Partnerships in Care Limited

Grafton Manor

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

The inspection took place on 20 and 23 September 2016 and was unannounced. Grafton Manor is registered to provide care for up to 26 people. The service offers open and community rehabilitation services for adults with either a traumatic or acquired brain injury, including that resulting from a stroke. At the time of the inspection we were informed that 22 people were using the service.

The service was rated good at the last inspection. We had been alerted by the Northampton safeguarding authority of an increase in the number of safeguarding notifications received from the service that had involved incidents between people using the service. The information prompted this inspection to be brought forward. We found the provider had notified the Care Quality Commission of all safeguarding incidents and had taken appropriate action to safeguard people using the service.

The service had a registered manager in post. 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.

People were kept safe by staff that could recognise signs of abuse and potential abuse and knew what to do to raise safeguarding concerns. Risk assessments and management plans were developed with people using the service and the multi-disciplinary team of healthcare professionals, nursing and care staff working at the service.

Robust recruitment procedures ensured that only suitable staff were employed to work at the service. Staff did not start working at the service until all of the necessary pre-employment checks had been carried out. The staffing levels at the service ensured there was sufficient staff available to meet people's care and treatment needs. Robust medicines administration and monitoring systems were in place to ensure that people received their medicines safely.

All staff were provided with comprehensive training based on best practice and staff supervision and support systems were embedded into the service.

People were fully supported to make decisions about their care and treatment. The registered manager and staff team were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's capacity to consent to their care and treatment was regularly assessed and any restrictions placed on people's liberty was legally authorised using the least restrictive means. A multi-disciplinary team based at the service supported people through the pathway of rehabilitation.

People's nutritional needs, including those relating to their culture and religion, were identified, and accommodated. People attended healthcare appointments and they had good access to a range of healthcare professionals.

Staff treated people with kindness and compassion and people's rights to privacy and dignity were fully respected. Each person had a named keyworker and an independent advocacy service was used to enable people to individually and collectively provide feedback, plan activities and voice their opinions. Visitors were welcomed and facilities were available for people to meet their visitors in private.

People's care and treatment needs were fully assessed on admission to the service and the care plans reflected their current needs. People using the service, relatives and staff were aware of the complaints procedure. Complaints raised with the service were responded to and investigated in line with the complaints procedure.

Effective systems were in place for people using the service and staff to provide feedback on how the service could improve. Established quality monitoring systems ensured that all aspects of the service were analysed on a weekly, monthly quarterly and annual basis. They were overseen by a senior representative from within the organisation. Areas identified for improvements had action plans with timescales put in place and the action plans had been met within the timescales.

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 knew how to protect people from harm and abuse.

Risk assessments and management plans were in place to reduce the risks of people coming to harm.

There were enough staff to ensure people were able to receive personalised care and support.

The staff recruitment systems were robust.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received comprehensive training based on best practice and staff supervision and support systems were embedded into the service.

Staff knew and understood the principles of working with the Mental Capacity Act 2005 (MCA) to support people in making decisions. They also knew that people could only be deprived of their liberty when it was legally authorised under the MCA.

People's nutritional needs, including those relating to their culture and religion, were identified and accommodated.

People attended healthcare appointments and they had good access to a range of healthcare professionals.

Is the service caring?

Good

Staff treated people with kindness and compassion.

People's rights to privacy and dignity were fully respected.

An independent advocacy service was used to enable people to individually and collectively provide feedback, plan activities and

voice their opinions.

Visitors were welcomed and facilities were available for people to meet their visitors in private.

Is the service responsive?

Good

The service was responsive.

People's care and treatment needs were fully assessed on admission to the service.

People's care plans reflected their current needs.

People and their representatives knew how to raise complaints and they were responded to and investigated in line with the complaints procedure.

Is the service well-led?

Good

The service was well-led.

Effective systems were in place for people using the service and staff to provide feedback on how the service could improve.

The registered manager and the multidisciplinary team of staff attended conferences and care forums to keep up to date with current best practice. In turn information from the meetings was cascaded throughout the staff team.

Established quality monitoring systems ensured that all aspects of the service were analysed on a weekly, monthly quarterly and annual basis.

Areas identified for improvements had action plans with timescales put in place and the action plans had been met within the timescales.

