GCH (Halcyon Days) Ltd

Halcyon Days

Inspection report

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31 May 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out 16 and 31 May 2016 and was unannounced

Halcyon Days provides care and accommodation for up to 57 people. At the time of our inspection there were 34 people living at the home. Some people living at the home may be living with dementia.

The home was required to have a registered manager in post but at the time of our inspection the manager had not completed their application to register with The Care Quality Commission as the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 received their medicines as they had been prescribed. Medicines were administered by staff who were trained and assessed as competent to do so.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

People's needs had been assessed before they moved into the home and they had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a variety of nutritious food and drink available to them. Snacks, fruit and a choice of drinks were available to people throughout the day.

Staff were kind, caring and protected people's dignity. They treated people with respect and supported people in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to. People were assisted to access other healthcare professionals to maintain their health and well-being.

People and staff were encouraged to attend meetings with the manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place.

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.

People's medicines were administered safely and as prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority when necessary.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People were supported to follow their interests and hobbies.

There was an effective complaints policy in place.

Is the service well-led?

Good

The service was well-led.

There was a manager in place who was in the process of, but had not yet completed, their application to register with the Care Quality Commission.

People were kept informed of developments to the service and their views were sought and acted on.

There was an effective quality assurance system in place.

Halcyon Days

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 16 and 31 May 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law. We also reviewed the report produced following a visit made by Healthwatch in January 2016.

During our inspection we spoke with seven people and three relatives of people who lived at the home. We also spoke with a nurse, a senior care worker, two care workers, the hostess who also assisted with activities, a cleaner, the deputy manager and the provider's group operations manager. The manager was not available on the first day of the inspection, but we spoke with them when we returned to the service on the second day. We also attended a meeting with other health and social care professional who worked with the service and gained their views of the care that was provided.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for four people. We completed Short Observational Framework for Inspection (SOFI) observations to help us understand the experience of people who were not able to tell us for themselves. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at three staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Good

Is the service safe?

Our findings

During our last inspection we found that acceptable standards of cleanliness and infection control had not been maintained in some areas of the home. We found that staff did not have an adequate understanding of their responsibilities to protect people from avoidable harm and failed to recognise when incidents needed to be reported to the appropriate authorities as safeguarding matters. Staff did not have the skills or competence to meet people's needs and were not deployed in a way that did so safely.

During this inspection we noted that there had been significant improvements in the level of cleanliness. The food store had been completely refurbished and the general level of cleanliness throughout the home had reached an acceptable level. This had been done through the introduction of checklists for every room which were attached to the wall of the room and changed weekly. The designated cleaner for each section signed when the cleaning of each part of the room, such as the windowsill, had been completed and the head of housekeeping checked these. We noted that the cleaning schedule for the toilets and bathrooms made no mention of cleaning the tiles on the walls. We brought this to the attention of the group operations manager who told us that this would be addressed immediately. We spoke with one of the cleaners who told us that each room was deep cleaned when someone moved out of it or if any 'accidents' had occurred. They told us that the carpets in the communal areas were deep cleaned regularly and some of them were scheduled to be replaced.

We found that the staff's understanding of their responsibilities to keep people safe and of the reporting processes relating to safeguarding incident had significantly improved since the last inspection. The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I had my training during my induction. If I thought someone was being abused I would report it to the manager. I could also report it to Care Quality Commission and the safeguarding team. The information as to who to contact is in a book in the office." Staff we spoke with were able to explain the types of harm that people may experience. Since the last inspection there had been no safeguarding issues at the service.

There were enough staff on duty who had the skills and knowledge to meet people's needs safely. People, relatives and staff we spoke with told us that there were enough staff on duty. One relative told us, "There are more visible staff now. There used to be a lot of agency staff but they have recruited new girls and I feel the new staff are proactive. I feel that they think and don't sit around and act only when absolutely necessary." A member of staff said, "There are more staff now." Another member of staff said, "There is enough staff. We are coping. If there were more residents we would need more staff. There are enough staff on at night." We saw that each person's level of dependency had been assessed but the operational manager explained that staffing levels had been determined by the provider based only on the number of people who lived at the home. During our inspection there was a visible staff presence in all the communal areas.

