Humber NHS Foundation Trust

Granville Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 April 2016 and was announced, as it was part of the wider inspection being carried out for Humber NHS Foundation Trust. This is the first inspection under the current registered provider.

The home is registered to provide care and accommodation for up to 20 people who have a profound learning disability. We were told that the service usually accommodated a maximum of 13 people. On the day of the inspection there were 12 people living at the home, including two people who were having respite care. The home is situated in Hornsea, a seaside town in the East Riding of Yorkshire. The home consists of two separate units on the same site, each with a kitchen, lounge / dining area, bathrooms and bedrooms. All of the accommodation is on the ground floor.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at Granville Court.

People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager, unit manager and staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them, including training on the administration of medication. We saw that medicines were stored, recorded and administered safely.

We observed that staff were caring, compassionate and encouraging; it was clear they understood the particular needs of the people they were supporting.

People's nutritional needs had been assessed and people were provided with meals and nutrition that met their individual dietary requirements.

We saw that any complaints made to the home had been thoroughly investigated and that people had been

provided with details of the investigation and outcome. There were also systems in place to seek feedback from people who lived at the home, relatives and staff, and to involve relatives in the running of the home.

Staff, relatives and a health care professional told us that the home was very well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote safety and optimum care to people who lived at the home. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Staff were aware of how to manage any identified risks and had received training on safeguarding adults from abuse.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and different types of meals were provided to make sure people's individual nutritional needs were met.

Records evidenced that people had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

We saw that staff were caring and compassionate and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as

possible, with support from staff.

We saw that staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and staff told us they would support people to make a complaint if they had difficulty in doing so.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was very well managed.

There were opportunities for people who lived at the home, staff and relatives to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Granville Court

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 12 April 2016 and was announced. One adult social care (ASC) inspector carried out this inspection.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities who commissioned a service from the registered provider. The registered provider was not asked to submit a provider information return (PIR) prior to this inspection. 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 the two days of the inspection we spoke with four relatives, two members of staff, the unit manager and the registered manager. We observed staff undertaking day-to-day support with people who lived at the home, and the interaction between people, staff and relatives. We also received feedback from two health care professionals.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, including those for quality assurance, health and safety, staffing levels and medication.

Good

Is the service safe?

Our findings

We asked staff how they kept people safe and they told us that their training on topics such as medication helped them to provide safe care. They said they had a robust training system and good staffing levels. One member of staff said, "We have a good skill set and the rota is always covered" and another told us, "Everything we do is based on keeping people safe; food / fluid intake, the right staffing levels and we have an epilepsy pathway to follow." A health care professional and all of the relatives we spoke with told us that they felt people were safe living at Granville Court.

The unit manager had one system to record accidents, incidents, safeguarding concerns, medication errors and concerns in respect of the control of infection. The registered manager had attended the safeguarding 'threshold' training provided by the local authority. This provided a monitoring system for managers to help them identify which incidents required managing in-house, and which incidents needed to be reported to the safeguarding adult's team. Information about the threshold tool was held in the folder. The recording of any incidents was very thorough and included the action that had been taken such as staff supervision, memos to staff and discussions at team meetings. Any incidents that were relevant to the NHS were reported to the Trust on an NHS Adverse incident report form. We checked the details of the incidents that had occurred since the beginning of 2016 and saw that they had all been checked by the registered manager. When families had raised a concern about an incident, they had received an explanation and an apology. In addition to this, any safeguarding concerns were reported to the Trust in a quarterly report.

Staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was evidenced in the training records we saw. Staff also told us that restraint was never used at the home. Some people had behaviour management plans in place that recorded the behaviours that they might display and how staff should approach the person to manage these situations. One person's care plan recorded, 'When [name] is shouting or appears agitated, follow these guidelines ……..' Care plans also recorded any known 'triggers' that might lead to behaviours that would need to be managed by staff. This meant that all staff were following the same guidance to manage any situations that might arise.

Accidents and incidents were recorded on an accident / incident form or an adverse incident report form, and transferred to an accident and incident report log. The unit manager told us that these were then recorded via the Trust's database and analysed to identify any improvements that needed to be made or patterns that were emerging. We saw that appropriate action was taken following any accidents or incidents, that body maps were used to record injuries and that consideration had been given to how the risk could be reduced. The unit manager told us, "We are striving for honesty; staff are now open about errors and accidents."