Grafton Manor

Detailed findings

Background to this inspection

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

This inspection took place on 20 September 2016 and was unannounced. It was carried out by one inspector and a specialist advisor who had a professional background in the care and support of people with mental health conditions. We received further documentation from the registered manager on 23 September 2016 for review to complete the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR. We also looked at information we held about the service from statutory notifications of events that the provider had submitted to the Care Quality Commission (CQC) as required by law. We also received feedback from commissioners that monitor the care and treatment of people using the service.

During the inspection we spoke with seven people using the service. We made general observations on how staff supported people through rehabilitation to partake in activities of their choice.

We spoke with the registered manager, the clinical services manager, the director of brain injury clinical services, a clinical psychologist, a qualified nurse and two care staff. We reviewed four people's care records, checked the medicine administration records and the systems for ordering, storing and disposal of medicines. We also looked at the recruitment files for four staff files and records in relation to the management and overall governance of the service.

Good

Is the service safe?

Our findings

People's feedback described that they felt safe living at the service. Staff had received safeguarding training and they were able to describe hypothetical scenarios that would constitute as abuse. One member of staff said, "It is so important we keep people safe and do what is best for them. If I had any concerns about anyone's safety or well-being I would report it directly to the manager." Through our discussions with the staff we established they fully understood their duty of care towards keeping people safe from all forms of abuse. They were aware of the reporting procedures and also of their responsibility to raise any concerns outside of the organisation to 'whistleblow' if they thought that the provider was not protected from abuse. The staff training records also evidenced that safeguarding training was provided for all staff.

The service managed safeguarding matters in an open, transparent and objective way. The Local Authority Safeguarding Team and the Care Quality Commission (CQC) had been promptly informed of safeguarding incidents. There was a culture of learning from incidents and the safeguarding investigations carried out by the service were thorough. We also saw that a confidential whistleblowing hotline was available for people to raise any concerns they had about people's safety. Safeguarding posters were on display in communal areas for people using the service and staff to access that gave the contact details to report abuse.

Arrangements were in place to continually review accidents and incidents to make sure that themes were identified and necessary action was taken to mitigate the risks of further occurrences. We saw that an electronic system was used to record all incidents and they were regularly analysed by the registered manager, senior managers and the clinical team identify any trends and develop action plans as required. The staff understood how to minimise the risks and followed the action plans that were put in place.

Risk assessments were in place that had been developed with the person and the involvement of relatives, the clinical team, nursing and care staff. We saw the assessments identified the risks to the person and how they could be supported to choose what they wanted to do in the safest way. For example, when out in the community and carrying out daily living tasks to promote independence.

Positive actions were used to manage behaviour that challenged the person or others. We spoke with a Psychology Consultant that regularly visited the service to work with people and staff in setting up long and short term goals. They held regular planning meetings with people and staff to review the positive behaviour support plans that were in place. We saw that all staff received training on behaviour modification, supporting people through positive interactions.

Throughout the inspection we saw that staff worked together as a cohesive team, sensitively supporting people and reacting to situations to alleviate anxieties. They worked with people using a calm approach, using their listening skills and providing people with reassurance.

All visitors were required to sign the visitors' book on entering the building and were issued with an identity card. This was to manage the potential risk of any strangers entering the building and also know who was in the building in the event of fire or other emergency. Contingency plans were in place for responding to any

emergencies or untoward events. We saw that personal emergency evacuation plans were in place for all people using the service. The information within the plans ensured that emergency services personnel would have the relevant information available in the event of an emergency requiring evacuation from the building. The service stocked a defibrillator and ligature cutter, along with standard first aid first aid equipment, so they could quickly respond to any life threatening situations and treat minor injuries.

There was enough competent staff on duty to meet people's needs and respond to unforeseen events. The service regularly reviewed the staffing levels and adapted them to people's changing needs. One person said, "I think there are enough staff here." Staff also said they believed there was enough staff available on each shift to meet people's needs. One member of staff said, "We work very well as a team, we work well together and provide cover if anyone is off sick." The registered manager told us that external agency staff were used as a last resort and in such cases they used the same agency staff to ensure continuity of staff to provide care for people using the service.

