Gracewell Healthcare Limited

Gracewell of Edgbaston

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection at this home on 7 and 8 June 2017. Gracewell of Edgbaston provides nursing care and accommodation for up to 70 people many of whom are living with dementia. There were 37 people living at the home at the time of the inspection 11 of whom were receiving short term care.

We carried out a comprehensive inspection in April 2016 where we found that the service required improvement and that the provider had not met legal requirements in relation to the safety of care provided, providing personalised care and the governance of the home. We last inspected the service in November 2016 where we carried out a focussed inspection to check whether these legal requirements had been met. At that inspection we found that the provider had followed their action plan and was no longer breaching regulation. However further improvements were still required.

The service has a registered manager who was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had been a number of management changes at the service since it opened in April 2015.

People told us they felt safe living at the home. People were supported by staff who had been safely recruited. People reported that they didn't think there were always enough staff available to support them.

People had the risks associated with their care identified by the home and steps had been put in place to reduce these risks. We found that monitoring of risks needed further improvement.

People were happy with the support they received with medicines. Improvements had been made to the supply of medicines to the home.

Staff informed us they had received sufficient training for their role and we saw there were systems in place to ensure staff knowledge was kept up to date.

People were involved in making choices about their care and staff ensured they sought consent from people before supporting them. Staff were able to tell us how they ensured people's rights were respected under the Mental Capacity Act (2005).

People had their individual dietary needs met and were offered choices at meal times. People received regular access to healthcare support.

Some people living at the home were living with dementia. Whilst we saw some evidence of good practice in this area, further work was needed to ensure people had consistent access to aids that would support

decision making.

People living at the home told us they felt cared for. The home was now fully recruited and new staff were in the process of getting to know the people living at the home. People were treated with dignity and were encouraged to remain independent.

We noted that the majority of care plans had been completed with people and their relatives. Other people had their reviews booked with staff to take place in the near future. Improvements had been made to the provision of activities on a group basis although further improvements were needed to ensure all people living at the home had access to activities.

People told us they were aware of and would feel able to make a complaint should they wish. We saw that the processes in place for managing complaints were not entirely robust.

Staff felt supported in their roles and told us how team work had aided this sense of feeling supported. There were systems in place to monitor the quality and safety of the service although we found they were not consistently effective. People were not sure who the manager of the service was.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not be sure that pressure areas to their skin would be protected well.

People could not be sure of their safety in the event of a fire.

People were happy with the support they received with their medicines and systems around medicine management continued to be improved.

People were supported by staff who understood how to recognise signs of abuse and action they would take to safeguard people living at the home.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received sufficient training to carry out their roles.

People were involved in making choices about their day to day care and were supported in line with the MCA.

People received support from healthcare professionals.

People's individual dietary needs were catered for.

Is the service caring?

Good

The service was caring.

People felt cared for by the staff team.

A more stable staff team was now recruited who were getting to know the people living at the home.

People had their dignity and privacy respected and independence promoted.

Is the service responsive?

Good

The service was responsive.

People's views and opinions were gained and staff respected people's wishes and choices.

Care records were reviewed.

There was a complaints system that people knew about.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of the service provided to people.

There were some systems in place to enable people to provide feedback about the service.

Staff felt supported in their roles.

Gracewell of Edgbaston

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 checked 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 unannounced inspection took place on the 7 and 8 June 2017. On the 7 June the inspection team consisted of two inspectors, a specialist advisor who has clinical knowledge of the needs of the people who used this type of service and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the 8 June one inspector continued with the inspection.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to plan the areas we wanted to focus our inspection on. We had received feedback from the local clinical commissioning group including their medicines team, the people who commission services from the provider and health watch. We used this feedback to help plan our inspection. The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We visited the home and met with some of the people who lived there. Some of the people living at the home were not able to speak to us due to their health conditions and communication needs. We spent time in communal areas observing how care was delivered and we 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.