People who lived at the home had a generic risk assessment in place; areas covered included epilepsy, gastrostomy care, moving and handling, awareness of danger, pressure ulcer care, mental health, communication, hot weather, using public transport and the use of bed rails. Risk assessments recorded the problem or risk, the assessment of risk and implications and how the risk should be managed. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date.

Some people were not able to verbally communicate that they were in pain or explain to staff when they were distressed. Care plans included a Disability Distress Assessment tool (DisDAT) that recorded 'cues to distress' such as the person's appearance and vocal signs that would indicate whether the person was content or distressed. This helped staff to monitor a person's physical and emotional well-being and also helped staff to make a decision about administering 'as and when required' (PRN) medication.

The home had a 'main' pharmacy provider but also used a local pharmacy to obtain newly prescribed medication 'out of hours'. Medication was provided in the original containers. It was stored in a locked trolley within a locked cupboard. The trolleys were fastened to the wall when not in use and included a separate drawer for each person's medication. Medication that needed to be kept cold was stored in a medication fridge; there was a system in place that recorded the fridge temperature and alerted the relevant team at the Trust if the fridge was not operating at the correct temperature. The temperature of medication cupboards was also checked and this ensured that all medication was stored at the required temperature. The packaging on creams and eye drops was dated when opened to make sure that these medications were not used for longer than recommended.

There was a separate clinical room where food supplements and medical appliances / equipment were stored. The clinical room also contained an emergency 'grab' bag, an 'oxygen' grab bag, empty bottles and containers that were collected by a contractor and medication waiting for disposal. The temperature of the clinical room was checked and recorded each day to make sure medication and food supplements were stored at the correct temperature. The staff nurse on duty checked the stock in the clinical room every night; there was one stock sheet for each person and for each medicine they were prescribed. This helped staff to re-order medications effectively and to dispose of any medicines that were close to being out of date.

The medication room on one unit contained a controlled drugs (CD) cabinet; CDs for both units were stored in this cabinet. CDs are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We checked that the amount of stock held in the CD cabinet matched the records in the CD book and we found that these balanced. The nurse on duty told us that the CD book was checked by a manager every Saturday and we saw evidence of these checks in the CD book.

We checked the medication administration record (MAR) chart folder. There was a photograph of each person living in the unit to aid identification for new and agency staff. Information about people's specific medical needs was recorded along with MAR charts such as individual PEG feeding regimes, epilepsy management plans, bowel care pathways and wound treatment records. We saw that any handwritten entries on MAR charts had been signed by two members of staff. This helps to reduce the risks of errors occurring when information is transcribed from labels on to the MAR chart. We noted that PRN medication was only recorded on MAR charts when it was administered.

Medication audits were being carried out and we saw the audit dated 8 April 2016. We saw that the audit included any areas that required improvement and the action that had been taken. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Unused medication was disposed of by nursing staff apart from CDs, which were destroyed on the premises by the home's pharmacist. The pharmacist recorded this in the CD book, on the stock sheet and on the 'destruction of pharmacy waste' form.

There were separate systems in place to recruit nurses and health care assistants via the NHS and care workers via the local authority. We checked the recruitment records for three members of staff, two NHS employees and one local authority employee. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring

Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that only people who were considered suitable to work with vulnerable adults had been employed at Granville Court.

In total, the service employed 16 NHS staff and 28 local authority staff. On the day of the inspection the unit manager, two nurses, a health care assistant, four care workers in the morning, three care workers in the afternoon / evening and a care worker providing one to one support with someone were seen to be on duty. The unit manager told us that these were the standard staffing levels during the day. The staffing levels on a night were one nurse, one health care assistant, two care workers (one in each unit) plus two care workers for people who required one to one support. In addition to this, the home employed a cook, domestic assistants (from a private company), an activities coordinator and a handyman. This meant that nurses, health care assistants and care workers were able to concentrate on proving care and support to people who lived at the home.

The staff rotas evidenced that staffing levels were consistently maintained and were flexible so the needs of people who lived at the home could be met. Staff told us that staffing levels had improved and that there were enough members of staff on duty. They said that the agency staff who were used were 'regular' staff, which provided some consistency for people who lived at the home. One member of staff added, "It would be good not to have to use agency staff" although they agreed that the agency staff they did use attended the home regularly so were well aware of people's individual needs. Relatives told us that more staff would be beneficial, although one relative said they were very pleased that the home now employed health care assistants. One relative said that the home sometimes "Struggled over the weekends" but they added that staff at the home always tried to use agency staff who knew their relative well. A health care professional told us that there was always a member of staff available to accompany them when they visited people at the home.

