The Council of St Monica Trust

The Garden House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 21 February 2017. It was an unannounced inspection. When The Garden House was previously inspected in July 2015, no breaches of the legal requirements were identified.

The Garden House provides personal and nursing care for a maximum of 102 people. At the time of the inspection there were 96 people living in the service. The service has four separate areas. The Oaks, Maples and Cedars accommodation provides general nursing and personal care for people. The Sundials accommodation specialises in providing care to people living with dementia.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The current registered manager was new in post and had been formally registered with the Care Quality Commission as the registered manager since 23 January 2017.

The service had not fully complied with the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The service had not consistently ensured legal conditions attached to people's DoLS had been completed. In addition, we found that best interest decision meetings for when people did not have the capacity to consent to a specific decision around their care or treatment had not been consistently undertaken in accordance with the Mental Capacity Act 2005.

People at the service told us they felt safe in their environment and with the staff that supported them. People were protected as staff understood their responsibilities in relation to safeguarding. There were sufficient staff on duty to support people and the recruitment of new staff was safe. People were supported with their medicines, however we found some recording discrepancies in relation to topical creams that had not been identified by the service management. People's risks were assessed and risk management guidance produced where required. Accidents and incidents were reviewed.

People felt staff were well trained, competent and delivering effective care. There were trained 'Champions' in specialised areas such as nutrition and hydration and dementia to support staff in providing effective care. The provider had a recognition scheme to acknowledge good practice and staff received support through appraisal and supervision. New staff received an induction and also worked towards achieving national accreditation in health and social care. Staff were supported to develop through nationally piloted schemes.

People had access to healthcare professionals as required and people's needs for eating and drinking were met.

People said that staff were caring and relatives we spoke with gave similar feedback. The service had received numerous compliments both at the service and via an online platform. Our inspection team made observations throughout our time at The Garden House that were mainly positive. People told us their privacy and dignity was respected and we saw the service had ways to achieve this. Social isolation risks were reduced as people's visitors were welcomed at any time and people's end of life care wishes and preferences were respected.

People said the service was responsive to their needs. Care records we reviewed were personalised showing people's care, communication and social needs. There was a system to raise a complaint or concern and people said they would feel confident in addressing any matters. There were activities for people to partake in if they wished and there were links with the local community and the registered manager planned to further develop this. We were given examples of when the service had gone the 'extra mile' to meet people's needs and make a positive impact on their lives.

People at the service and staff gave mixed feedback about the management and leadership. The provider had systems to demonstrate that employee welfare was a priority and there were systems to communicate with staff through meetings. However, we did find there was no uniformity throughout the service as to the frequency of meetings in different accommodation areas of the service. There were systems to communicate key messages to people and their relatives. Governance systems were in operation to monitor the health, safety and welfare of people at the service, however not all had been recently completed in accordance with the provider's required frequency. The registered manager told us they felt well supported by the provider since taking post.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The administration and recording of some medicines was not always safe.

People at the service felt safe in their environment and with staff.

There was sufficient staff on duty and recruitment was safe.

People's risks were assessed and managed as required.

Staff understood their responsibilities to safeguard people.

There were systems to ensure the environment was maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent to care and treatment was not always sought in line with legislation.

The service had not met the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff received training, supervision and appraisal.

There were 'Champions' to support and guide staff.

People were supported with eating and drinking as needed.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the care they received.

The service had received a number of compliments.

People's privacy and dignity was respected.

People's visitors were welcomed to the service to reduce isolation.

People's end of life care needs and wishes were respected.

Is the service responsive?

Good

The service was responsive.

People told us staff were responsive to their needs.

People's records were personalised and reflected their current needs.

There were activities available for people.

The service had links with the local community.

We saw examples of the service improving the quality of people's lives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff gave mixed feedback about the management.

There were systems in place to communicate with staff.

Governance systems monitored aspects of people's care delivery.

The registered manager felt supported by the provider.

The Garden House

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 was carried out by three inspectors, a specialist nurse advisor and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. When The Garden House was previously inspected in July 2015, no breaches of the legal requirements were identified.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with 31 people who used the service and four people's relatives. We also spoke with 11 members of staff. This included the provider's head of care homes, the registered manager, deputy manager, nursing staff and care staff who were providing care to people on the day of our inspection.

We looked at people's care records and additional records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Requires Improvement

Is the service safe?

Our findings

Medicines were generally managed safely. We observed part of a medicines round. The Medicine Administration Records (MAR) we reviewed had current photographs of people on them, and people's allergies were listed. Person centred detail in relation to how people preferred to take their medicines was documented. For example, 'Likes her medicine off a spoon with yoghurt' and 'After each tablet likes to have sips of water through a straw.' There were protocols in place for PRN (as required) medicines. The protocols listed the reasons why people might require additional medicines and also detailed other strategies the staff could follow to assist people. For example, one person had been prescribed an inhaler to open their airways if they became wheezy or short of breath. The protocol detailed the breathing techniques staff should encourage and the best position for the person to sit in in order to relieve the symptoms.

Medicines were stored safely. Items that required refrigeration were stored in locked medicine fridges. We saw that the temperature of these was monitored daily. Controlled medicines were stored safely and when medicines were no longer required they were safely disposed of in line with the provider's procedures.

