Gracewell Healthcare Limited

Gracewell of Fareham

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 25 and 26 November 2015. We found breaches of legal requirements and gave the service an overall rating of inadequate. After the comprehensive inspection, we issued warning notices requiring the provider to take action to meet the requirements of three regulations by 23 March 2016. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check whether the provider had complied with the warning notices and to confirm whether they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the "all reports" link for Gracewell of Fareham on our web site at www.cqc.org.uk. As this inspection did not look at all the areas covered in a comprehensive inspection we have not changed the ratings assigned following the previous inspection.

This focused inspection took place on 4 and 5 May 2016. It was unannounced.

The previous comprehensive inspection found the provider was not meeting the requirements of regulations concerning care and treatment that met people's needs and preferences, protecting people at risk from abuse and improper treatment, and maintaining proper records. This inspection found that improvements had been made with respect to all three regulations. The provider was meeting the requirements of regulations concerning protecting people from abuse and improper treatment. However they needed to show further sustained improvement to fully meet the requirements of the other regulations.

The service is registered to provide accommodation, nursing and personal care services for up to 89 older people and people who may be living with dementia or a physical disability. At the time of this inspection there were 69 people living at Gracewell of Fareham. They were accommodated in a purpose built building consisting of three floors and six bungalows for people with greater independence. The ground floor accommodation was intended for people with less complex needs, people living with dementia were supported on the first floor and the second floor accommodated people with other, more complex nursing needs. Each floor was divided into two named wings. Each wing had a shared sitting and dining area and each floor had a larger, central shared area. The ground floor had a hair dressing salon and cafeteria area.

The service had been without a registered manager since January 2015. 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. Since October 2015 the provider had appointed interim home managers who were registered for other locations.

The provider had put in place new systems to protect people from avoidable harm, including new wound and bruising records and new accident and incident reporting forms. Staff followed these new procedures,

and there was evidence concerns were followed up and reported to the relevant authorities.

The provider had reduced their dependency on agency staff and established new, nurse-led teams to make sure people received care and treatment that met their needs and took into account their preferences. They had audited and rewritten people's care plans which were reviewed and assessed monthly to make sure people's care was in line with their assessments and changing needs. In most cases people received appropriate care and treatment, but there were still concerns about people who were at risk of not drinking enough fluids, people who were prescribed "as required" creams, and people who needed support to reposition themselves regularly to prevent pressure injuries.

The provider had taken steps to improve records relating to people's care and treatment and to the employment of staff complied with the regulations. All the required recruitment records were in place. Care records were individual, thorough, detailed and contained information staff needed to support people to meet their needs and respect their preferences. However, some people were at risk of inappropriate support or treatment because their records were inconsistent or not fully completed.

We identified two continuing breaches of the Health and Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we told the provider to take at the end 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?

Inspected but not rated

People were protected against the risk of avoidable harm or abuse because staff followed procedures to report, investigate and follow up concerns.

Is the service responsive?

Inspected but not rated

People with prescribed creams, and people at risk of pressure injuries or poor fluid intake did not always benefit from support and treatment that met their needs.

Otherwise we found people's care, support and treatment was delivered in line with care plans that took into account their needs, preferences and wishes.

Is the service well-led?

Inspected but not rated

People's care records were not always consistent and fully completed, although the provider had taken steps to make care plans more thorough, detailed and individual to the person.

People did not benefit from continuity and consistency with regard to the management and leadership of the home.

The provider had not been displaying their ratings as required by regulations.

The provider maintained the required records in relation to the employment of staff.

Gracewell of Fareham

Detailed findings

Background to this inspection

We undertook this unannounced focused inspection of Gracewell of Fareham on 4 and 5 May 2016. The purpose of this inspection was to check that improvements to meet legal requirements required by warning notices issued after our comprehensive inspection on 25 and 26 November 2015 had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, responsive and well led? This was because the service was not meeting some legal requirements in these three areas.