As part of the inspection we spoke with nine people and six relatives. We also spoke with the nominated individual, director of operations, the head of care, the registered manager, the deputy manager, two nurses, six staff and the chef. We looked at records including the sampling of seven people's care plans. In addition we spoke with three healthcare professionals. We looked at two staff files to review the provider's

recruitment process. We sampled records from staff training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

We found that where people had developed pressure areas on their skin, action had been taken to monitor these areas regularly to ensure they did not worsen. Whilst steps had been taken to use equipment to reduce the risk of sore skin full assessments had not been carried out to determine the correct use of the equipment and therefore there was a risk that the equipment could further compromise the person's sore skin. We saw that one person had developed bruises although we noted there was not always clear analysis or recording of why this had happened. We raised these issues with the registered manager who took immediate steps to address the specific issues. They also assured us that additional training would occur with staff to enable them to understand the importance of monitoring people's risks.

We spoke with staff about how they would support people in the event of a fire. Although staff were aware of the general fire procedure they were unclear about the action they would take to support individual people to evacuate. We saw that individual evacuation plans had been developed which contained detail of the equipment people needed to support them to leave the building safely. People had not been assessed as safe to use this equipment and the equipment stated in some people's records would not have been suitable for them to use. Some people had recently moved floors within the home. Consideration had not been given to how their needs in relation to fire safety had changed as they were in a different place in building. The registered manager agreed that further detail and assessments were needed in relation to people's evacuation plans and assured us this would be rectified.

The local team from the clinical commissioning group (CCG) had been working alongside the service for a number of months to support them in issues that had arisen with the supply of medicines at the home. These were in large part due to concerns arising from the previous pharmacy supplier. We spoke with a health professional who had been working with the service who informed us that improvements had been made. Tighter processes had been developed around the management of boxed medicines and in checking medicine administration more regularly. We were informed that another different pharmacy was due to commence supplying medicines to the home. We were advised that a new system would be established to include other staff in taking responsibility for the ordering and booking in of medicines.

Although some people that we spoke with did not think there were always enough staff available, we found that staff met people's needs in a timely manner. One person told us, "They seem a bit short of staff at times." During our inspection however we found that staff were available to meet people's needs. Although we observed that staff were always available in communal areas of one floor of the home, the registered manager may need to consider the deployment of staff to ensure staff are always available to people. Staff we spoke with told us that generally there were enough staff working at the home although one staff member informed us they felt there was not enough staff at night time. The service had recently opened another floor of the building and was in the process of increasing staffing levels at night. We spoke with the registered manager who informed us that staffing levels were based on the dependency of the people living at the home and that as people's needs changed the staffing levels would be increased.

We looked at how the service ensured people were supported safely where risks had been identified with

their care. We found that risks to people had been identified and in the most part steps had been put in place to minimise the risk for the person. Where people needed support to move around the home we saw there was guidance available for staff about the equipment people needed to do this safely. Where accidents had occurred initial checks on the person's well-being were carried out. Following this further analysis of the cause of the accident took place and any accidents that had occurred were monitored on a monthly basis to look for trends which could reduce the risk of re-occurrence.

Where people had been identified as at risk of losing weight additional supplements had been recommended to be used to reduce the risk of further weight loss. Where these had been prescribed by the persons' GP they were being given and recorded appropriately. Where other drinks, known as 'build up shakes', had been included in the persons care plan, we noted these were part of people's fortified diet that the home provided.

People that we spoke with told us they felt safe living at the home. One person we spoke with told us, "I feel safe here and I have my own room key which I like." Another person commented, "I do feel safe, you can always approach the girls and talk to someone if you need to."

Staff told us about the recruitment checks that had been undertaken before they were able to support people living at the home. The systems in place for the recruitment of new staff included obtaining an up to date Disclosure and Barring Service check before staff worked with people. In addition the suitability of staff had been checked by obtaining references from previous employers. Where nurses were employed, checks had been made on the registration of nurses working at the service to make sure that their registration was current. These systems ensured people were supported by staff who were safe and suitable to do so.