People and relatives we spoke with told us they felt that they or their relative was safe living at the home. One person said, "I do feel safe here. I am looked after and waited on hand and foot. If I want to go out of my room I have the door open and everything is still where it should be." Another person said, "I would not be here if I didn't feel safe." A relative told us, "I know my [relative] is safe because I know everybody is watching over [them]."

The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm but would also be used to ensure that the building was properly evacuated in the event of an emergency.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the use of bedrails and wheelchairs and people's medicines, such as warfarin. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. One staff member told us, "We get some people who keep on falling and we have referred them to the falls clinic."

Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and talking about people's experiences, moods and behaviour at shift handovers. One staff member said, "At handover we discuss if someone has been unwell or had any accidents or falls." This gave staff up to date information and enabled them to reduce the risk of harm occurring.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Checks were also carried out to ensure that equipment such as lifts and hoists had been serviced and portable appliances had been tested. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the manager. We saw that they kept a record of all incidents, and where required, people's care plans and risk assessments had been updated. The records were reviewed by the manager to identify any possible trends to enable appropriate action to be taken to reduce the risk of an accident or incident re-occurring.

We looked at the recruitment documentation for three members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Staff who administered medicines had been trained and assessed as competent to do so. Each medicines administration record (MAR) included information about any 'as and when required' (PRN) medicine a person had been prescribed, including information about the medicine and the circumstances under which it was required. We looked at the MAR

charts for four of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held which were in accordance with those recorded. There were robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills that were required to care for them. One person said, "The girls are good. They are well trained up to a point. The younger the girls, the better I get on with them." A relative told us, "I know they are doing a lot of training."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I had to work through everything in my induction such as the rules and regulations. I shadowed (observed the working practice) experienced staff for a week and had support afterwards. I could go to them with anything."

They went on to tell us of the on-going training that they received and that they felt supported by regular supervision. They said "We have supervisions every two months. We talk about what is good and what I want support or training on. I am doing my NVQ at college. The manager suggested it." They went on to tell us about training they had received in dementia. They told us, "It was brilliant. It gave me an insight in what it could be like to live with dementia. It made you realise how different environments were to people."

Staff also had a regular appraisal. One member of staff told us, "I have an appraisal every year. It is a positive thing and we can talk about training and development. I have got NVQ levels two and three and now I have enrolled to do NVQ in team leading." This demonstrated that staff were supported to maintain and increase their skills to enable them to support people effectively.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. 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 looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest.

People told us that staff asked for permission before they supported them. One person told us, "They have to ask for everything." We observed staff ask people before they provided care or support to them. Staff told us that they always gained consent to support from people. One staff member said, "I check that everything is okay and get their permission, for example if I am supporting them with personal care. If they say 'No' I

would leave them for a while and ask again. I would keep trying until they agree. If people are not able to tell me then I will tell them what I am planning to do and watch for their reaction. They react in different ways. We also use aids such as pictures." Another member of staff told us, "We use body language or sometimes, even if we don't understand what they are saying we can tell by the tone of their voice whether they are happy to accept care."

People told us that they had a variety of nutritious food and drink which they thought was adequate. One person told us, "The food is edible. They put too much on your plate but you know what you are going to have. The only meat I eat is turkey or chicken and they know that. There is always something I can eat." A relative told us, "The food is edible. It is okay. [Relative] put on weight when [they] came here but it has stabilised now." The food was externally sourced and provided to the home in frozen form. Whilst nutritionally balanced, the group operations manager told us it was recognised that the meals were not as appetising as they would like. They told us there was a plan to reintroduce a full team of cooks and kitchen staff in the longer term, and that home cooked meals would be reintroduced at this time.

