Care Quality Commission

Gracewell Healthcare Limited

Highclere House Care Home

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

Overall summary

The inspection visits took place on 19 and 20 August 2015 and we spoke with professionals over the following week.

Highclere House Care Home is a purpose built nursing home registered to provide care for up to 60 people in a residential area of Weymouth. At the time of our inspection there were 38 people living in the home, one of whom was in hospital. People were living on two floors of the three floors. Most people with nursing needs lived on one floor and people with dementia care needs mostly lived on the other floor.

The service did not have a registered manager at the time of our inspection and the manager was away on annual leave. The deputy manager was available throughout the inspection and they explained that the manager had put in an application to be registered. The last registered manager had left the service in December 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We heard some mixed opinions from people as to whether there were always enough staff and call bell records indicated people may be having long waits for staff to attend to their needs in some instances. However, most people and all the relatives we spoke with told us there were enough staff and during our inspection people received care and attention quickly. Managers were covering nursing hours and this had an impact on the

Summary of findings

management of the home. Audits were not being undertaken regularly and incidents and accidents had not been reviewed to ensure lessons were learned. There was recruitment being undertaken during our inspection to ensure senior staff were able to undertake their management functions.

Staff were confident and consistent in their knowledge of people's care needs but not all staff had received an appropriate induction or undertaken training necessary for their role. Staff were not able to explain how they cared for people within the framework of the Mental Capacity Act 2005. The provider had plans in place to rectify this situation.

People were protected from harm because staff understood the risks they faced and knew how to identify and respond to abuse. Care and treatment was delivered in a way that met people's individual needs but records were not always accurate. This increased the risk that people could receive inappropriate care. Where people needed to live in the home to be cared for safely and they did not have the mental capacity to consent to this Deprivation of Liberty Safeguards had been applied for.

Nurses undertook hourly checks on people to ensure that all care needs and any comfort needs were met in a timely manner. People received their medicines safely and as they were prescribed.

People were engaged with a wide range of activities that reflected individual preferences, including individual and group activities. People spoke highly of the activities staff.

People described the food as excellent and there were robust systems in place to ensure people had enough good food to eat and enough to drink.

People's rooms and communal areas were kept clean throughout our inspection.

People and their relatives were positive about the care they received from the home and told us the staff were compassionate, kind and attentive. Staff treated people, relatives, other staff and visitors with respect and kindness throughout our inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

People had mixed views regarding whether staff were always available to meet their needs.

People felt safe and were protected by staff who understood their role in keeping them safe.

People were supported by staff who understood the risks they faced and provided consistent support to reduce these risks.

People received their medicine safely. Medicines were administered and stored safely.

Requires improvement

Is the service effective?

People had not had decisions about their care made clearly within the framework of the Mental Capacity Act 2005. This put them at risk of receiving restrictive care.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

People were cared for by staff who understood the needs of people in the home and felt supported.

People had the food and drink they needed. They told us the food was excellent.

Requires improvement

Is the service caring?

People received kind and compassionate care. People and relatives spoke highly of the staff. Staff communicated with people in a friendly and warm manner.

People and their relatives were listened to and involved in making decisions about their care.

People were treated with dignity and respect and their privacy was protected.

Good

Is the service responsive?

People received care that was responsive to their individual needs because staff shared information. Care plans were not all accurate and work was being undertaken to ensure they were maintained effectively.

People were able to take part in activities tailored to their needs and preferences.

Good

Summary of findings

People and their relatives were confident they were listened to and complaints were viewed as learning opportunity	
Is the service well-led? There were systems in place to monitor and improve quality but these were not effective because senior staff were providing nursing cover and this detracted from their management hours. People, relatives and staff had confidence in the management team. Staff were able to share their views and these were acted on when appropriate.	**Requires improvement** 

Highclere House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 19 and 20 August 2015 and was unannounced. The inspection team was made up of two inspectors and a specialist adviser. The specialist adviser had nursing expertise.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us about safeguarding concerns. Before the inspection the provider completed a Provider Information Record (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with seven people living in the home, six visiting relatives and 11 members of staff. We observed care practices and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at 10 people's care records, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring audits.

We also spoke with three social care professionals and two healthcare professionals who had worked with the home or had visited people living at the home.

Requires improvement

Is the service safe?

Our findings

People had varied opinions about whether there were enough staff. Three people told us they sometimes waited and one person said , ""It is a bit hit and miss if they come." Two of these people felt that the waits were acceptable and did not feel they had a negative impact on their care. However one person told us they had waited for 45 mins for pain relief. Another person reflected the more common view and said, "I am never rushed." Relatives all told us they felt the staff were able to attend to people's needs when they needed support. One relative told us, "I am never aware of staffing problems. It is always the same faces." During our inspection we saw that people were not waiting for staff to support them and there were always staff available in communal areas. However, the call bell system indicated that people may be having long waiting times. For example we reviewed a sample week in the month prior to our inspection and saw that on 10 occasions people were potentially waiting for more than 20 minutes for staff to attend to their needs. The people living in the home all had dementia or nursing needs so these time scales may have put people at risk. We also saw one person was assessed as needing support with exercises and this was not happening.