There was a chart at the front of the MAR file for staff to document any missing signatures they noted during a medicine round. Where recording omissions had been identified, action was taken to ensure people had received their medicines as prescribed and entries were made on the chart to reflect this. We saw no missing signatures on the MARs we reviewed.

Some people had their medicines administered covertly and this was done by the medicines being disguised in their food or drink. Other people were having their medicines crushed. We discussed this with staff who informed us they had consulted a pharmacist to be certain if the medication was licensed to be crushed, however there was no documentation of any telephone calls or meetings with the pharmacist found on record. We looked at the records for these people and saw that in general, capacity assessments had been completed and best interest decision meetings had taken place. However, this was not fully consistent throughout the service and this has been highlighted under our 'Effective' domain within this report.

Some people could self-administer their medicines. We looked at the self-medication risk assessment that had been completed for one person. They had been assessed as safe to self-administer their medicines and had signed a consent form to indicate they agreed. This was in line with the provider's self-medication procedure. Some people had been prescribed additional medicines by the community palliative care team. However, there were no protocols in place for when these should be administered, although the medicine charts did describe the indication, such as 'agitation' or 'pain.'

Topical medicine administration charts had not always been signed by staff to indicate they had been applied as prescribed. In addition, some of the supporting documentation had not been completed in full. We looked at a sample of 'Delegation of Creams' application forms. The form instructions were listed as, 'Detail name, purpose of product, how to use it and the duration of treatment', but not all of the required detail had been listed on the forms we reviewed. For example, one form detailed the amount of cream to be

applied, the frequency and where it should be applied, but did not detail the reason why the cream was required. Other forms detailed the type of cream to be used, but the duration was not documented.

On the Oaks accommodation, one person had been prescribed a cream twice daily, but records indicated the cream had only been applied once per day on 11 occasions since 6 February 2017. On one day, the chart had been signed twice and on four days the chart had not been signed at all. We reviewed the creams records for the same time period for another person who had been prescribed a cream twice daily. Their chart had only been signed twice per day on two occasions and had not been signed at all on five days. Although this had not resulted in a negative impact on people, the absence of robust record keeping by staff produced a risk that people's skin condition and cream applications could not be safely monitored.

Although the service undertook regular medication audits, topical administration records were not routinely audited. We were shown an audit that had been undertaken during July 2016 and issues in relation to topical administration had been identified. This was referred to in the provider's audit action plan as, 'The Lotion project.' We also saw that this issue had been discussed during a nurse meeting in February 2017. One nurse said, "We have been discussing how to rectify this. I think the creams are being applied, but that staff forget to sign the charts." The deputy manager showed us a new chart they were starting to implement in order to improve chart signing. Other medication errors were reported and investigated and actions completed.

Staff were clear on their responsibilities for reporting and recording any accident, incidents or near misses. We reviewed incident and accident records and saw a description of what had occurred, any injuries and the immediate action taken. Accidents and incidents were investigated by a manager within the service and any actions taken to reduce the risk of reoccurrence were recorded.

People at the service felt safe. The feedback we received from people was positive when asked about how safe they felt within the environment in which they were cared for and the staff that provided their care. One person we spoke with commented, "This is a safe environment, everything is extremely well organised. I have security." Another person said, "I am perfectly safe and comfortable here, this is my home now and I am safer here than when I was at home." Comments about the staff we received included, "Staff are very good. They are knowledgeable about my needs. I cannot speak highly enough about them." Another said, "Staff are very good."

Relatives and visitors we spoke with also mirrored the comments we received from people living at The Garden House. The feedback we received was positive and the relatives and visitors we spoke with felt their relatives were safe. One relative we spoke with said, "This place is lovely, I have reassurance that my loved one is in safe hands." Another comment was, "My [person's name] settled down well, and they have the right equipment to manage everything." Another relative said, "My loved one is safe and well cared for."

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. In addition, the service had ensured that where necessary a staff member's registration with the relevant body was current. This included nursing staff being correctly registered with the Nursing and Midwifery Council.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had dedicated staff that monitored all aspects of the environment and the equipment within the service. We

received information from the provider's Facilities Operations and Health & Safety Manager that detailed the regular maintenance and servicing of mobility equipment undertaken within the service. Environmental aspects such as legionella risks and lighting were frequently audited. Mobility equipment such as wheelchairs, hoists and slings were also subject to regular checks and servicing. Passenger lifts were subject to regular servicing and the testing of the fire alarm and associated fire fighting equipment was undertaken.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of alleged abuse. Policies and procedures were available to everyone who used the service. Staff confirmed they attended safeguarding training annually as part of their training schedule. The registered manager and staff understood their duty of care to raise safeguarding concerns with agencies including the local safeguarding team, the Care Quality Commission and if needed, the police. The registered manager also kept a log of current safeguarding concerns to ensure they were concluded as required and information was shared as needed.

All of the care plans we looked at contained risk assessments for areas such as moving and handling, falls and mobility. Where people had been assessed as being at risk, care plans provided clear instructions for staff on how to reduce the risks. For example, when people were at risk of falls during transfers, the care plans detailed the type of hoist that should be used and the size of sling. We saw one risk assessment that informed staff to, 'Remind [Name of person] to arise slowly. Always ensure they have their call bell in reach or their pendant alarm on her.' In addition, this information was kept in folders in people's rooms so that care staff could access it easily.