Staff we spoke with had a good knowledge about the different signs of abuse and described appropriate action they would take should they have concerns. Staff explained that their knowledge of safeguarding people had been gained through training they had received. Records we viewed confirmed that staff had received this training. The registered manager was aware of their responsibilities to safeguard people from harm and knew the appropriate agencies to report any concerns to. The registered manager informed us of further planned developments in this area where reflective practice would occur following safeguarding incidents to promote learning and to reduce the chance of a similar incident occurring.

People told us they were happy with the support they received with their medicines and one person told us, "They are good with my tablets and always give them on time." The service had ensured that only staff who had received training in safe medicine management were able to give medicines and that staff's competency to do this safely had been checked. Checking staffs competencies is a way of ensuring staff have the skills to carry out medicine administration safely. We observed staff supporting people with their medicines in a kind and relaxed manner and staff took time to wait until the person was ready before offering further medicines. A review of medicine records confirmed that medicines had been given as prescribed. People had received their medicines safely.

Good

Is the service effective?

Our findings

People were supported by staff whom they felt could meet their needs. One person we spoke with told us, "I have the help I need. I do think the staff know me." Another person told us, "We are very well looked after." A relative we spoke with commented, "They all make a tremendous effort to cater for all of her needs which are quite specialised."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People told us they were offered choices in their care and one person commented, "I can get up and go to bed when I want. There is no pressure from anyone." Staff had a good understanding of the MCA and informed us that they offered and promoted people's choice and were able to describe how they worked in people's best interests. One staff member told us, "We ask her about every aspect of her care." Another member of staff described their knowledge of the MCA as, "Presume people have capacity until proven outright and support people with decision making." We saw staff asking people for consent before supporting people with meals and with taking their medicines.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Applications had been made for a DoLS where restrictions on people's care had been identified in order to keep them safe. The service was in the process of developing systems to ensure any approved DoLS applications were renewed when required to ensure people's right to freedom was being respected.

People were supported by staff who had received the necessary training to meet their needs. Staff informed us about the induction they had received when they first started working at the service to prepare them for their role at the home. This induction period included essential training and working alongside a more experienced member of staff to enable the new member of staff to get to know the people living at the home. All staff were in the process of completing the care certificate which is a nationally recognised induction course which aims to provide untrained staff with a general understanding of how to meet the needs of people who use care services. There were systems in place to ensure training was completed by all staff and that staff received updates to ensure their knowledge was kept up to date. Staff informed us they received the opportunity for supervisions where further guidance was given around certain themes which most recently had been safeguarding.

Some people at the home were living with dementia and the service had dedicated one floor of the home to provide care to people living with dementia. The service had access to a dementia lead who was available for advice and guidance about people's specific needs. We saw staff supporting people living with this

condition with confidence and care. We saw one person had been supported to use doll therapy to help them with expressing themselves. Staff were respectful to the meaning the doll had for the person and consistently referred to the doll as requested by the person and ensured the person had access to this at all times. Although this was a positive use of an aid for this person we were informed by some staff that there were no further resources to support people living with dementia or aids to support people's communication. One staff member we spoke with gave an example of the benefit communication aids would have for one person's decision making. The registered manager informed us that some communication aids were available and that staff would be reminded of the availability of these.

People had access to routine healthcare and one person told us, "If I need to see a GP or optician, I just ask them and they will arrange it for me depending on the urgency." We saw evidence that the service had ensured healthcare professionals were involved in people's care. One healthcare professional that we spoke with told us, "I think people get a good quality of care here, they look after them well." Another healthcare professional told us that staff followed their directions and worked to increase people's independence.