We discussed staffing levels with the deputy manager and they told us that they had recently altered staff deployment following feedback from the staff. They acknowledged that the person was not getting support for their exercises and explained that this would require additional funding as it required more staff time than the fees provided. The person had not been told they could not have this support without paying additional fees and care plans indicated they should be doing the exercises. They were however happy with the care they were receiving as they were not planning to stay in the home on a long term basis. Staff also had varied opinions. Care staff felt there were enough staff to meet people's needs but nurses acknowledged that some of their tasks such as reviewing and updating care plans were not happening due to the demands on their time. We saw that care plans were not all up to date.

Staff were recruited in a way that protected people from the risks of being cared for by staff who are not suitable to work with vulnerable people. The home had not, however, made sure that agency staff had the appropriate checks and training in place to work safely with vulnerable adults. This information was available with the agency but it had not been available in the home when the staff were working. We spoke with the deputy manager about this and they assured us that these documents would be checked.

People told us they felt safe. One person said: "Oh I definitely feel safe." Some of the people living in the home were living with dementia and did not used words to communicate their emotions. We saw that they were relaxed with staff; often smiling when staff were with them. All the relatives we spoke with shared a confidence that their relative was safe. One relative told us, "I don't have to come in all the time. I know (relative) is safe and cared for." Staff were able to describe how they protected people from the risks of abuse by describing the signs they needed to be aware of and knowing where they would need to report any concerns they had.

Staff were able to describe how they minimised risks that people faced. They were able to describe confidently and consistently the measures they took to keep people safe. For example they described how they reduced risks relating to falling and moving and handling. A health professional told us that all the moving and handling practice in the home they had seen was done safely. Where the risks people faced had changed we heard from staff that they discussed this in handovers. Relatives told us they were involved in discussion about risks. Risks were managed in a way that supported people's dignity and we saw that when people were being supported during periods of agitation and anxiety this was done gently with kindness and patience from staff. One person was being nursed in their room as they were unwell. This was being done in a way that protected other people from the risk of catching the illness. The clarity of documentation was varied about both the risks people faced and how reviews following incidents had led to changes in care and support. We did not see this reflected in varied approaches to people's care however, inaccurate and incomplete recording heightened the risk of people receiving unsafe care.

People received their medicines safely. There had been recorded incidents of medicines errors and an audit had been completed in July 2015 which had led to changes to tighten the systems. During our inspection we observed two nurses administering medicines and this was done safely. Medicines were stored and administered safely. A person who was supported to take medicines told us the

Requires improvement

Is the service safe?

medicines were done well. Nurses had a good understanding of people's medicines, for example one nurse described the importance of balancing the use of a medicine someone took when they were anxious with the impact it had on their mobility and the risks this caused.

The home was clean throughout our inspection. People commented to us that it was always clean and fresh. One relative commented that it was "always spotless".

Requires improvement

Is the service effective?

Our findings

People's care plans did not consistently reflect the principles of the Mental Capacity Act 2005 (MCA) and care practice did not always reflect the Act. The care plans were being updated and moved onto new paperwork and these files held clearer information but were still missing important documentation. For example when people do not have the capacity to make decisions for themselves then decisions must be made within the framework of MCA. This is particularly important when people refuse care and treatment as it is the Act that gives staff the authority to act in people's best interests. A person often refused care and at times became aggressive. Staff described how they usually used non-restrictive techniques to encourage the person with personal care and this was clearly recorded in their care records. However, records also showed that staff had been hurt supporting this person at a time when they had needed to provide personal care whilst the person was indicating with aggression that they did not want this. There was no best interest decision recorded to provide a legal framework for these staff interventions. The majority of staff had not received training about the MCA and staff we spoke with were not aware of how it provided a legal framework for how decisions were made.

Consent for treatment had been signed by people who did not have the legal status to do so, and one person who was assessed as not having capacity to make decisions about their care had signed their consent forms. This showed the provider was not following MCA 2005 which is designed to reduce the risk of people receiving care and treatment that did not reflect the least restrictive option. We spoke to the deputy manager about this and they explained the care plans were in the process of being updated and that staff were booked on MCA training. This training had just started with the first tranche of staff being trained the week before our inspection.

The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately. Deprivation of Liberty Safeguards. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely.