People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake that provided detailed information on what they had consumed. The service had recently introduced a hostess who visited every person at the home to ensure that they had drinks available to them. They told us that they also arranged snacks for the afternoons. We saw that they had cooked flapjack for people to have with their afternoon tea that day. Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

People told us that they were supported to attend appointments with other healthcare professionals, such as dentists, opticians and chiropodists, to maintain their health and well-being. Records we saw confirmed this. One person told us, "I see a chiropodist here." One member of staff told us how they involved other health care professionals in the care of the people who lived at the home. This included district nurses, speech and language therapists, physiotherapists, occupational health professionals and GPs. Records showed that people had been supported to attend appointments with opticians and dentists. Health Care professionals that worked with the service told us that the staff worked cooperatively with them and followed their advice when providing care to people. They reported a significant improvement in their relationship with staff since the last inspection and said that communication from the home was now good.

Good

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "They are all very caring and considerate. I admire them for the job they do." Another person told us, "They treat me nicely and talk to me. I am not just happy. It is my life." A relative told us, "They come and sit and chat with people and hold their hands."

Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the life histories within people's care records. Life histories had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. One member of staff told us, "They chat to us all the time. I speak to them and ask them questions so I get to know them."

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff communicated appropriately with people. Interactions were not all task focussed and we saw that staff took opportunities to sit and chat with people throughout the day.

People told us that the staff protected their dignity and treated them with respect. Staff were able to describe ways in which they respected people's dignity. For example one staff member said, "We always keep the door and curtains closed when we are supporting people. If they only want a female carer we make sure they get one." We saw that there was a 'Dignity Board' in place that displayed information about the role of the 'dignity champion' and the ways in which people's dignity would be promoted. Staff were able to explain how information held about people was treated as confidential. One member of staff told us, "Personal information is locked away. We don't discuss anything outside of the home."

People told us that they were encouraged to be as independent as possible. One person told us, "I am most independent." Another person said, "I do anything they ask of me. They know what I can do." A relative told us "[Relative] is empowered to do as much as [they] can, although [they are] able to less and less [because of their age]." A member of staff told us how people were encouraged to be as independent as possible. They told us, "I will give them the flannel to wash their face, even if they need help with the rest."

People were supported to maintain relationships with friends and family. One person told us, "A group of friends come up about every six weeks and bring fish and chips and coke. We take over the dining room and we eat from the paper and drink from cans. They bring a dustbin liner and take all the rubbish away." A relative told us, "We had a meeting last week when [manager] told us that they have people here who can't contact any relatives and they act as next of kin for them. It is sad."

Information was displayed on notices in the hallway for people and visitors. This included information about safeguarding, the complaints system, fire evacuation instructions and details about planned activities for the month. This meant that people, their friends and relatives had the information that they needed and could plan how they wanted to spend their time.

Good

Is the service responsive?

Our findings

At our last inspection in November 2015, we found that people's individual needs were not met. There was a lack of engagement with people by staff and very little meaningful activity provided. Many people spoke of feeling lonely and bored. We saw several people who were very isolated and withdrawn. Staff were not familiar with people's needs and preference and some of those asked confirmed that they had not read people's care plans. Complaints were not managed appropriately, and as a result, people and their relatives had raised their concerns with the care quality commission and the local authority instead of making the complaint to the provider organisation.