We saw that meal times were an opportunity for people to socialise should they wish to. People had the option of two main meals a day and we saw staff take time to explain the choices of meals to people with patience. We were informed of different ways the service had thought of to enable people to make choices with their meals although we observed this did not always happen in practice. Although some people had the opportunity for drinks and snacks at different times during the day two people told us they did not routinely get offered snacks and had to request these from staff. In addition we saw that drinks stations situated around the home did not always have cups available to support people to help themselves to have a drink should they wish to.

People's preferences for food and any specific dietary requirements had been documented and shared with the chef. One relative told us, "The kitchen in particular have been excellent with helping to find suitable and enjoyable options for her meals as she has swallowing issues." Systems had been developed to ensure the chef's and staff at the home had key information about people's allergies to food and the specific way some people's food needed to be prepared. We spoke with the chef who was aware of the people who needed their food prepared in a specific way and was able to explain how to do this. These systems ensured people received food that was based on their preferences and that was safe for them to eat.

Good

Is the service caring?

Our findings

People that we spoke with told us they felt cared for. One person we spoke with told us, "I feel that the staff do know me and they always give me time." Another person told us, "The staff are very nice and they can't do enough for you." A further person told us, "The care is good, the staff are nice and they look after me well." Relatives described the staff as caring and one relative told us "The care is good." A healthcare professional we spoke with told us, "I think this is a good home and people are safe and happy. The staff are really nice to people."

There had been a high staff turnover at the service within the last twelve months. We were informed that staffing levels were now stabilising and that all permanent posts had been recruited to. Staff we spoke with were working hard at getting to know the people living at the home and some staff who had worked at the home for a longer length of time had got to know people's likes and dislikes and family histories well. One staff member told us, "We get to know what people want by asking them informally." The service had introduced staff teams who were based on each floor of the service. These staff teams would remain working on the same floor and this aided staff in getting to know the people living at the home.

Staff that we spoke with enjoyed their role of supporting people at the home and we observed many kind, caring interactions between the staff and people. We observed staff offering reassurance when people were upset or when they had got confused and we saw staff respecting people's wishes for their care. One staff member told us the best part of their job was, "Residents. They make my day better by their stories and it is nice they know my name." Another staff member told us, "It's an honour to serve people….and have a laugh together with the residents. The residents want to see your personality so remember to smile." Another member of staff told us, "My team is good, they do care about the residents."

People were supported to maintain contact with those who were important to them. We saw a regular flow of visitors at the home and relatives we spoke with informed us there were no restrictions on when they could visit.

People were cared for with dignity and respect and one person we spoke with told us, "Everyone is always respectful." We saw that care had been taken to ensure people's well-being was promoted through their appearance. People were dressed appropriately, in clean clothing and had the opportunity to have their hair styled at the on-site hairdressers. Staff told us how they respected people's privacy and ensured people preserved their dignity during personal care. One staff member told us, "I always respect people, we ask people before we do personal care, we never force people. I'd always close the door." Staff informed us how they promoted people's independence by prompting people to carry out as much personal care for themselves and one person we spoke with told us, "They very much respect my independence, yes, and allow me to do things for myself."

Good

Is the service responsive?

Our findings

Our observations during the inspection showed that staff were responsive to people's requests for support. For example, we saw staff responding promptly to people's requests for support to move around the building. However we were informed by a relative of how the service had not been responsive to one person's request, which had been raised some weeks before the inspection, to have a different method of calling for assistance. We brought this to the attention of the registered manager who resolved this on the day of the inspection.

Although we saw evidence that records were reviewed, reviews with people living at the service had not occurred on a regular basis and some relatives, who anticipated that they would be involved, informed us they had not been involved in reviews of care. We noted that some people living at the service were there for short periods of time and therefore they and their relatives may not have had time to be involved in care plan reviews.

