who used the service.

The interactions we observed between staff and people who used the service were positive and friendly. We observed staff sitting and spending time chatting with people about pets and families. A relative told us "They [staff] are really caring. I have no concerns about any of them, but there are a few in particular who seem especially kind and caring". Another told us "Staff are very helpful, friendly, caring and smiley. I can't praise them enough. The two main words I would use to describe them are caring and committed".

People who used the service told us they had choice and control about their care and felt their views were acted on. One person said "Staff seek permission or wait until I ask for help". We observed staff offering people choices, such as what they wanted to eat and whether they wanted to join in activities. Staff responded to requests made by people. In people's six-monthly review meeting records, we saw that specific questions were asked about whether the person felt their choices, privacy, dignity, rights and independence were recognised. People had responded positively to these questions.

The deputy manager told us that many people had contact with relatives or friends. One person using the service told us that they had two friends who visited occasionally and were made to feel welcome by staff. All the relatives we spoke with visited regularly and said they were always made to feel very welcome. One told us "I can drop in at any time. We don't usually tell them in advance that we're going, apart from when we're taking our relative out, and it's never a problem". Relatives also felt that they were kept well informed if there were any changes or concerns about their relative in between their visits.

People using the service told us that their privacy and dignity was respected. When we spoke to staff they were able to explain how they respected people's privacy and dignity. They gave examples such as ensuring they closed the door of people's rooms when supporting them, ensuring they covered people when providing personal care and talking to people throughout, so people were aware what to expect. One person told us "Staff knock on the door before they come in; they couldn't be nicer". A relative told us that staff respected their relative's dignity by always supporting them discreetly when they were occasionally incontinent of urine. They said staff made sure their relative always had a clean continence pad on, and they had never had any concerns about the support their relative received with personal care.

We observed that when staff passed on information to each other about people using the service, such as requesting assistance to support someone with personal care, they were generally discreet. However, we observed one occasion where a staff member was indiscreet passing on information.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. Staff told us that some females preferred to be supported by female care staff and this was respected. On the day of our inspection there was a 'fellowship meeting' at the home, run by the local church, that people were invited to attend if they wished.

Good

Is the service responsive?

Our findings

All of the people using the service had a care plan. We saw evidence that people had been involved in discussions about their care plan and six monthly reviews of their care.

We saw that the registered provider completed an initial assessment of people's needs and a 'resident induction'. They also completed other initial documentation on arrival, such as information for kitchen staff about people's dietary needs and preferences. Care files included information about people's life history.

We saw that care plans developed by the registered provider included some person centred information about people's needs and preferences. Care plans were in place regarding people's needs in relation to; medication, circulation and breathing, communication and sensory needs, continence and catheter support, personal hygiene, moving and handling, skin integrity, sleep and night time support, bed rails, mental capacity, mental health and end of life care wishes. The care files also contained detailed records of contact with professionals and family members, as well as daily records and an inventory of people's possessions. Where relevant, there were also care plans in relation to finances and infection control.

People's preferences were indicated in some of the care plans, and the staff we spoke with were knowledgeable about people's needs and preferences.

We noted that although three of the four care files we reviewed were up to date at the time of our inspection, there had been gaps over the previous six months where the care plans had not always been reviewed monthly as per the registered provider's policy. The deputy manager told us that they were aware that there had been some gaps in the monthly reviews, and we saw a copy of an action plan the registered provider had in place to address this.

The registered provider had recently employed an activities coordinator to work at the service five days a week, and people who used the service and relatives commented positively about this. A person using the service told us "The activities coordinator is full of good ideas". A relative told us "Since the activities coordinator came that has helped create a livelier atmosphere, with things going on".

On the day of the inspection, we observed the activities coordinator inviting people join in some gardening; potting seedlings. In the afternoon, the activities coordinator was running a general knowledge quiz in the main lounge. There were a number of people who particularly enjoyed the quiz and were actively engaged throughout. There was a pictorial activities board in the hallway of the home, showing the activities available each day of the week. This included games and crafts. We noted that the activities shown on the board for the day of the week we visited did not reflect the activities available on the day, which could be confusing for people who lived at the home.

People using the service told us they would be comfortable making a complaint if they were unhappy about something. People told us "I would speak to the office or one of the carers in charge. They would listen and put it right if they could". Another person said "I would complain to [deputy manager] and they would

listen". A relative told us "If I had any concerns I would tell [deputy manager]. I feel they would take it on board happily". There was a complaints policy and procedure in place, and we looked at the registered provider's complaints and compliments log. Records showed that in the last six months there was one informal complaint about laundry and five compliments and positive comments recorded about the service.

We saw evidence of resident and relatives meetings taking place. We saw the minutes of the most recent meeting, which was held in January 2016. People were updated on changes in the company and at the home, and feedback was sought from those attending. Feedback about the home was positive, and suggestions were given by relatives about ways the home could involve families more in events and activities.

We looked at a resident satisfaction survey that was conducted in 2015. People were asked a variety of questions and nine responses were received. When asked how people would rate the service overall, all responses were 'good' or 'excellent'. One person using the service told us "I have had a survey but I didn't fill it in; I would rather speak to people".