A team consisting of two inspectors and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. During the inspection we spoke with eight people who lived at Gracewell of Fareham and four visitors. We observed the care and support people received in the shared areas of the home

We spoke with the provider's director of operations, the interim home manager, a consultant manager, and other members of staff including nurses and care assistants.

We looked at the care plans and associated records of nine people. We reviewed other records, including internal checks and audits, training and supervision records, and action plans. We looked at the recruitment records for five staff members.

Before the inspection we reviewed information we had about the service, including previous inspection reports, action plans and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law.

Inspected but not rated

Is the service safe?

Our findings

After our comprehensive inspection at Gracewell of Fareham on 25 and 26 November 2015 we issued a warning notice because the provider was not meeting Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management system in place did not make sure that staff followed the provider's safeguarding procedures when people were at risk of abuse or improper treatment. We found four examples where staff had noted and photographed unexplained bruising, but there had been no incident report, investigation, follow up or referral to the local authority safeguarding team.

At this inspection we found that improvements had been made and the provider was no longer in breach of the regulation. People we spoke with were happy they were living in a safe environment.

The provider had introduced a new procedure for identifying and monitoring wounds and bruising. People's care plans contained a record which listed wounds and bruises with the date they were noted, a description of the wound, the cause where this was known, and the date the wound healed. These records were signed by staff members. Staff had access to a camera to make a photographic record of new wounds and bruises. Where appropriate, people's care plans included wound management plans to direct staff how to deal with the wound and steps to take to encourage healing. The home manager included statistics on wounds in their weekly report to the provider.

The provider had introduced a new procedure and form for recording accidents and incidents. These were in use and showed that staff were making records of untoward events. Such events were followed up, investigated and lessons learned. Where appropriate these lessons led to changes in the person's care plans, for instance to reduce the risk of falls in future. The home manager included statistics on accidents and incidents in their weekly report to the provider.

All nurses employed at Gracewell of Fareham had received training in skin integrity and root cause analysis. This training was intended to improve the management and reporting of wounds and other accidents.

The interim home manager told us staff morale and confidence had improved, and as a consequence staff were more ready to raise any concerns they had. The consultant manager had a meeting twice a week with nurses to discuss safeguarding concerns. They had also met with the local safeguarding authority to establish procedures for investigating safeguarding concerns. Three investigations were in progress at the time of our inspection.

The interim home manager told us all safeguarding incidents were reported to the local authority and to us. We had received eight notifications of incidents since the last inspection which referred to six individual incidents. The notifications showed the provider had taken appropriate action and notified the local authority in all cases.

Inspected but not rated

Is the service responsive?

Our findings

After our comprehensive inspection at Gracewell of Fareham on 25 and 26 November 2015 we issued a warning notice because the provider was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management system in place did not make sure people's care plans were reviewed and changed when their conditions or needs changed. We found four examples where significant changes in or aspects of people's needs had been recorded in their daily notes, but this had not been followed by appropriate changes to their care plans.

At this inspection we found that improvements had been made, however further improvements were needed to meet all the requirements of the regulation.

People we spoke with told us their care and treatment met their needs and took into account their preferences and wishes. One person told us they were supported to have a shower every evening which was their preference. Another person told us they were supported to take pain killing medicines regularly. They said, "Staff sort out my tablets for me. I can't open the bottles and packaging is difficult." Another person who said they needed "a lot of assistance" with their personal care and daily activities was satisfied their needs were met and their preferences respected. They said, "The care staff are nice and help me."

A visitor told us they were involved in their partner's care planning because they could not always express their own needs and preferences. The visitor said their partner received "individualised care", they could consult other healthcare professionals, and facilities such as a wet room and a low rise bed were available to help staff meet their needs.

The provider had identified that a root cause of the problems we saw at the previous inspection of people receiving care that did not meet their needs was poor continuity and consistency of staffing. Since the previous inspection they had recruited more permanent staff. This had reduced their dependency on agency staff. The provider had recruited a full team of qualified nurses and established new nurse-led teams. We found both nursing and care staff to be open, confident and informed about people's care and needs.