Staff from the casual 'bank' and agency staff were used to cover any staff shortfalls due to annual leave and sickness. They took part in team meetings and had supervision meetings with a manager. The unit manager told us that they did 'refuse' some agency staff who they felt did not have the skills to work with the people who lived at the home. The registered manager had produced a report that identified eleven extra staff needed to be recruited to enable the home to cease using agency staff but there had been no outcome so far. The unit manager told us that this was currently being considered by the local authority.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, portable appliances, mobility hoists, the fire alarm system, emergency lighting and fire extinguishers.

The handy person carried out in-house checks on the fire alarm system, emergency lighting and fire extinguishers, and carried out a monthly fire safety inspection. Fire drills were also taking place; this helped to make sure that people who lived and worked at the home understood what action to take in the event of a fire. In addition to this, there was a business continuity plan in place that included emergency contact numbers and guidance for staff on how to deal with emergencies.

We saw that care records included information about visual checks on hoists and slings, wheelchairs and bed rails and that these had been carried out on a regular basis. A health care professional told us that the overhead tracking did break down on occasions and the unit manager told us they were aware of this and that this would be rectified during the forthcoming refurbishment of the premises.

We walked around both units and saw that the premises were being maintained in a clean and hygienic condition. Domestic assistants were employed and we observed them carrying out their duties on both days of the inspection. Their cleaning duties included 'deep cleans' for bedrooms used by people having a respite stay at the home to ensure that the room was clean and hygienic for the next person to be using the room. Night staff also had a cleaning schedule to follow during the night when communal areas of the home were unoccupied.

Tools were used to monitor the prevention and control of infection such as a hand hygiene assessment tool and a C.Difficile data collection tool. C. Difficile is a bacterium that can infect the bowel and cause diarrhoea. The unit manager carried out a cleanliness check each week, and the registered manager completed a quarterly audit. We reviewed the quarterly report that the registered manager completed and noted that this included information about hand hygiene, screening for infections when people returned home from hospital, staff training on the prevention and control of infection, the outcome of the annual environmental audit (including an action plan update) and general cleanliness of the premises. The report noted that one member of staff was wearing nail varnish (which did not meet the Trust's policy and procedure). However, it was also noted that care staff employed by the local authority were not required to abide by the Trust's standards. These kinds of anomalies were regularly identified as a concern at Granville Court. Relatives told us they had always found the home to be clean, but one relative said that it was not always tidy.

Good

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 MCA 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw evidence that best interest meetings had been held to make decisions on behalf of people who lacked capacity to consent such as for the use of bed rails and lap belts, and about the risks associated with people taking a holiday. We saw that one person had 19 best interest decisions recorded in their care plan, which indicated that the unit manager was following the principles of the MCA. Relatives told us that they were appropriately involved in decision making about their family member's care, including best interest decisions. A health care professional told us, "Staff have always acted in the best interests of the residents and their knowledge of clients has been apparent during best interest meetings."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We found that the unit manager and staff displayed a good understanding of their roles and responsibilities regarding MCA and DoLS and promoting people's human rights. Any authorisations in place were being appropriately managed; the unit manager showed us a list of existing authorisations and the dates that applications for renewal needed to be submitted. We noted that when people had a DoLS authorisation in place, these details were recorded in their care plan, including a copy of the related capacity assessment and best interest decision.

People's care plans included a section about consent and recorded, 'Please take into account the five principles of the MCA 2005'. We saw that staff obtained 'implied' consent when they were supporting people throughout the day; they continually checked that people were happy with the care or support being provided. One person's management plan recorded, 'Always ask [name's] permission'.

Staff described to us how they helped people who lived at the home to make day-to-day decisions, such as choosing meals and clothes. Staff said, "We have lots of non-verbal communication; we can tell if someone is unhappy", "We ask some people, use gestures with other people and facial expressions with others", "[Name] can say yes or no so we ask him" and "[Name] has different outfits and we show them to her."

We observed that staff had the skills they needed to carry out their roles. NHS staff were required to attend the Trust's three-day corporate induction training programme, including the healthcare assistants who had been employed via an apprenticeship scheme. Local authority employees (care workers) were recruited via the local authority policies and procedures and attended the local authority induction programme. They were also required to complete the Care Certificate within 12 weeks of their employment. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life. The unit manager was required to send a completed induction programme for new

employees to the local authority training section to evidence new employees had completed the required training. Staff attended regular meetings with the unit manager during their induction period (we saw evidence of this in their personnel records) so their progress could be monitored, and also shadowed experienced staff for a two week period before working as a full team member.