The staff recruitment systems were robust and made sure that suitable staff were recruited to keep people safe. The staff we spoke with confirmed they had to provide evidence of their identity and suitability to work at the service as part of the recruitment process. We saw that staff references were obtained from previous employers and checks had been carried out through the government body Disclosure and Barring Service (DBS).

Staff managed medicines consistently and safely. We saw the medicines policy for the service covered all aspects of the safe management of medicines at the service. The policy also gave reference to best practice guidance from the National Institute for Health and Care Excellence (NICE) the Nursing and Midwifery Council (NMC) and the Mental Capacity Act (MCA) code of practice. We saw that MCA assessments have been completed in relation to decisions as to when staff took on the responsibility of administering medicines.

We also saw that information on the types of medicines in use was available on the provider website for people to access, which gave information on the condition the medicine was used to treat and any side effects to observe for.

We saw that medicines checks were completed weekly. They included checks being carried out on the stock and balance and the medicines administration records (MAR) charts. Records showed that any discrepancies were quickly identified and appropriate action was taken to address them. For example, one person had recently missed a dose of a prescribed medicine and statements had been taken from staff involved and investigation was on-going.

Some people lacked the capacity to understand the serious consequences of refusing to take essential medicines, prescribed to treat their physical and / or mental health conditions. As a last resort essential medicine had to be administered 'covertly', (in a disguised format). We saw documentation that demonstrated an MCA capacity assessment and best interests' decisions had been reached in consultation with the person's GP, pharmacist and the family representatives acting on the person's behalf. Deprivation of Liberty Safeguards (DoLS) applications had also been submitted to the local authority for authorisation. Records detailed how the medicines were to be administered to the person following the covert medicines protocol and were subject to regular review by all parties concerned.

At the time of the inspection there were no controlled drugs in use at the service, however should they have been prescribed for any people using the service, there was appropriate storage and recording facilities available. The medicines storage area was secure and had sufficient space to store people's medicines safely.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff with the right skills and knowledge. One person said, "The staff seem to know what they are doing, we get on very well."

Systems were in place to ensure that all staff received support through induction, supervision, appraisal and training. One member of staff said, "The training here is really good, before I provided any care to people I spent time doing a four day induction and two days shadowing other staff, purely observing and reading the care plans." The staff training records showed that staff were provided with mandatory health and safety training, such as, safeguarding, moving and handling, infection control, food hygiene, first aid and fire safety. In addition training was provided for staff on behaviour modification and de-escalation techniques. We saw that notices were on display in the staff areas informing staff of the planned dates for various training sessions.

The staff told us they received support from the registered manager and senior staff that they had regular supervision and appraisal meetings to discuss their performance and training needs. We saw that dates were planned for staff to regularly meet with their supervisors and in addition regular team meetings took place. We saw minutes from a recent meeting with the nursing staff they were given information on the National Early Warning Sign (NEWS) training to update their skills in compliance reporting and improve their clinical practice. We also saw that information was provided on a new system that had been introduced to revalidate their registration on the National Midwifery Council (NMC) website.

We saw that meetings took place with the rehabilitation keyworkers and items discussed included planning leisure activities with people, how to support people who had suicidal thoughts, caring for people with diabetes, diet and nutrition and writing reports on the clinical notes.

An employee of the month scheme was in place and all staff were invited to nominate a colleague. The person nominated received recognition and a prize. There was also a 'Your Voice Matters' staff forum for staff to share their thoughts and ideas for improving the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 saw that the service was working within the principles of the MCA and DoLS. The staff training records showed that staff received training on MCA and DoLS. The registered manager was aware of their responsibilities to comply with the MCA and DoLS codes of practice. We saw that MCA assessments had been carried out where people's capacity was in doubt and best interest decisions had involved their

representatives. We also saw that the registered manager had submitted DoLS applications to the Local Authority as required

We saw evidence in the care plans that the service had considered people's ability to make decisions about their care and treatment. MCA assessment had been completed for elements of people's daily care and support. Where people were assessed as not to have capacity to make specific decisions, the provider had worked with their representatives and other health and social care professionals to reach best interest agreements.