We saw evidence that people's needs were met to reduce their risk of harm. For example, when people had been assessed as at risk of pressure sore development, the care plans detailed how staff should care for the person in order to prevent skin breakdown. For example, one person had an air mattress in situ and required their position to be changed regularly. The mattress was set correctly for the person's weight and position charts showed the person had been moved frequently.

Within the Sundials accommodation we saw care plans accurately reflected the needs of people and how they wished to be supported. Risk assessments were creative and supported the person's independence as much as possible. For example, one person enjoyed going out for walks was and was at risk of coming to harm during these periods. The person had previously been seen by the dementia wellbeing service who recommended some physical activity and taking the person out for walks in the garden. This information was factored into the person's risk assessments. Staff told us this person was now more settled in the unit. Other assessments had been completed in relation to letting a person continue to shave themselves to promote their independence.

There were enough staff on duty to meet the needs of people using the service. We observed that call bells were answered promptly during the inspection and people's needs were met. People we spoke with commented positively and felt that all their needs were being met by regular staff who knew them and their ways, their likes, dislikes and preferences. One person we spoke with said, "Staffing levels are very good." Some people did comment that at times they had to wait but this was not frequently. One person said, "Staff are very busy and sometimes you have to wait." Another said, "You press the button and they come. I've had to wait for the commode sometimes." A further comment was, "I try not to be a nuisance. You're never refused or kept waiting." A staff member said, "We generally have enough staff. If someone goes off sick we can use bank staff or agency. We have regular staff who help out." Staff told us that agency staff were sometimes used but the service had a reliable bank system in place.

Requires Improvement

Is the service effective?

Our findings

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

We found that consent to care and treatment was not always sought in line with legislation and guidance. Documentation relating to mental capacity assessments within care records was inconsistently completed. For example, we reviewed a mental capacity assessment for one person dated October 2016 where it clearly demonstrated the process taken around a health decision. The assessment showed how written and verbal communication had been used to assess the person's capacity to understand and retain the information being communicated to them, and how conversations had taken in place at different times to verify the person's understanding. This was demonstrative of good practice being undertaken in line with legislation and guidance.

However, in contrast we reviewed two people's care records that showed the people were currently using bed rails. We confirmed with senior care staff that these bed rails were currently being used. The use of bed rails can be restrictive to people, therefore their use needs to be carefully considered. No capacity assessments had been completed to assess if these people had the capacity to consent to their use. One person's care record stated, 'Does not understand bed rail use.' We reviewed several capacity assessments around health and medical decisions where the assessment concluded that the person did not have capacity in that area of care or support. However, it was not clear from the assessment how this had been determined, as legislation and guidance had not been fully followed. For example, the assessment did not record the person's contribution to the assessment, what they had communicated, how information had been presented to them in different formats or what information they had or had not retained.

Within a different person's care records, we saw a best interest decision had been made for the person to have the flu vaccine. Whilst other people had been consulted in this decision, such as a family member and staff, there was no record of the person's involvement in any way or their past wishes or feelings in this area. In the best interest decision process it stated, 'Details of the best interest decision made explaining what has been considered and why.' In response it was recorded, 'A best interest decision has been made to have the flu vaccine.' It was not documented the other options considered or discounted or the benefits to the person the decision would bring.

For another person, we saw that several best interest decisions had been made in regards to their medicines being crushed, the person being given their medicines covertly, having a course of a particular medicine and in having a blood test undertaken. Whilst best interest decisions had been made in consultation with others, no background information was given as to why these decisions were in the person's best interest, why these were the least restrictive options, what other options had been considered or discounted and how the person's past wishes or feelings had been taken into consideration. We saw that reviews of these decisions

had taken place on a regular basis. However, these reviews consisted of the same information being restated.

Within the Sundials accommodation, we spoke with staff about people living with dementia and how they received their medicines. Staff told us how some people took their medicines covertly as they were not complicit in taking their medicines when offered. During a review of the records held relating to the administration of medicines covertly, it was not clear what was taken into account when making a best interest decision. For example, one person commenced their covert medicines in February 2016. The person's GP had signed the covert administration form and there was a sentence that the decision to give medication covertly was agreed by the person's relative, the multidisciplinary team and manager, however there was no evidence of how this decision was made.