At our last comprehensive inspection we had identified that the activities available to people needed to improve. At this inspection we found that some improvements had been made and some people we spoke with were happy with the provision of activities at the home. One person told us, "There are always activities going on, they produce a weekly programme." Another person said, "Yes I do activities. I enjoy it when I join in with things." One relative told us, "They try hard with activities; in fact they are very good." The service had recruited an activities co-ordinator who had formulated a group activity schedule for weekdays. These group activities were based on people's interests and people were able to feedback whether they had enjoyed the activity or not or make suggestions for different activities. Plans were in place to further improve the activities on offer by forging links with the local community.

Activities for people to join in if they wished had improved and people told us they enjoyed the activities that were available to them. During the inspection we saw that staff engaged in a meaningful way with people in the communal areas and supported them well to enjoy the activity.

People were informed of the complaints procedure when they first moved into the home and one person told us, "If I had a problem I do feel I could tell someone." Another person told us, "I haven't needed to complain but I would go to the top if I did." We found that the service had a complaints process that people knew about.

Good

Is the service well-led?

Our findings

There has been a number of management changes since the home opened in April 2015. Since this time five registered managers have been in post. At this inspection we were informed that another new manager had been appointed who was due to start managing the service at the end of August 2017.

There were systems to monitor the quality of the service although we found they had not always been effective in monitoring all aspects of the service. Checks were not always effective in identifying where complaints processes were either incomplete or that outcomes could be used for learning. We found that there was further detail needed in the recording of complaints and in the details of how investigations had been carried out. Although complaints had been monitored on a monthly basis, no consideration to the learning that could take place across the organisation had happened. There was no detail noted about whether the person was satisfied with the outcome of the complaint. The registered manager completed regular audits of key areas of the service which were sent to a representative of the provider for analysis and monitoring. These audits had not identified these issues.

Some people knew who the manager of the service was whilst others didn't. People's comments included, "I think it is managed well. I would know the manager if I saw her, you do see her sometimes but she doesn't really talk to you." Another person said, "There are lots of managers but they don't talk to me." Relative's we spoke with told us how the service was improving and that communication was getting better.

Whilst some staff reported that the changes in management had been unsettling other staff were positive about the changes that were occurring at the home. One staff member told us, "Presently the home is being well-led. Things really are getting better, really improving. Everyone is so passionate about getting things right." Staff felt supported by the deputy manager of the home and one staff member told us, "The deputy is good and she listens to you." Another member of staff told us, "I think I could approach the management with concerns. The deputy manager definitely comes and asks us every day." A further staff member told us, "I'm very supported by the managers." Staff described the benefit that team work had on their own sense of being supported.

Staff meetings occurred monthly. Although some staff felt able to make suggestions other staff felt that feedback given was not always acted on.

The provider had ensured consistent oversight of the home was occurring with the director of operations and head of care visiting the service regularly. In addition regular phone calls were taking place between the management teams to monitor the service.

The registered manager was aware of their responsibilities to the commission and had ensured we had been notified of certain events that had occurred at the service. Additionally the registered manager had ensured that the most recent inspection rating was displayed both at the home and on the provider's website. There was a leadership structure in place with a deputy manager being in post and available should the registered manager be absent.

Questionnaires had been sent to people using the service to monitor their satisfaction with the home and support provided. We saw that there was a general satisfaction with the service and where concerns were raised action had been taken to resolve these for the person. We saw evidence of people and relatives' satisfaction with the service received through compliments cards.

People and their relatives had been invited to meetings at the home which were occurring more regularly to enable people to comment on their care. One person told us, "They do have meetings every so often where you can give your opinions." Only a small number of people and relatives attended these meetings although the registered manager informed us that each person was spoken with individually for their feedback. Whilst some people and relatives told us they had been asked for feedback others reported that they hadn't been asked for their feedback about the service.

We were informed that as the service was beginning to stabilise they were now in the position to begin developing the service. The provider had plans to develop the staff as a team due to improved stability. In addition plans were in place to develop systems for electronic care recordings with the aim to improve consistency and quality of recordings across the staff team and would also allow the manager to monitor these.