Qualified nurses had all received training in care planning. People's care plans had been audited and rewritten since our previous inspection. They were reviewed monthly by the qualified nurses and a sample was audited each month by the provider's regional head of care and nursing. Each floor had a "resident of the day" whose care plan was checked against their needs and preferences on that day. This meant systems had been put in place to verify that people's care and treatment met their changing needs.

People's care plans we looked at were detailed and organised in a consistent way, which meant staff would be able to find information about people's care more easily. The plans contained records which showed that people's dependency assessments, risk assessments and care plans were reviewed monthly and updated if necessary.

Care plans were in place to manage people's conditions and meet their assessed needs. For instance where

a person was identified at risk of choking, their nutrition care plan was checked and amended every month. Another person who was at risk of poor nutrition had their weight checked every month. Their care plan review noted where there was a small weight gain, or loss, each month. Where people were prescribed medicines for specific conditions, this was reflected in their medicines care plan. During our inspection we observed that staff offered people pain relief if they appeared to be in pain.

Changes to people's needs and conditions were noted and reflected in their care plans. One person had developed a small, low grade pressure injury. There was a "wound dressing care plan" in place for them. Another person's risk of falls had increased and their care plan was updated with measures to reduce the likelihood or impact of falls. Another person's medicines care plan was changed following a review of their prescribed medicines by their GP.

Although improvements had been made with the result that more people's care met their changing needs, we still found examples where we could not be certain people had received appropriate care. In two cases we found records of creams and ointments applied did not reflect the care plan instructions. We noted that the provider's own checks and audits had identified concerns about the recording of topical medicines in March and April 2016. We discussed this with the interim home manager and consultant manager. They were aware of problems with the recording of topical medicines prescribed "as required". The provider's procedures stated if these were offered but declined, staff should record this as "NR" for not required on the medicine record. Staff did not always do this, and blank records meant it was not clear that the medicine had been offered but declined by the person. This meant we could not be certain people always had their creams applied if they felt they needed them.

Where people's skin integrity care plan showed they should be supported to reposition themselves regularly, their records did not always show this was done. Staff used "intentional rounding" charts to record regular activities to support people. These charts for two people whose care plans said they should be repositioned every two or three hours actually showed they had spent most of the day in the same position, either sat in bed, or sat in their chair. The consultant manager told us these were due to "coding errors" on people's records. These people were at increased risk of skin breakdown because it could not be shown staff were following their repositioning regime.

Where people were at risk of poor fluid intake, the associated records were inconsistently completed. They were not adapted to the person's individual needs, but relied on a standard, average minimum and target intake. Of a sample of 21 records, 11 had not been totalled so it was not clear whether staff had responded to the person's inadequate intake not. One person on three consecutive days was recorded as drinking 520ml, 600ml and 800ml compared with a recorded minimum intake of 1500ml per day. Their daily totals were not recorded, and there were no actions recorded to respond to the low intake. These people were at risk of dehydration because their fluid intake was not monitored effectively.

Failure to make sure that people's care and treatment was appropriate and met their needs was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service well-led?

Our findings

After our comprehensive inspection at Gracewell of Fareham on 25 and 26 November 2015 we issued a warning notice because the provider was not meeting the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management system in place did not make sure that accurate and up to date records were maintained with respect to people's care and treatment and to the recruitment and employment of staff.

At this inspection we found that improvements had been made, however further improvements were needed to fully meet all the requirements of the regulation.

People we spoke with gave us mixed views of their involvement in making sure their care plans and other records were accurate and reflected their wishes and preferences. One person said they did not know about their care plan, but staff had talked to them about their care and what they would like to happen if it was possible. Another person told us they had been involved in a review of their care plan during the previous week. They said, "The carer asked me the same questions as when I came in."

People's care plans were detailed and thorough, and contained records which showed they were reviewed and updated regularly. They contained information about the person's background, life history and preferences. The interim home manager told us all care records had been audited and rewritten since our last inspection. There were systems in place for the review and audit of care plans by staff and by the provider's regional head of care and nursing.