Another person's records showed that their medicines were crushed and administered covertly and this had been agreed by the person's GP. There was no supporting evidence of a decision specific capacity assessment being completed or a best interest meeting being completed. We also noted that during a review of governance records, a social care professional commissioned by the provider had completed a review of the service against the five key questions the Care Quality Commission ask during our comprehensive inspections. During this review in May 2016 it was highlighted to the provider there was a shortfall in information held and recording around best interest decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Applications had been made where appropriate to the local authority and five people currently had an authorised DoLS in place. Three people had conditions attached to their DoLS authorisations which the service is legally obliged to action or facilitate. For one person we found one condition that should have been met in August 2016 had not been completed. This was in regards to completing capacity assessments and if necessary best interest decisions in specific areas of care which may be restrictive. This included the use of a sensor mat, door alarm, particular friendships and drinks. We saw that some of these care needs had been discussed with a family member. However, capacity assessments and best interest decisions had not taken place as required in the condition and staff confirmed the person currently had a restrictive sensor mat and a door alarm actively in use. The registered manager produced the minutes of a meeting with the person's relative in which some of these matters were addressed, however this was not a requirement of the DoLS conditions for the person. The other conditions that had been actioned had not always been clearly recorded in regards to their outcome.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about staff and told us they were sufficiently skilled to meet their needs. The feedback we received demonstrated people felt they were cared for by competent staff. One person said, "Staff are all well trained, they could not do better, I admire what they do and am grateful." Another person we spoke with said, "Staff are efficient and competent, they do things the way I like them, they know my

routine." A further comment was, "Staff are capable, competent and very helpful."

Staff received effective training to carry out their roles. All of the staff we spoke with said they were given sufficient training to effectively support people and meet their needs. Staff had received appropriate training in a variety of relevant topics to meet the needs of the people who used the service that included moving and handling, health and safety, fire and safeguarding. The provider had a scheduled, 'Mandatory Update Day' to allow staff to complete a full day of update training in specific subjects. These annual training days included subjects such as health and safety, first aid, moving and handling, safeguarding, the Mental Capacity Act 2005 and equality and diversity. We spoke with a nurse who told us they had access to professional development. They commented, "I did some training at the end of last year about hospital admissions. I've also completed syringe driver training and death verification training."

Staff received regular performance supervision and appraisal. The 'Advancing Colleagues Contribution' process ensured staff received regular supervision and an annual review. Staff we spoke with said they felt supported through this process and said it gave them the opportunity to discuss their development with senior staff, together with any concerns they may have. The 'Advancing Colleagues Contribution' process also ensured staff annually completed a document that incorporated a personal training and development plan for the following year.

The provider had ensured staff had the opportunity to develop in their roles. Unique, additional training opportunities had recently been provided for staff. The provider had secured a number of places on a national project that was being piloted. The project was to identify and train care staff into the role of 'Nurse Associates.' This role was a bridge between care staff and registered nurse. A letter had been sent to all care staff inviting them to apply for the role or to discuss the role with the registered manager. An explanation of the course, including the time length and expected commitment from staff was contained in the letter. This showed the provider was proactive in supporting staff to develop.

The provider supported new staff through a formal induction. Staff also completed the Care Certificate. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. There is an expectation that all new staff working in the care industry should complete this induction during their first three months. A staff member we spoke with confirmed they had completed the induction and had received their Care Certificate accreditation.

The corporate induction given to new staff by the provider was a comprehensive four day induction. The provider had also increased the induction period of staff to five days if they were working with people living with dementia. New staff completed the four day induction followed by a period of shadowing senior staff. They would then be monitored by senior staff to ensure they were competent at their role. The induction included training in subjects such as moving and handling, safeguarding, equality and diversity and infection control. We spoke with a member of staff that had recently completed the induction who spoke positively about it. They told us, "[The induction] Was really good. I looked forward to starting after the induction." Dementia training was included. I did three days shadowing after the induction."

The ROSE (Recognition of Special Endeavours) Award was an annual event held by the provider. The award was primarily to celebrate staff and volunteer achievements during the year. Staff, volunteers and residents can be nominated for an award at any time during the year. A number of people would be chosen to win a ROSE award and these were given out by senior managers as a surprise. An annual awards dinner is also held at a local venue where awards were given out linked to the provider's values. These were, 'We are

people people, we are caring, we are responsive, we are honest, we are inspirational and we are dedicated.' Two members of staff from The Garden House had previously won a ROSE award.

The service had 'Champions' in different specialisms to support staff in delivering care that provided a positive outcome for people. We discussed this with the registered manager who told us the service currently had champions in areas such as dementia, tissue viability, end of life care, nutrition and hydration and activities. Champions received training in their key area to allow them to support and guide their colleagues in the specialist area they championed.

People had access to health and social care professionals. People living at The Garden House had the benefit of two nominated GPs attending twice a week to see people in relation to any health concerns they may have. Within people's care records there was clear evidence of external professional involvement which included district nurses, physiotherapists, social workers and tissue viability nurses. There were quarterly meetings with the local GP to review and discuss events within the service. This included deaths, admissions, occupancy and any admissions to hospital. People we spoke with said they could request a visit from their GP if they wished or if nurses felt it is necessary. Several people told us they had been unwell with a variety of illnesses over winter, and had been treated by their GP.

Care plans contained nutritional risk assessments. People had been assessed for the risks of malnutrition and dehydration. When risks were identified, care plans contained guidance for staff on how to reduce the risks. We looked at the care plan for one person who had been assessed as a high risk of dehydration. The plan informed staff that the person was unable to drink without assistance, and that housekeeping staff had been informed to report if they found drinks untouched in the person's room. In addition staff were informed to use a straw and, 'Offer drinks regularly.'