We observed that staff sought people's consent and offered them choices before supporting them with their care. One person said, "The staff always check that I am in agreement before we do anything." Throughout the inspection we observed the staff explain to people what they were doing and gave people time to understand what was said before providing their care and support. Within the care records we saw that people had signed to show they had been consulted and agreed with their care and treatment. They also signed to show that they agreed to health and social care professionals involved in reviewing their care to read their care plans.

People were supported to eat and drink and maintain a healthy balanced diet. We spent time with people in the dining room over lunchtime. We saw that the meal was served from a hot holding serving trolley so that people could serve themselves and choose what they wanted for their meal. There was a selection of meat and vegetarian dishes and a hot and cold buffet and salad selection. People said the meals were nice, one person said "I enjoy the meals and I look forward to the 'takeaway' meals each week, its Chinese this week, I like that."

People's nutritional needs, including those relating to their culture and religion, were identified, monitored and accommodated. We saw that one person has had a swallowing assessment completed by the speech and language therapist. There was clear guidelines within their care plan for staff to follow to ensure their nutritional needs were continually monitored and met. We saw records that demonstrated their weights and food and drink intake were closely monitored. Some care plans stated that people were at risk of dehydration and fluid balance charts were used to monitor how much they drank during the day. Observations during lunch time showed that people were offered a choice of hot and cold drinks.

The provider had arranged for a translator to work with a person whose first language was not English. They had devised a list of words and phrases in the person's language that made communication more effective. We saw that the person's cultural and dietary needs were being met in accordance with their wishes.

People told us they involved people in menu planning. The chef old us they consulted with people as to what they wanted on the menus, to make sure they were happy with the meals provided. They were knowledgeable of the dietary needs of people using the service and ensured they were all accommodated for.

People told us that they attended healthcare appointments and they had good access to a range of healthcare professionals. We saw that a team of healthcare professionals worked at the service, they included a consultant neuropsychiatrist and a neuropsychologist, an assistant psychologist, social worker, occupational therapist a physiotherapist, a speech and language therapist, and rehabilitation assistants. We saw that people also had regular appointments to see their GP, dentist, optician and chiropodist. We were told that clinical governance meetings took place regularly and a resident representative attended the meetings. They in turn shared what had been discussed with other people using the service at the weekly community meetings.

We saw the staff recorded within people's care plans when they had attended health checks. For example, one person required their blood glucose levels to be closely monitored. The staff kept records of the levels and the person regularly attended a diabetes clinic for regular checks. Another person had stated their desire to stop smoking and staff had arranged a referral to the local smoking cessation service for the person. Another person had experienced shoulder pain and a physiotherapist had worked with them to develop exercises with step by step guidance to follow.

Good

Is the service caring?

Our findings

Positive caring relationships were developed with people using the service. People using the service told us that they had a member of staff assigned as their keyworker and that they had good relationships with them. One person said they had enjoyed going to the gym with a member of staff during the morning, they spoke of how much they had enjoyed it and was looking forward to going again. Another person spoke of staff being very supportive and how they respected their choices. We observed throughout the inspection, that people and staff spent time with each other chatting and the atmosphere was relaxed.

People were treated with dignity and respect. For example, the staff responded to people that showed some anxiety in a calm sensitive way. Their approach helped the person to manage their emotions and work through them with staff support. It was also evident from our observations that the staff knew each person very well and talked about things that mattered to them. For example, one person talked of enjoying visits they had from their daughter and their love of football and music.

People were involved in the planning of their care. Regular Care programme Approach (CPA) meetings took place, involving the person, their representatives and the clinical team. People were supported to share their feelings and review their personal goals and discuss their progress. People were also supported to chair the meetings if they wished. The CPA meetings were seen as an important element of the persons' treatment pathway.

Arrangements were in place to make sure that, people were listened to, involved in making decisions and their views were acted upon. People told us that community meetings took place and were run by people using the service. We saw the meetings took place weekly and were chaired by an elected chairperson and a meetings secretary. They provided the forum for people to get together to discuss issues that directly affected them and look at how they could be solved. They also provided a forum for two way communication between people using the service and the provider. The registered manager and or the clinical services manager only attend the meetings by invitation.