A relative told us, "I have nothing but praise for the nursing staff" and "The nursing care is excellent and staff work well as a team." The registered manager told us that nurses were trained in catheter care, bladder / bowel care and percutaneous endoscopic gastrostomy (PEG) feeding. PEG is a medical procedure in which a tube is passed into a person's stomach through the abdominal wall to provide a means of taking food, fluid and medication when oral intake is not adequate or safe. In addition to this, a decision had been made for nurses to undertake 'verification of an expected death' training and a nurse who we spoke with confirmed they had completed this training. This meant that the nurse on duty at the home could verify expected deaths and that there was no need for the emergency services or GP to be called out to the home. District nurses continued to 'take the lead' on tissue viability and the Speech and Language Therapy (SALT) team provided training from nurses and care staff on dysphagia awareness, communication awareness and intensive interaction.

The training record evidenced which training was considered to be essential by the service, which training was considered to be 'additional' and how often refresher training was required. Essential training included safeguarding adults from abuse, fire safety, food safety, health and safety, medication, data protection, infection control, epilepsy awareness, the MCA and managing challenging behaviour. The registered manager told us that staff training was being reviewed and they had decided that care workers would not attend medication training in future, as they had no responsibility in respect of the administration of medication. We saw that most staff had completed essential training and that some staff had attended additional training such as dementia awareness, autism awareness, basic stroke awareness, end of life care, diabetes awareness, and equality and diversity.

Quarterly training days were arranged and staff were asked to give feedback on how useful they had found the days. Staff told us they had attended a variety of training courses in the last year; these included fire safety, moving and handling, catheter care, data protection and DoLS. Staff also told us that they worked well as a team. One member of staff said, "We are a good team and we want to share good practice with agency staff."

The unit manager told us that they aimed to have supervision meetings with staff every four to six weeks, including agency staff. The registered manager, unit manager and one of the Band 6 nurses (as a development opportunity) supervised the Band 6 nurses, Band 6 nurses supervised Band 5 nurses, who in turn supervised the health care assistants and care workers. The unit manager was supervised by the registered manager. In addition to this, nurses had peer supervision meetings each month and all staff had an annual appraisal. We noted that objectives for the forthcoming year were discussed and set during appraisal meetings. Staff told us they were well supported, both by their colleagues and by the registered manager and unit manager. Comments from staff included, "We are encouraged to speak", "Nurses support each other and we have de-briefs [following any incidents]" and "The team are good 'across the board' and [Name of unit manager] is marvellous."

We observed a staff handover meeting and noted that staff discussed information about people's diet, seizure activity and general well-being; each person who lived at the home was discussed. These meetings ensured that staff were made aware of any changes to a person's care needs, and that they had up to date information about each person who lived at the home. Staff also used a communication book that recorded more general information such as updates about the home's planned refurbishment, people who had

visited the service or were due to visit and any new instructions about people's care.

We saw that some people's care plans referred to best practice, such as guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Nursing (RCN) and information about the administration of Buccal Midazolam, a medication that is used in the treatment of epilepsy. This information helped staff to adhere to good practice guidelines.

Nutritional assessments and risk assessments had been carried out and we saw that advice had been sought from dieticians and speech and language therapists (SALT) when there were concerns in respect of eating and drinking. Some people had food and fluid charts in place and were being weighed on a regular basis as part of nutritional screening. Care plans recorded the equipment people required to enable them to eat independently, such as adapted crockery and cutlery. These arrangements enabled staff to monitor people's nutritional well-being.

We observed the serving of lunch and noted that people were offered clothes protectors to protect their dignity when eating their meal. Tables were set with tablemats that were printed with the person's lunchtime prescription as developed by SALT, plus any equipment they used to assist them to eat and drink and a record of their likes and dislikes. These served as a reminder to staff about the person's specific requirements in respect of food and drink. A health care professional told us, "During mealtimes, choices will be offered and staff will follow the individual's mealtime prescriptions to enable clients to eat and drink safely but also to enhance mealtime enjoyment for the individuals." We saw that individual meals were prepared for people who had specific dietary requirements, including people who received their meals by PEG. People were offered a variety of choices, especially people who were reluctant to eat. When people required assistance to eat their meal, this was provided on a one to one basis by staff, and we saw that people were allowed to eat at their own pace.