Staff told us they felt supported to do their jobs and described how guidance from colleagues ensured they were up to date with people's needs. They all spoke competently about the care and treatment of people living in the home but they had not all received an appropriate induction. A nurse who had started in June 2015 had not received an induction. Another staff member had started in June 2015 and they had not had training around infection control and safeguarding until August 2015. This was in line with the provider's policy which detailed that this training should be undertaken within 12 weeks. We spoke with the deputy manager about this and they acknowledged that inductions were not happening consistently. The Care Certificate had not been introduced in the home; the deputy manager told us this was in the process of being introduced by the provider. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

People, relatives and staff all told us that the food was good. One person told us," The food is really excellent." Lunchtimes were calm and social events for those that wanted to eat together on both days of our inspection. People who needed support received this discretely with staff sitting down to assist them or eating at the table themselves to provide behaviour to copy. People who preferred to eat in their rooms were supported to do so.

The chef knew about everyone's nutritional needs and made homemade fortified drinks and foods for those identified as at risk of malnutrition. The meals were designed by a chef and a nutritionist and nutritional information was available for all meals and supplements. The chef also made up graze boxes for people who could become at risk of malnutrition because they spent so much time walking during the day. These boxes were placed in people's rooms and provided snacking options throughout the day.

The chef spoke passionately about the importance of good food and nutrition as part of people's care and visited the floor on both days to check that people were happy with their meals. People's preferences were taken into account with food. For example one person, who did not want their meal, was asked what they would eat if they could have anything at all. They made a request and this was brought to them shortly afterwards. Where people had guidance in place from the Speech and Language Therapist we saw

Requires improvement

Is the service effective?

that this was followed and they were able to eat and drink safely. Food and drink intake was monitored as part of the hourly checks undertaken by nurses and people were offered drinks and snacks regularly through the day.

People told us they were supported to maintain their health. One person said, "It's like a five star hotel and the GP visits every Friday." Another person told us that the doctor had been out twice to see them recently. A GP who worked with the home observed that the staff communicated effectively with the surgery and recognised health issues promptly and appropriately. One person who had difficulty with their breathing told us that a particular member of staff "takes me out in the garden as the fresh air helps my breathing." This person also identified staff support as playing an important role in their mental wellbeing describing their attention as "keeping me going". This observation was reflected in the views expressed by relatives. Records around the role of staff in undertaking continence care tasks were varied in respect of their accuracy. Whilst people and relatives told us that staff helped them to maintain good health and have access to healthcare the inconsistent record keeping could put people at risk of not receiving appropriate care.

Good

Is the service caring?

Our findings

People and relatives described the service as caring. One relative told us, “The care here is absolutely fantastic.”

Staff took time with people throughout our inspection; offering reassurance whenever necessary. One person said, “The staff are absolutely splendid – there is nothing they wouldn’t do.” Another person said, “The care workers are so patient and kind.” This view of the staff was also shared by visiting relatives who praised the staff for their attentiveness and compassion, which they explained extended not just to the person living in the home but to the whole family. One relative told us, “If we need any assistance they’re there to help. If I’m worried I always ask their advice. There is always someone.”

Staff took time to build relationships with people in an individual way. One person had been in discomfort and a member of staff went to see them and asked how this was. The staff member shared a relevant personal experience and they had a giggle together. Another person who did not use words to communicate was upset in a communal area. A member of staff sat and sang gently with them and stayed with them until they had completely relaxed. These relationships were meaningful to people. One person described the importance of these relationships, “(Staff member) regularly pops in to see me – they keep me going.”

People were supported to make choices throughout the day and care reflected this. People were encouraged to choose their food and clothing, what activities they joined and day to day decisions such as when they slept. One person told us that they had discussed the time they wanted to go to bed with staff and this happened. Relatives told us they also felt listened to and were involved in care decisions.

People were clean and well-dressed throughout our visits. Staff spoke to people in ways that reflected their individuality. Some people preferred a more formal communication style and others a more familiar approach. Staff could talk confidently about people’s likes and dislikes and were mostly aware of people’s social histories although care records did not always reflect this knowledge. All staff were respectful of people living in the home, relatives, and each other. This promoted a relaxed and friendly atmosphere.

Care was provided in a way that protected people’s privacy. People’s personal care was managed by staff discretely and staff did not talk about people’s care needs in front of other people.

Good

Is the service responsive?

Our findings

People's care was delivered in a way that met their personal needs and preferences. Staff noted what people told them, for example, one person had said they would like to attend a church service and this had been noted to ensure they were reminded when the next service was held. Staff responded to what people communicated with their actions when they didn't use words. We saw a person who could not settle, was restless and a member of staff found a cushion for them and they settled straight away. People told us that their requests were generally met in a timely manner although three people told us that at busy times this was not always the case.