The person was having their fluid intake monitored, but there was nothing documented within the plan of the daily target of fluid intake for the person. We looked at the fluid charts for the person for the previous five days. The recorded fluid intake was only 250 millilitres for the day prior to our inspection, although the total had not been documented on the chart. There was nothing documented within the persons records to indicate if this was normal or not, had been noted as abnormal or not, or escalated within the team. This meant it was not clear on this record if the person's hydration needs were being met. In addition, poor fluid intake on previous days had also not been documented within the progress notes. We discussed this with the deputy manager and the person's care plan was amended at the time this issue was identified. In addition, the daily handover sheet was also amended with the instruction for staff to, 'Encourage fluids.'

Other food and fluid records were completed. Care plans associated with these people explained why their food and fluids were being monitored and the charts had all been completed fully. These records showed that people were getting enough to eat and drink. One person was receiving their nutritional intake via Percutaneous Gastrostomy Tube [PEG]. The care plan contained details of the PEG feeding regimen as prescribed by the nutrition nurse. The plan also detailed how staff should care for the tube and records showed these instructions had been followed. This demonstrated this person's needs for eating and drinking were being met.

Comments we received about the food quality were positive. One person said, "Very good choice of food, soup is always excellent." Another person told us, "Food is lovely. Plenty of it." Another person commented when asked about the dining experience, "I take my [person's name] to the dining room every day, this is a highlight, not only the food but meeting up with the other residents and socialising."

The service was able to demonstrate they understood the importance of eating and drinking well. In

addition to the links with dietary professionals, The Garden House had introduced 'hydration stations' within the service. These hydration stations had a daily choice of flavoured drinks to promote good hydration. The flavoured drinks were sugar free to ensure that they were consumable to all of the people in the service. In addition to the drinks at the hydration stations, snacks were readily available for people to help themselves. A staff member told us these stations were popular with people's relatives who often helped themselves and will often take something in for the person living at the service as well.

Good

Is the service caring?

Our findings

People and their relatives were very positive about the caring nature of the staff at the service. All of the people we spoke with told us they felt well cared for by staff and said they were treated with dignity and respect. One person commented, "I get on well with staff, they encourage me to do what I can for myself, they are organised and caring." Another said, "I cannot speak highly enough of the staff." A further comment received was, "Carers are excellent - they have time to sit and chat and have a laugh with me."

The feedback we received from people's relatives and visitors echoed those given by the people who lived at The Garden House. One relative we spoke with said, "Staff do a brilliant job, they are always smiling and nothing is ever too much trouble. They care for my [person's name] in the way they want, they have a good relationship and a good understanding of each other." Another comment was, "It is impossible to achieve 100% perfection, but what we have here is as close as it can be."

The service had received 47 compliments about the care and support provided since January 2016. One compliment read, 'Staff are always happy to help, so accommodating and friendly. I am very thankful to all the ladies here who constantly make mine and my families lives better.' Another compliment said, 'Tender loving care is no exaggeration for the staff, this has been the experience for the family since their visits at Christmas they have all remarked on the quality of care [Name of person] is receiving.' Another person remarked, 'I would like to thank-you for all so much for all the kindness and care you gave to my dear friend [Name of person] in the last few months of her life. You went out of your way – the David Bowie music, pampering baths to make her more comfortable, always with dignity and respect, this didn't go unnoticed and I truly thank-you for it.'

The provider encouraged people or their relatives to use a national website to give feedback on the service. There was information about the website displayed in the main entrance to the service. The service had received three reviews since December 2015 and all were positive. An extract from the review read, 'My Grandmother is excellently looked after mentally and physically, with thought and genuine care. The staff are really wonderful and their communication between themselves, and with the family, is first class. For instance, when she first arrived, I talked to a carer about what my Grandmother likes, where she used to live, etc. When I asked another member of staff a couple of days later, they knew who had visited, and the same information I'd told the carer on the first day. They were all briefed and informed.'

Most of the observations we made between people and staff were positive. For example, we observed a member of staff during a mealtime. They came down to people's eye level to speak with them. We saw they showed people the menu and described the choices available. The member of staff said to one person, "You could try this and see how you get on. I can always get you some shepherd's pie if you prefer? That is nice and soft." The member of staff offered to one person, "Would you like me to chop this up?" They waited for a response and did what the person directed.

People were sat in a sociable way, so they had enough space to eat comfortably but were able to talk with other people around them. People engaged in conversation with each other and the staff member. There

was laughter and jokes and a pleasant atmosphere. People spoke about how nice the dessert was. People were able to come to the mealtime at a time that suited them and we saw people arrived at different times. Signs were displayed on the table indicating the size of portion, the type of crockery and utensils people preferred. One person independently stood up to exit the room. A member of staff responded by walking out with them to offer support if necessary and to ensure they were safe.

In contrast to this, we observed another member of staff supporting someone to eat their lunch. They did not try and engage with the person during this dining period. The member of staff did not describe the food they were giving to the person or explain what they were doing. For example, the person's food protector was changed during their lunch but the person was not informed. At times during this person's dining experience, we observed another staff member stood next to the person being supported by the member of staff and was talking to the staff member supporting the person with their meal. This did not consistently show dignified practice to the person having their meal. In addition to this, during a subsequent review of the person's care records it was clearly highlighted, '[Name of the person] likes to be talked to.'