Staff told us they would recognise if someone was unwell, even if they could not verbally express this, because they supported the same group of people each day and got to know them very well. They told us that if they felt someone was unwell, they would inform the nurse on duty; the nurse would carry out basic observations using the National Early Warning Score (NEWS) that recorded a person's respiratory rate, blood pressure, body temperature and heart rate, and the nurse would decide if the person needed a GP visit or other medical attention.

We saw that any contact with health care professionals was recorded, including the reason for the contact and the outcome; all of the entries we saw had been signed and dated appropriately. People's records evidenced that advice that had been sought from health care professionals, such as dentists, district nurses, the community learning disability team, chiropodists, occupational therapists and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. Health care professionals confirmed that staff asked for advice appropriately and that their advice was followed. They told us that they also attended multi-disciplinary team (MDT) meetings at the home, when they were able to discuss any issues further. Relatives told us that they were kept informed of important events such as GP visits.

People also had an annual health check undertaken by their GP and this helped to identify any health concerns before they became a serious problem.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that patient passports included detailed information about the person, such as their medical conditions, their

support needs in respect of personal care and with eating and drinking, the mobility equipment they used, details of how their epilepsy presented and how they communicated. Important contact telephone numbers were also included.

There were clear indicators included in care plans to advise staff what action to take if a person became unwell. In addition to this, there was clear information about people's postural management, including photographs to make it clear to staff where any equipment should be placed to improve positioning, to make the person more comfortable and reduce the risk of pressure sores developing.

All accommodation at the home was on the ground floor. We observed that some people spent the day in large specially designed wheelchairs or chairs and that the premises were not large enough to allow space for the equipment and the staff who needed to assist people. Communal rooms, bedrooms and bathrooms all contained less space than was comfortably needed. This was raised by staff and by relatives; a member of staff told us, "Our client group has changed and we have outgrown the building" and another member of staff said, "We need more space but this is the service user's home and they are content here."

Relatives agreed that the premises needed to improve; they mentioned that people needed en-suite bathrooms to promote their privacy and dignity and to enable their individual needs to be met, and that private meeting rooms were needed.

The registered manager told us that an independent review of the service and another service operated by the local authority on the same site had been commissioned by the Clinical Commissioning Group (CCG). As a result, the service was "Out for full procurement via a tender process."

Good

Is the service caring?

Our findings

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient in the way they interacted with people.

Staff told us they were very confident that all staff who worked at the home cared about the people they supported. One member of staff said, "Yes, without a doubt" and another said, "We absolutely dote on them. We are passionate about their care and give attention to every detail." Relatives told us that staff genuinely cared about people who lived at Granville Court. Comments included, "Staff really care; they have some exceptional staff", "You couldn't have better staff" and, "[Name of registered manager] told us she loved our relative and [Name of unit manager] told us it would be an honour to look after them." Two relatives described how the unit manager had improved the service. One relative said, "The service has changed for the better. Staff are more motivated. There are two nurses on duty; there is less tension and staff are more relaxed." One health care professional told us that staff cared about the people who lived at the home, especially the unit manager. They said, "New staff are recruited and they follow the manager's example." Another health care professional said, "Staff genuinely care for the residents who live at Granville Court and always put the client's best interests first."

A health care professional also told us that they could rely on staff to share up to date information with them when they visited people at the home. They said, "All of the staff have a good understanding of all of the service users." Another health care professional told us, "Over the last year the staff team are more consistent. This enables staff members to become familiar with the individuals and understand their likes / dislikes / communication / emotions and health needs."

Staff explained to us how they respected people's privacy and dignity. Their comments included, "We make sure curtains are closed and cover people to protect their modesty, and we make sure bathroom doors are always closed" and "This is someone's home so we knock on the door and we have 'protected' mealtimes." The health care professionals who we spoke with said they felt that the lack of space sometimes compromised people's privacy and dignity. They said, "The home is not big enough. They could do with extra rooms, for example, a quiet room and an activity room." However, they added that staff did the best they could with the space they had.

Relatives told us that the building was outdated and that "Staff do the best they can within the environment." They gave examples of people having to be taken down the corridor in a wheelchair to the bathroom, and houses overlooking bedroom windows. However, they told us that people were always covered to protect their modesty and that windows had been replaced with special glass to prevent people from seeing into bedrooms.

We saw that people's bedrooms had just enough space to enable them to see visitors and health care professionals in private, although there was a lack of space in other areas of the home to hold private meetings and for people to have 'quiet' time.