However we found examples of inconsistent information in the care plans. One person had a "do not attempt to resuscitate" form which stated the decision had not been discussed with the person or their family because the person "lacks capacity and does not have a welfare attorney". Elsewhere in the plan there were records to show the person's daughter had a lasting power of attorney. It was not clear from the records that the decision not to resuscitate had followed a proper best interests process to protect the person's rights.

Another person's skin integrity care plan stated they should be turned or repositioned every two hours. Their night care plan originally read that they should be repositioned every two to three hours. This had been amended to read "three hours" but the change had not been initialled or signed. This person was at risk of inappropriate care because their records were inconsistent and had been changed without adequate oversight and control.

A third person's prescribed medicines had changed. They had been prescribed co-codamol to replace paracetamol as their "as required" pain relief. Guidance in the care plan stated that other products containing paracetamol should not be given with co-codamol. This change had not been reflected in all the relevant records in their file. There was still a protocol for "as required" paracetamol in place, and their medicines profile still referred to paracetamol. The provider had notified us of four errors in administering medicines in the previous five months. They had taken and were taking action where errors occurred. This

person was at risk of receiving the wrong medicines because their records were not consistent. However the risk was low because records showed there was no paracetamol in stock for this person.

Records of the care and support people received were not always completed. Daily logs were in place to record this, and other records were in place where appropriate, such as a pain diary for a person who was recovering from a broken hip. "Intentional rounding" charts were in place to record regular checks on people, including skin checks, repositioning, continence, nutrition, personal hygiene and falls prevention measures. These were completed and signed by the nurse in charge. We found two people's "intentional rounding charts" did not show they were supported to reposition themselves according to their care plan. The consultant manager told us this was due to "coding errors" in their records.

There were examples of records for the administration of topical medicines which were not filled in properly, and records of fluid intake which were partially completed. One person had a recovery care plan following an operation on their hip. This included "gentle exercises". There was no reference to these exercises in the person's daily logs or other records. A nurse described how they supported the person with exercises and explained that the person was sometimes reluctant to do them. This person did not have an accurate record of the care and support they received.

Failure to maintain accurate and complete records of people's care and treatment and of decisions taken in respect of their care and treatment was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2015 we found the provider was not maintaining records required by the regulations with respect to staff employed at Gracewell of Fareham. In particular certain records of checks made that people were suitable to work in a care setting were missing from employee files.

Since November the provider had reviewed all employee files and identified where records were missing. Where possible these records had been obtained retrospectively. Where this was not possible there was a note from the home manager explaining what had been done. For instance, where there was no contemporaneous record to show that an employee had completed their probationary period, there was a note referring to their subsequent conduct and performance.

The staff records we checked contained all the records required by regulations. They included proof of identity, photo ID, a record of previous employment with explanations for any gaps in employment, and evidence of satisfactory conduct form previous employers and character references. The records included evidence that Disclosure and Barring Service (DBS) checks had been made. These checks identify if applicants for jobs had a criminal record or were barred from working with children or people who are vulnerable as a result of their circumstances. There was evidence that qualified nurses' registration with the Nursing and Midwifery Council was up to date. Records were in place to show applicants had declared any medical reason they could not carry out the duties required of them.

There had been no registered manager for Gracewell of Fareham since January 2015. Since October 2015 the provider had taken steps to make sure the home was managed by a suitably qualified manager who had been registered elsewhere. However they had not completed an application to register for Gracewell of Fareham.

The previous home manager had resigned in March 2016 and had worked until the week before our inspection. The interim home manager at the time of our inspection had been registered for another location but not for Gracewell of Fareham. They were the seventh home manager in three and a half years

which meant people were not benefiting from consistent leadership. The provider was actively recruiting a new, permanent home manager with the intention they would register with us. We asked the provider to keep us informed about the progress of this recruitment.

When we started the inspection on 4 May 2016, the provider had not displayed their ratings from the previous inspection as required by Regulation 20A of the Health and Social Care Act 2008 (regulated Activities) 2014. We pointed this out to the home manager who arranged for the ratings to be displayed by 5 May 2016.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of service users did not always meet their needs. Regulation 9 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) and (2) (c)