Within the Sundials accommodation, we observed most people were cared for in the communal areas. We heard one person in the lower Sundials asking for help and we saw staff responded immediately, closing the door and putting up the sign that the room was engaged when assisting the person with personal care. Staff said this person preferred to get out of bed late and said that they, "Did not rush anyone to get out of bed early or go to bed early." We observed staff closing the door and heard staff spoke with the person in a kind manner.

We observed how people's privacy and dignity was respected. Personal care was done behind closed doors as generally people seemed to prefer to stay in their rooms during the day. Staff interacted with people in a kind and compassionate manner and were heard to refer to people by their preferred name, using appropriate volume and tone of voice. People told us they had a good relationship with staff and looked comfortable when approached by them. All of the people we spoke with agreed that they are treated with respect and dignity, and said that their privacy was maintained. People confirmed that staff knocked and waited for a response before entering their rooms, and told us their doors were closed and curtains drawn before any personal care was carried out. This was confirmed from our observations, and we also saw an 'Engaged' sign was also shown on the door to reduce the risk of others entering during care provision.

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection several visitors came to the service to see people. It was clear that staff knew the visitors well when we heard them speaking with them.

People were supported at the end of their life to have a comfortable, dignified and pain free death. Care plans contained details of people's preferences and choices in relation to their end of life care. For example in one person's plan, there were details in relation to who should be contacted, which was the person's preferred funeral director and the type of service they preferred. The person had been prescribed medicines when required to ensure they were pain free and comfortable. However, it was noted the plan did not provide detail on these medicines, or any guidance in relation to when they should be commenced. Instead it had been documented, 'All oral meds stopped. Has end of life meds prescribed.' A relative we spoke with commented positively on the end of life care provision and said, "They are doing everything they can to make [person's name] as pain free and as comfortable as possible during the final period of their life."

Good

Is the service responsive?

Our findings

People felt staff at the service were responsive. People said they felt their needs were met from staff that were attentive and said they were involved in care and treatment decisions. One person commented, "I am quite satisfied with all aspects of my life here, staff understand me and my ways and respect my need for independence." Another person told us, "I am involved in decisions – my family is included too. I am not good at making decisions." A further comment around care reviews we received was, "[Person's relative], as next of kin, deals with all affairs directly with the home, and had a review recently"

The service had a complaints procedure and this information was available to people and their relatives. None of the people spoken with said they had reason to complain, but would have no hesitation in doing so if required. The complaints procedure gave guidance on how to make a complaint and the timelines and manner in which the service would respond. There was information on how to escalate a complaint to the government ombudsman should people wish to contact this department. The service had received seven complaints since January 2016. We saw that complaints were fully investigated and responded to. Actions were taken in response to any complaints made and these were communicated to the complainant to ensure they were satisfied with the outcome.

Care records contained an up to date photograph, any known allergies and contact information for family members and health professionals. People's life history was described giving an insight into people's interests, past employment and religious and cultural needs. For example, one care record described how a person used to run dog training classes. This meant that staff could use the information in care records to engage people in conversation or know the things that were important to them. For example, we saw for one person their pets had been very important to them. Their care record listed all their past pets names.

Care records showed people's usual routines. This enabled staff to offer care and support in the way that people wished. For example, one person's care record said, 'Likes to wake up naturally.' This ensured that staff did not go and wake the person before they were ready. Other care records described people's night time routines such as, 'Likes to go to bed between 8pm-10pm' and 'Likes to sleep on her back with two pillows.' People's personal preferences were documented. For example, 'Does not like tuna or corned beef,' and 'Likes talcum powder to help her dry and as a fragrance.'

Care records showed that the service respected people's individual lifestyle choices. For example, one care record said, 'Sometimes watches television in the middle of the night.' Another care record said, '[Name of person] likes to choose her own clothes every day and staff are to offer choice.' Care records described how people's privacy and dignity was maintained. For example, 'Whilst giving personal care staff to ensure white net curtains are closed and doors are shut, with the engaged signs on to ensure [Name of person] dignity and privacy.'

When people had communication needs these were clearly documented and informed staff how to ensure they understood people and also how to ensure people understood the staff. For example, 'Speak slowly and clearly', 'Ask simple questions' and 'Staff must not pretend to understand if unclear what [person's

name] wants.'

When we reviewed the care records within the Sundials accommodation, it was clear people's diverse needs were fully recognised and records showed how care should be delivered in a person centred and holistic way. People's preferences, likes and dislikes had been documented, for example, in one plan it had been documented that the person liked knitting and walking. In another person's plan it was documented that a person had their own waking up routine. Records showed involvement of the person where possible and other significant people involved in their lives. For example, a person's review showed that their Power of Attorney for health and welfare and financial affairs had attended a care review meeting.

Although we observed that in general people's care and treatment needs were met we did find an example within a person's care records where poor record keeping did not clearly demonstrate how the person's needs would be met. One person's records showed they had been admitted to The Garden House with a pressure sore. The wound care plan described the wound in detail, including the dimensions and the grade of the wound. Records showed the wound had been redressed in accordance with the care plan. However, there was no photograph in place for staff to visually assess any improvement or deterioration. One nurse said that photographs were not routinely taken of wounds and this was confirmed by the registered manager. In addition, although the person had a pressure sore, there was no skin integrity plan in place to inform staff how to prevent the development of further skin breakdown. Although the person had an air mattress in situ, which was correctly set in accordance with the person's weight, there was nothing documented to inform staff how often they needed to change the person's position. This may present a risk the person would not receive care as needed.