One relative told us that they were concerned about their family member's forthcoming hospital stay and surgery, as they felt 'mainstream' hospitals did not cater for the needs of people with a profound learning disability. However, they had been reassured by the action taken by the unit manager; they had arranged for staff who were familiar with their family member's needs to be at the hospital over each 24-hour period.

Staff told us that they were able to promote people's independence. They said there were sufficient numbers of staff on duty to allow staff to spend as much time with people as was needed. In addition to this, they had equipment that supported independence. For example, they had plates that were designed to keep food warm, so people could take as long as they needed to eat their meals. One member of staff said, "We are very aware of what people can do. Staff encourage people and persist." They gave us an example of how one person was encouraged to walk by staff when they were sometimes reluctant to do so.

Relatives told us that people were encouraged to be as independent as possible, although one relative felt that their family member had "Regressed a little" since they lived at the home, and that staff could be more proactive in promoting independence.

Information about advocacy was available for people and their relatives. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. One person's care plan included information about a visit they had from an Independent Mental Capacity Advocate (IMCA).

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care plans recorded clear guidelines for staff around when additional support would be required. One person's care plan recorded the different types of seizures they might experience and identified when medical attention would be required. Their care plan also recorded triggers that might lead to seizure activity. When people were having a seizure, we noted that staff were calm and reassuring, and then straight away went to record the time and type of seizure.

Good

Is the service responsive?

Our findings

Relatives told us that they had input into their family member's care needs assessment. We saw that a variety of assessment tools were used such as the Malnutrition Universal Screening Tool (MUST), assessments to check for the suitability of bed rails, an oral health assessment tool and the Waterlow pressure care tool. There was also a learning disability nursing assessment that included details of the person's current nursing and care needs and a list of other professionals who were involved in the person's care. Any risks that were identified during the assessment process were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk.

We saw that information recorded in initial assessments and risk assessments had been incorporated into a care plan. The areas covered in care plans included general health, the management of epilepsy, minimising the risk of pressure sores, maintaining a safe environment, nutrition, meaningful activities, communication and sleep.

An additional care folder included fluid output charts, seizure activity charts, bowel charts, weight charts and abdominal massage charts, plus a copy of the person's activity plan for each day of the week.

It was clear that staff understood the needs of each person who lived at the home. One relative told us, "Staff know how to 'read' [name]. They know his facial expressions." Care plans included either a 'one page profile' or a document called 'This is about me' that recorded information under the headings 'This is how I communicate', 'My daily routine', 'My best day', 'The way I eat and drink' and 'The things I like and don't like'. Care plans also included specific information about people's preferences and needs, such as 'An immersion bath relaxes me' and 'If [name] is not awake by 10:00, staff to gently rouse him returning at five to ten minute intervals until [name] is ready to get up and dressed'. This led to people receiving person-centred care. We observed a senior staff member helping someone to take their medication via percutaneous endoscopic gastrostomy (PEG) feeding. We saw that this staff member had eye contact with the person and used appropriate language and gestures. The person concerned responded appropriately and this led to good interactions and successful administration of medication.

We saw evidence that care plans were reviewed and updated each month. Staff told us that any changes that had been noticed would be added to care plans; this would also be recorded in the communication book with a message to alert staff to read the updated information. More formal reviews had been organised by care managers from either the Trust or the local authority to ensure that the person's current care needs were being met.

A health care professional told us that there had previously been a lack of activities for people who lived at the home. They said that this had been 'taken on board' by the unit manager and that regular activities were now arranged, such as themed days and visits outside of the home. On the first day of the inspection we saw that people went out with staff and there was a musical activity on the second day of the inspection.

Relatives were aware of activities that their family member took part in. One relative told us that staff tried to

look for things that gave their family member pleasure, and they mentioned the recent 'themed' day when activities were based on the anniversary of D-Day. Another relative said that their family member enjoyed one to one attention and they told us about a short break they had taken with the assistance of staff. A third relative told us that their family member had an activity sheet in their bedroom, and they had noted that the activities listed were appropriate for them. We saw other activity sheets and saw they included activities such as audio books, disco and music in the lounge, back massage, bingo, one to one time chatting, TV programmes and a walk along the sea front. Other activities on offer included 'pat' dogs, aromatherapy, visits from the church and 'Music for Health'. One person had their own car and staff used it to take them on visits into the local community.

The unit manager told us that each person who lived at the home had special one to one time with a member of staff; one person had been accompanied to a wrestling event and another had been to see an orchestra.