People's care needs were recorded alongside plans to meet these needs in their records. These plans were being reviewed by nurses and updated at the time of our inspection and some plans in the all the files we reviewed were not up to date. For example one person had 11risk assessments in place of which two had been reviewed in the previous two months. Another person was at risk of falls and there was no care plan covering this. Where records had been kept they evidenced regular review and appropriate care and treatment. For example one person had a pressure sore that was treated over a month. The plan was clear about what staff needed to do and the records evidenced the wound healing in response to effective treatment. Staff acknowledged that care plans were not all in place but told us that they knew what people's needs were. They told us that handovers and verbal communication ensured this was the case. People and relatives described care that was personalised and met their needs. One relative told us, "They are compassionate and take an interest in the residents. Caring as you would a close family member." The compliments book reflected this with comments such as "…could not have received better care". There is a risk that people may receive inappropriate care if records are not accurate and nurses were clear they were trying to find the time to ensure that records were maintained effectively. They had discussed this with managers and had a plan in place to spend time on the records.

The nurses undertook hourly checks on everyone living in the home and this intentional rounding meant that people's changing needs were responded to quickly. Intentional rounding is a nursing method that ensures nurses assess people on a regular and planned basis. At Highclere House Care Home these rounds were done hourly and each round covered basic care needs and comfort and a record was available of what people were offered and care they received at this time. Where people used aids these were regularly checked and we observed that people had all the equipment they needed for mobility, hearing and sight.

Activities were planned for groups and individuals and the activities staff had a strong link with the care staff. This communication meant that people received one to one attention when they needed it and activities could be planned that met people's needs and preferences. Activities included spending time outside in the garden, cooking with involvement from the chef and exercise. The building was newly built and included a cinema and salon for beauty treatments. Group activities also reflected individual preferences. A men's group decided to do some cooking and had cooked a meal that was meaningful to one of the members of the group. This attention to detail reflected a person centred approach to care. People told us they enjoyed the activities and we saw that a person who spent most of their time walking was encouraged to join a baking group and they stayed sitting for the majority of the activity.

Staff had a positive attitude to complaints and mistakes. Staff told us that they would be comfortable identifying a mistake and were certain they would receive guidance and support and a senior member of staff told us: "Every complaint is a learning curve." There had been three complaints received in the last year and two had been dealt with in the time scales outlined by the policy of the home. All three complaints led to learning and action being taken. Relatives and people told us they would be comfortable to talk to staff about any concerns they had. One relative explained this worked well, and told us, "Any glitches are immediately dealt with."

Requires improvement

Is the service well-led?

Our findings

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. For example there were audits and reviews undertaken by senior staff and meetings scheduled to ensure consistency and shared understanding. Staffing was having an impact on the effectiveness of these systems as the deputy manager and clinical lead in the home were spending regular hours each week covering nursing responsibilities. One nurse told us, "If nursing support is needed this is often covered by the clinical lead or deputy." Whilst this meant they had a good knowledge of people's care and treatment needs, it also meant that some management tasks, such as ensuring audits and record reviews, had not been undertaken. Where audits had taken place they were effective in ensuring change. For example, an audit of medicines had led to changes in the system that made it safer. However, some audits had not been undertaken for more than six months including an audit of call bell times. This meant that the potential risks faced by people due to long waiting times had not been identified or investigated. We spoke with the deputy manager who told us they had been unable to print off the call bell times and acknowledged they had not reviewed them. Incident and accident forms had been completed by staff but not reviewed by managers which increased the risks of trends not being identified and responded to. Care records were not consistently reviewed and updated. These concerns were not reflected in the experience of people and relatives during this inspection but they raised risks of unsafe and inappropriate care and treatment if not rectified. We spoke to the deputy manager about this and they identified the current strain on nursing and management time as the reason for these gaps. They were in the process of recruiting new nursing staff to resolve this problem.

The service was held in high esteem by people, relatives and staff. One member of staff said, "I love working here and I'm proud to say I work here." A relative told us, "The home is excellent." There was a defined management structure in the home and all staff knew what their responsibilities were. The last registered manager left the service in December 2014. The service had recruited a new manager who had applied to become the registered manager. The current management team had been in post for less than a year and had been making changes as they developed their understanding of the needs of the service. For example they had recently identified that supervision was not being achieved and had devised a new structure that spread the supervision responsibilities throughout senior staff. This was being implemented at the time of our inspection. The managers were also making changes in response to information put forward by the staff team. Staff had identified that they were struggling to meet care needs in the mornings and this had led to a review of how staff were deployed. Staff told us they were happy with the new rota and felt it meant they were able to meet people's needs more effectively.

Staff felt heard by the management and respected them. One staff member said, "I think they are very good." Another said, "They are a very good team to work for." People and relatives spoke highly of the managers but reflected that they could talk to all staff. One relative said, "There is a community feel."