There were activities for people to be involved in. There was a detailed timetable in the entrance foyer and on each different area of accommodation about the activities available. The pre-arranged activities available were primarily arranged over Monday to Friday and included a newspaper group, coffee group, singing, music and movement, religious services, sherry and stretch and new residents welcome meetings. Photographs of activities and previous events were displayed in folders for residents and visitors to enjoy, this included the Christmas party and Burns night celebrations. People also had access to the provider's minibus periodically for trips to the local area.

Very few of the people we spoke with told us they joined in activities at the home, preferring to stay in their room. We received mixed feedback and enthusiasm levels from people about the activities. For example one person commented, "[I] Choose to stay in my room now. I used to do activities – can't be bothered now at my age. I watch TV – don't mind being on my own." Another person said, "I don't have activities. I like to go out in the garden. The Church people come regularly to see me." A further comment was a person saying they would, "like a bit more structure" to the activities. Another said, "I join in the activities. I would like to go to the theatre or Cribbs Causeway. There are not many trips out and about at the moment."

The registered manager explained there were some links with the local community however part of the development plan of the service was to increase this in the near future. Currently, a weekly coffee morning was held where people from the local community were invited to The Garden House every week to enjoy events and socialise with people at the service. Such an event was held on the day of our inspection which was well attended. People living in the Sundials accommodation were actively encouraged to participate and join in this event. The coffee morning finished with people, their relatives, visitors and staff involved in group singing.

An additional community link was established with the local pre-school. The school currently completed an annual Sports Day within the grounds of The Garden House and the Cote Lane site. This has been in place

for a few years and the people living at the service get to watch the Sports Day and then meet and talk with the children afterwards. The Garden House is also used annually as the 'dress rehearsal' location for the plays put on by the school. This includes the annual nativity performance and people living at the service are invited to watch this.

We spoke with people who gave examples of how the service had supported them in certain tasks which had impacted positively on their lives. For example, some people had their spiritual needs met by going to the chapel on site on Sundays. One person attended regularly with a relative who also lived on site and the minibus drove them to and from the chapel. However, if the weather was bad or they were too unwell to attend, they watched the service from within their bedroom as it was transmitted live from the chapel onto their TV. A second person we spoke with told us they did the same thing. For both of these people it was an important part of their life and they appreciated this facility.

The service was sensitive to the needs of a person who enjoyed music and singing. The person had been a member of a specific choir for a period of their lives prior to moving into The Garden House. The person said being in this choir was an important part of their life. As a result of the person not being able to remain an active member of the choir, staff arranged for members of the choir to come to sing at the service to involve the person living at The Garden House. This event had to unfortunately be cancelled and to date has not been rescheduled, however it was demonstrative of the service being responsive to people's needs.

We were told of other examples where the service had gone 'the extra mile' to be responsive to the needs of people at the service and have a positive impact on their lives. We were told of how staff had arranged a party for a person living at the service and their spouse to celebrate a significant wedding anniversary. Another person told us how they had been given a party to mark a special birthday. One person told us how when staff realised they were having difficulty using their mobile phone, staff had provided a handset with large numbers to be connected to a landline to allow the person to continue to make calls. Another person told us how the service had supported them with getting access to the internet. They told us, "I couldn't get online and they sent someone in to help me. I'm now connected so I can contact my family by email. The IT support was fantastic."

Requires Improvement

Is the service well-led?

Our findings

The service has failed to fully meet the regulations and we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was also identified that our inspection team identified similar concerns to that of a social care professional commissioned by the provider in May 2016 to review compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was evident that not all of the governance systems in operation had identified the issues we have reported under the 'Safe' and 'Effective' sections of this report.

People and their relatives gave mixed feedback in relation the management of the service. Some people we spoke with told us they were unaware there had been a recent management change but others were able to tell us the name of the registered manager. The provider was able to demonstrate they had communicated the management change to people and their relatives through newsletters. The information the old registered manager was leaving was communicated in August 2016. The announcement of the new registered manager was made in the October 2016 newsletter, and this also included an invite for people and their relatives to the leaving function of the previous registered manager. Comments we received indicated overall satisfaction. When asked about the management team, one person said, "I could go to the manager with any sort of problem, she will sort it out as she did when I had trouble with my TV." Another said, "I have not had any dealings with the manager, have not needed to, I know perfection." A further comment was, "I am happy, I believe the place is well run, I do not have any problems." A person's relative said, "Everything is slick, good communication between everybody." One person told us, "[Registered manager name] and [deputy manager name] are very open to change, they listen."