Staff told us that many family members visited the home and other relatives were kept in touch with events, sometimes via the home's newsletter. Staff were arranging for one person to have a holiday in another area of the country, close to a relative. This would enable very regular visits to take place during the holiday period. Staff also told us they sometimes wrote letters to relatives on behalf of people who lived at the home. Relatives told us they were able to visit the home at any time and that they were made to feel welcome. They said that they were informed about important events that affected their family member, as well as other information about the home. This was sometimes on a one to one basis and sometimes via the home's newsletter. One relative told us, "We visit three times a week so we usually know about things before the newsletter comes out!"

We saw that any concerns, complaints or compliments that had been received by the home were reported on every three months; this enabled any concerns or complaints to be analysed. We checked the complaints log and saw that concerns and complaints had been recorded, including the investigation that had been carried out and the outcome. Investigations included checking care records and supervision meetings with staff to establish the facts and discuss how to avoid the same issues reoccurring. We noted that, when the concern or complaint had been received by a relative, a letter of apology had been sent.

In addition to the home's own complaints procedure, there was a leaflet entitled 'Make your experience count' on display that invited people to share feedback with the local authority.

Staff told us that, if someone raised a concern with them, they would record the details and pass them to the registered manager. They said that the views of people who lived at the home and staff were always listened to. One member of staff told us, "People are listened to; things are open and shared. There would be learning and we would apologise."

Relatives told us they were confident that any concerns or complaints they raised would be listened to by the unit manager and that "She would sort them out straight away." One relative told us about a concern that they had raised and that this had led to their family member receiving what they felt was better care. They said that the unit manager had a good relationship with their family member's GP and this had led to a better understanding of their needs. This had made the relative have more confidence that the care provided was appropriate for their family member's needs.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration and there was a registered manager in post on the day of this inspection; this meant the registered provider was meeting the conditions of their registration.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. The registered manager had submitted notifications in respect of deaths but had not submitted them for some other events. However, none of the incidents we saw recorded in the safeguarding / incident folder were significant and the unit manager had submitted incident reports to the Trust about these events. They assured us that they would also submit notifications to the CQC in future so that we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

We saw that there were clear lines of communication between the registered manager, the unit manager and staff. However, a health care professional told us that, although communication at the home had improved, there was 'room for improvement' in the way nursing staff shared information with care staff.

We asked staff, relatives and health care professionals about the management of the home. Comments from staff included, "The manager is awesome – she has reignited my passion", "[Name of unit manager] leads from the top. She has made a lot of improvements and that has led to us having a good team" and "[Name of unit manager] has made a huge difference. This is a completely different place to when I started to work here." A relative said, "[Name of unit manager] is excellent. There has been a big difference since she took over. Things have changed for the better due to her leadership. Staff are happy; they like and respect her." A health care professional told us that management had improved at the home. They said, "Things have improved under the new manager and staff morale is higher."

The requirements in respect of quality assurance were different within both organisations; this led to numerous quality audits being carried out, with some repetition. We saw that a variety of audits were being carried out by the registered manager and unit manager to monitor the safety of the service and whether the service was meeting people's assessed needs. This included audits for infection control, the environment, staff supervision, medication and privacy and dignity. Records evidenced that the environmental audit had identified that new notice boards were required in the kitchen and wall hooks were required for 'grab' bags. We saw that there was a record of when this work had been completed. The privacy and dignity audit was based on Department of Health guidelines and following the audit, privacy curtains in bathrooms, film on windows and towels with hoods had been introduced. Another audit had been carried out on 'Defensible Documentation' (effective recording) in December 2015. The audit included a summary of the findings, the key areas of learning and the agreed actions. There was evidence to show when actions had been

completed and that the outcome of the audit had been discussed at staff meetings. We also noted that the outcome of audits and when the next audit was due was displayed on the notice boards throughout the home; some of this information was in symbol format to make it easier for some people to understand the information recorded. This showed that the registered provider, managers and staff were continually looking at ways to improve the service provided.

Various methods had been used to gain people's feedback, such as the quality circle, staff meetings, relative meetings and staff memos. We saw that memos were sent to staff to remind them about the home's policies and procedures in respect of the dress code and 'no smoking', the restructuring of the service and the Care Certificate. In addition to this, all staff had been required to complete a quiz on where important documents and equipment were stored such as the fire safety file, information on infection control and safeguarding adults from abuse, the team meeting minutes and the defibrillator. There was a date when all staff had to return the completed quiz to the unit manager.