Each person had a named key worker and time was regularly set aside for them to meet up to discuss progress in meeting goals and objectives. People also had access to use an independent advocacy service and an advocate visited the service weekly. One person said, "The advocate is brilliant and really helpful in getting things done." We saw that people had the opportunity to speak with the advocate in confidence and also support them in attending their CPA meetings if they so wished.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Pre admission assessments were carried out and a care and treatment plan was put in place on people's admission into the service. People told us they felt fully involved in putting together their care plans and they were aware of the information that what was contained within them. We saw the care plans were regularly reviewed and updated with the involvement of the person and the staff and health care professionals involved in their care.

We spoke with a person who had moved to live in supported living accommodation onsite of Grafton Manor. They said, "I have had some tough times, but with the help of the staff I have made really good progress, I do my own cooking and everything." They said they had access to all of the main facilities at Grafton Manor and they didn't feel isolated.

People were able to follow their own hobbies and interests and daily rehabilitation programmes were put in place to plan specific activities based on people's individual preferences. Most of the people we spoke with thought they had enough to do in with their time, attending clubs and activities in the community and within the service. The multi-disciplinary team of staff based at the service worked with people to put together individualised treatment plans. One person told us they set the dining tables and that they had perfected the art of napkin folding. We saw the programmes involved daily living activities from managing personal care, cooking and community activities to gain independence and work opportunities.

Systems were in place to regularly seek feedback from people using the service. This was achieved through holding regular community meetings. In addition people and their representatives were also asked to complete satisfaction questionnaires. We looked at the responses that had been analysed from the most recent survey findings. We saw that as a result of feedback a log cabin had been purchased and constructed in the garden for people to use. One person had been involved in the construction of the cabin. One person said "I can't wait to start using it; I am hoping we can put a snooker table in there." The registered manager said the request was being considered alongside other requests and a final decision would be made by the people using the service.

The service routinely listened and learned from people's experiences, concerns and complaints. People told us they were aware of how to complain and they felt confident any complaints would be dealt with appropriately. We looked at records of complaints and saw that they had been dealt with in line with the provider's complaints policy. This ensured that complaints were fully taken on board and responded to in a timely manner.

Good

Is the service well-led?

Our findings

People, their family and friends were regularly involved with the service in a meaningful way, helping to drive continuous improvement. People told us they felt involved in making decisions about their care and that the provider encouraged them to bring forward ideas on how the service could improve. They said they thought their ideas and views were listened to and acted upon.

People knew who the registered manager was and who the key members of staff were that supported them with their care and treatment. We observed that relationships between people using the service and staff were open and relaxed and people appeared at ease with the staff and other people using the service.

In discussion with the registered manager they demonstrated they had an in depth knowledge of all people using the service. The ethos of the service promoted an open and inclusive environment where people's views mattered. The vision and values of the service were understood by the staff and put into practice. One member of staff said, "I feel very proud to work here, people are genuinely treated with great respect." We found the culture was person-centred and people's diversity and human rights were promoted. Regular meetings took place that were led by people using the service to discuss issues that affected them and any areas for improvement.

The service worked in collaboration with other health and social care professionals to achieve the best outcomes for people using the service. The registered manager and other health professionals working at the service regularly attended conferences forums to keep up to date with current practice in the care and treatment of people with acquired brain injury (ABI). They also gave talks to other care providers on promoting good practice in meeting the needs of people with ABI conditions.

Staff were supported to question practice; they had received training on safeguarding people that included the whistleblowing procedures. They were aware of their responsibility to raise safeguarding concerns outside of the organisation if they felt that people were not being protected from abuse. The registered manager took all safeguarding concerns seriously had informed the local authority safeguarding team and the Care Quality Commission (CQC) of all safeguarding matters. Investigations had been carried out appropriately and necessary actions had been taken to protect people from abuse.

The staff told us they had regular team meetings and said they were used to share information and ideas. One member of staff said, "I feel like everyone has a chance to contribute and we are listened to." Discussions with staff indicated they took pride in working for the service and that they felt valued.

Quality monitoring systems ensured that all aspects of the service were analysed on a weekly, monthly, quarterly and annual basis. They were also overseen by a senior representative from within the organisation. Any areas identified for improvements had action plans with timescales put in place and the action plans had been addressed and met within the timeframes.