Staff gave variable feedback about the overall management of the service. For example, some staff said the registered manager and deputy managers visited the different areas of the service and spoke with staff to find out how they were. Other staff said they mainly had contact with the deputy manager who had a visible presence in all areas of the service. Another staff member we spoke with when asked about the registered manager told us, "I don't have much to do with her." They did however say, "I remember from my induction being told the door is always open and it is." Another member of staff said morale was, "Generally quite good" and, "We've had a high staff turnover lately, but we're recruiting." A further comment was, "I feel able to speak up and I know I would be supported." Staff we spoke with also knew who their clinical supervisor was and also confirmed they had received supervision.

There was evidence that the service placed employee welfare as a key priority. In addition to staff telling us they felt supported and the incentive schemes available, we found additional measures were taken to support employees when needed. For example, following a review of the infection outbreak policy in 2016, a decision was taken to ensure the provision of free flu vaccinations for staff. This was aimed at giving staff protection from the virus and also to reduce the risk associated with people in the service therefore having a positive impact on their lives. In addition, we saw documentation that employees were invited to meetings as part of the provider's 'Explore' programme to discuss aspects of care provision and the Trust progression.

A staff survey was distributed to staff to allow them to express their views and opinions on their

employment. We the most recent survey completed in 2016. The response to the survey was 43 responses. We saw the survey requested staff views and opinions on matters such as communication, pay, staff benefits, work processes and colleagues. The results were mainly positive, with staff stating they were aware of the strategic plan of the trust, that they received appropriate training and that there was a good working relationship with their colleagues.

Messages were communicated to staff through meetings. The registered manager told us that meetings were currently held for different accommodation areas within the service and currently no 'whole service' meetings were held but this was being reviewed. We saw that meetings held within different areas were inconsistent in frequency between different areas of accommodation. For example, on Cedars there were meetings held in July, September and November 2016. In Maples meetings had been held in April and September 2016, and a further one held in January 2017. However, in Oaks there was no record of a meeting being held since July 2016 and in Sundials since August 2016 for day staff. This did not demonstrate consistency for the service as a whole.

Additional meetings were held with relevant staff. For example, we saw a management meeting had been held in November 2016 and also that a monthly registered nurses meeting was held to discuss clinical matters within the service. The facilities team completed frequent meetings to discuss matters such as catering, housekeeping, health and safety and infection control. The administrative team also held periodic meetings. The provider also held management meetings for relevant managers within the trust to discuss matters such as staffing levels, survey results, auditing programme and other matters relating to the provision of care and treatment. This demonstrated information was shared throughout the trust to allow continual learning.

We saw that additional key messages that for matters that could have an impact on the health and welfare of people were produced by the provider who distributed a 'Care Bulletin' across the provider's locations. For example, following an incident at the location, information about undertaking safe hoisting practice was immediately communicated. Other communications included the registered manager being able to display a 'message of the day' to staff on the computer system when they logged on. We saw messages about annual leave, the ROSE awards and a request from the physiotherapy team had been communicated this way.

There were systems to communicate with people's relatives. We saw that since assuming post, the newly appointed registered manager had held a meeting for people living at The Garden House and their relatives. In February 2017, the registered manager had held a meeting and formally introduced themselves. They took time to explain the vision of the service for 2017 and what they as the registered manager hoped to achieve. For example, they explained the role of the Care Quality Commission and the key lines of enquiry reviewed during inspection. They discussed activities and how they aimed to involve people in the recruitment of staff, together with the keyworker role and recruitment. There was also the opportunity for people and their families to ask questions and new staff team members were also introduced.

There were some effective governance systems to assess, monitor and reduce the risks associated with people's care and treatment needs. For example, we saw there were audits in relation to pressure ulcer and wound care, together with medicine audits and call bell response time audits. There were systems that monitored the welfare of people eating a modified diet, and those were at risk of malnutrition or obesity. Additional audits in staff hand hygiene practice were also completed. Although these governance systems were in place, it was evident that during the interim period of the management changeover some audits had not been consistently completed. For example, the audit of call bell response times was listed at a frequency of monthly. Records indicated these had not been completed in any of the different

accommodation areas in the service for the four month period of September to December 2016.

Provider level audits were completed to ensure the service was delivering care and treatment in accordance with requirements. Service quality audits and meetings were completed by members of the provider's senior management team. These service quality auditing systems ensured the service undertook a 'self-assessment' against the five key questions the Care Quality Commission asked of a service when completing our comprehensive inspections. In addition to this, trustees undertook a quality assurance visit to monitor the quality of service provided. During these visits the trustee's also engaged with people and staff to seek their views. The provider also employed the services of an external social care consultant to review the services performance against the five key questions. We were given records that showed the last trustee visit was completed in May 2016.

The provider was a member of Care and Support West. Membership of this group helped ensure the provider's locations were aware of current guidance, legislation and best practice. In addition to this, participation in the local Care Home Provider Forum allowed the service to learn and contribute to the sharing of best practice. We spoke with the registered manager about the level of support they had received since assuming post. They told us they felt they had received 'tremendous' support from their line manager. There was also currently a supernumerary manager employed at The Garden House who was pending assuming post at a newly built location operated by the provider who provided support. The registered manager commented that support and guidance was immediately available from both their line manager and peers if and when needed. The Provider Information Return (PIR) we requested was completed by the registered manager and the PIR was returned as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in accordance with the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured conditions attached to people's DoLS authorisations had been consistently met. Regulation 13(4)(d)