Relatives confirmed that they were invited to meetings at the home and that they received a regular newsletter. We saw the newsletter dated November / December 2015 and noted that it included information about forthcoming events, staffing, staff training, the quality circle, 'employee of the month' and awards / nominations. The registered manager and unit manager had won an 'Outstanding individuals' award via the Trust, a member of staff had won the 'Rising Star' award and another member of staff had been shortlisted for a 'Compassion in Practice' award. This showed that there were incentives for staff and that staff were encouraged to work towards outstanding practice. The newsletter also included a nomination form for the Granville Court 'employee of the month' award. A member of staff told us, "I'm certain parents feel listened to. If they raise a concern, we listen. If we can't change the situation, we explain why."

There was a quarterly quality circle and we saw the minutes of the meeting held in March 2016. Topics discussed were the external review that had taken place about the service, improvements to the environment, activities, a staffing update and 'You Said We Did'. 'You Said We Did' is when managers and staff give feedback about any issues raised and the work that has taken place to try to resolve them.

Multi-disciplinary team (MDT) meetings took place that were attended by staff from the home plus representatives of SALT, the community learning disability team, an epilepsy nurse and an occupational therapist. We saw the minutes of the meeting held on 5 April 2016 and noted that the topics discussed included best interest decisions, mobility hoists, the quarterly reports and discussions about individuals who used the service. The meeting minutes were stored securely as they included confidential information. Topics for discussion were listed under the headings 'What is working well?' and 'What do we need to improve on?' This showed that professionals involved in a person's care were able to express their opinions and offer advice that could lead to improvements in a person's well-being.

In addition to MDT meetings, other staff meetings were held; these included monthly meetings for the full staff team, meetings for night staff and meetings for nurses. The unit manager told us that there were specific meetings for Band 6 nurses and Band 5 nurses and that they had plans in place to hold meetings for health care assistants. Staff told us they attended staff meetings and that they could raise concerns and issues. One member of staff said, "[Name of unit manager] actively encourages involvement – staff meetings are an open forum" and another told us, "We have monthly staff meetings."

Staff told us that they were confident that any incidents that occurred at the home would be used as learning experiences. They said they would discuss any incidents openly to try to find solutions and to prevent incidents reoccurring. Staff told us they had also introduced a feedback form for service users having respite care; this was introduced so that staff could learn from those people to improve the service

for everyone who used the service. We saw that the survey was in symbol format so that it could be completed by people who had used the service as well as their relatives. When specific issues had been raised, we saw that the unit manager contacted the person who had provided the feedback to try to resolve the issues raised. A relative told us about an incident, (a medication error), that had occurred and how the home had put this right. They said that the unit manager had been "Up front" about this error; she had telephoned the relative to inform them of the incident and this had been followed by a letter to explain the action they had taken to rectify the situation.

We saw the record of compliments that had been received by staff at the home. These included comments from health and social care professionals, such as 'This is one of the best care plans I have seen' and 'It is always a pleasure to visit this home. Record keeping is good and information is accessible. I am always made welcome'. An agency worker had recorded, 'I love working here'.

The unit manager told us that their ethos was 'First Do No Harm or Become Harmful'. We saw a notice that described 'Excellence' and included comments such as, 'We are what we repeatedly do', 'Excellence is not a skill it is an attitude' and 'Every job is a self-portrait of the person who undertakes it'.

We asked staff to describe the culture of the service. One member of staff told us, "It is homely but vibrant" and another said, "We are like a big family – like The Waltons! The building isn't ideal but people get good care in spite of that." A health care professional told us, "It's a pleasure to visit Granville Court" and "The manager and staff recognise that this is someone's home." One relative described the home as "Responsive, generally happy, caring but shabby around the edges" and added "It is now a good place to be." Other relatives said, "People need more private space but the atmosphere of the home is positive and welcoming [especially the nurses]" and "Staff make you feel welcome. They talk and they offer you a cup of tea. They are friendly."

Staff told us they would use the home's whistle blowing policy if needed, and that they were confident the registered manager and unit manager would respect their confidentiality. One staff member said, "Staff would be very confident about whistle blowing" and "Things would be kept confidential."

Meetings had been held with relatives of people who lived at Granville Court to inform them about plans for the re-development of the two units on the site. One relative said that they were told they might be providing one bathroom between two bedrooms, and they felt that individual bathrooms would be more appropriate for the people who lived at the home. Another relative told us, "We were asked in person for our views." This meeting and other information that had been shared with relatives showed that people had been openly consulted about future developments at the home.