Our discussions with people who used the service, along with residents meetings and satisfaction surveys showed us that people were encouraged to share their experiences and had opportunity to raise any concerns. There was a system in place to respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration. There was no registered manager in post on the day of our inspection and, as such, the registered provider was not meeting their conditions of registration.

However, there was a deputy manager in post, who was managing the home in the absence of a registered manager. The deputy manager had been working at the home for approximately four months. They told us that the registered provider was awaiting recruitment checks back for a new manager they had offered the position to, and that they hoped the new manager would be in a position to start approximately four weeks after our inspection. There had also been recent changes within the senior management team of the registered provider.

People using the service, and relatives, felt that because the previous long standing registered manager and deputy manager had both left towards the end of the 2015, and a new manager who was appointed then left within approximately three months, this had been unsettling for people and staff. They said that a number of staff had left in the last six months, and they were aware that the registered provider had recruited some new staff. The relatives we spoke with did not however, feel that this had impacted on the quality of care their relative had received. They spoke positively of the deputy manager, and told us "I think they have done an amazing job. The previous manager and deputy had been there a long time, but [name] seems to have done a great job in the time they've been there". Another relative told us "[Deputy manager] is doing a really good job. We will be pleased when they get a home manager to support them as well".

Staff we spoke with felt supported by the deputy manager. They told us "[Deputy manager] has worked like a trooper to keep things together" and "[Deputy manager] is very approachable so I wouldn't hesitate to speak to them".

The deputy manager told us they kept abreast of good practice by attending quarterly managers meetings run by the registered provider and through email updates from the registered provider.

We found that the recent changes in management and staffing at the home, along with the changes in senior management of the registered provider, had had some impact on consistency. This was particularly evident in relation to care planning documentation. Over the previous six months there had been a number of gaps in the monthly reviews of people's care plans and risk assessments. The area manager bi-monthly audit had also not been completed in January 2016 or February 2016. The registered provider had already identified these issues, and there was an action plan in place to ensure care plans were brought up to date and consistently reviewed. The operations manager had completed the area manager audit in March 2016 and we were also advised that the new deputy operations manager would be completing these audits moving forward.

We looked at a range of policies and procedures, and noted these were issued between April 2015 and September 2015. The registered provider had appointed an independent organisation to complete a

comprehensive quality assurance audit across the company, and told us that they were in the process of updating their policies and procedures to reflect current legislative guidance and changes in the care sector.

There was a quality assurance system in place and the deputy manager completed a range of audits. The deputy manager completed a weekly manager's audit, which asked questions about the environment and rooms in the home. They also completed a monthly health and safety audit, which was to ensure that a range of checks had been completed; these checks included weekly and monthly water temperature checks, call bell checks, window opening restrictors, bed rails, bath hoist checks, monthly slings checks, and fire alarm, door release and fire extinguishers checks. The health and safety audit also required the manager to complete the dates when equipment servicing and safety certificates, such as electric and gas safety certificates, had last been completed. In addition to the health and safety audit, there was a monthly environmental kitchen check which was countersigned by the manager, monthly housekeeping checks, mattress audits, finance audits, monthly meal service audits and checks on personal care records.

The deputy manager completed a monthly medication audit and a sample of four care file audits per month. There was also evidence that an analysis of weight loss was completed by the deputy manager monthly, indicating what action had been taken in relation to any individual weight loss. There was evidence of monthly falls audits and an analysis of accidents and incidents, with actions taken. This weight loss and falls information, along with other key information, such as the number of pressure ulcers, hospital admissions and infections each month, was included in a monthly key performance indicator review.

These records and audits were generally accurately and appropriately completed. The records showed us that the service had quality assurance systems in place and were able to measure and review the delivery of care. We did, however, note that the health and safety audit had not been effective in identifying that bed rail assessment checks had not been regularly completed for two people whose care records we reviewed.

We saw minutes of resident and relatives meetings and the findings of surveys which showed that people had opportunity to raise concerns or suggestions about the service. The findings of these surveys had been collated and analysed.

The most recent staff satisfaction survey had been conducted in 2014. However, we saw that staff had other opportunities to share their views. We saw evidence of team meetings and records of induction and supervision meetings with staff, where feedback was given to staff on their performance. Some staff supervisions were not up to date, which had been recognised in a management audit. The staff we spoke with were positive about their work, and one told us "There is really good management and senior staff; they have the resident's needs at heart. I could speak to any of them with a problem". They described the atmosphere of the home as a "Friendly and loving environment; like a big family unit".

One person who used the service told us that the service "Couldn't be better". Another said they would describe the home as "Pleasant surrounding and quite good". A further person said, "I can't think of anything that could be better".

Relatives we spoke with were unanimous in their praise of their home. One told us "Overall they are doing an excellent job; I wouldn't want my [relative] to go anywhere else". Another told us "[My relative] was really struggling to cope and getting depressed before they moved to Grimston Court, but since they have moved there they are so much better and I feel like it's given them another chapter in their life".

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not consistently assessed and reviewed. The provider did not complete regular assessments of bed rails in order to ensure this equipment was safe for use and was used in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not robust, because appropriate checks were not always consistently completed before staff started work.