At this inspection we found that very significant improvements had been made to respond to people's needs appropriately. People we had previously seen withdrawn and isolated were engaged in activities and appeared animated, enjoying positive relationships with staff and each other. One relative told us, "There are a lot of new activities now. They do a lot more activities now and are doing all sorts of things. Sometimes [relative] was a bit overstimulated. Now they make sure [they] take time to sit and watch. They only encourage [them] to take part if [they] show interest in the activity." At the time of our inspection the full time activities coordinator was on holiday. There was also a part time activities coordinator and a hostess who also assisted with activities. These included making cocktails and smoothies and afternoon tea in the garden when the weather was suitable. One of the cleaning staff told us that they also assisted with activities on a one to one basis after they had completed the cleaning on their unit. This included painting people's fingernails and encouraging them with their hobbies, such as colouring. During our visit, the hostess had arranged reminiscence activities in one lounge involving props to help trigger people's memories. She also played a quiz with people involving remembering the final words in well-known sayings and songs. The hostess worked at a pace which included everyone and people joined in ways that were meaningful to them and it was clear that this was a positive experience for people. We saw a timetable on the noticeboard which showed there were a variety of activities on offer throughout the week.

At this inspection we found there was an effective complaints policy in place and the manager listened to people's concerns. Although the people we spoke with were aware of the complaints system they said that they now had no cause to use it. One person told us, "I have no complaints." A member of staff told us that if someone wanted to make a complaint they would, "Get the deputy manager to talk to them. If they give us a complaint we will take it further for them." Another member of staff told us, "There was a complaint about someone's bed not being changed as often as it should have been. We now have a sheet where we keep track of when people's beds have been changed." Another member of staff told us, "We discuss learning from complaints at staff meetings. The home is much cleaner now following previous complaints." This showed that complaints were used to improve the care and support provided. At the time of this inspection the Care Quality Commission had received no further complaints about the service.

People and their relatives told us they had been involved in deciding what care they were to receive, how this was to be given and that the care they received reflected their individual needs.

Care Plans included information on personal history, their individual preferences and interests. Each care

plan was individualised to reflect people's needs and included clear instructions for staff on how best to support people with their specific requirements. People or their relatives had been involved in reviewing of their care needs. One relative told us, "[Name], the key worker is waiting to finalise [relative's] care plan. We talked about what care [relative] needs. We do it a couple of times a year or if anything happens. They always tell me if something has happened." Staff told us that care plans were reviewed on a monthly basis or more often if this was appropriate due to changes in people's physical or mental health. The care records that we looked at showed that care plans had been reviewed each month.

Good

Is the service well-led?

Our findings

At our last inspection in November 2015, we found that the service had not encouraged people to share their views about the quality of the care they received and quality monitoring audits had not been kept up to date. Staff morale was low, which was having an impact on the care delivery. Frequent changes in management in the service and in the wider provider organisation had contributed to instability within the service and the lack of leadership had left staff with little direction. A new manager was in post who, along with the group operations manager and senior management team, was working hard to address the significant shortfalls in the service and to provide some clear leadership for the staff team. Unfortunately, a few weeks after our last inspection, the new manager made the decision to leave their post. However, a manager from another of the provider's homes transferred to the service and has since been working with the senior team to address the issues in the service.

At this inspection we found that the leadership of the service had improved. Although the manager was not yet registered with the Care Quality Commission (CQC) they were in the process of applying to do so. The manager was familiar with the service and known to the staff team as they had worked at the home previously. Staff we spoke with were very positive about the manager, and stated that the changes made since their arrival were significant. One member of staff said, "It's made such a difference. Staff morale is so much better. It's nice coming to work now, and that rubs off onto how we work with people. It's a happy place now." People and staff had confidence in manager and the deputy manager. They found them to be open and approachable. A relative told us, "[Manager] is a force for good. [Deputy manager] is lovely and knows what's going on." One member of staff said of the manager, "[Manager] is really good. I can go to her with anything. I feel that I can talk to her."

The management team had worked very hard to address the shortfalls in the service and had approached this task with openness and honesty with people and their relatives, staff and other health and social care professionals involved in the service. They communicated in person, by letter and at meetings with all parties about the progress made in making improvements, consulting people and taking their views on board. They were honest with people and their relatives that changes would not all happen overnight and provided realistic timescales of when each phase of improvement would take place. They produced a service improvement plan which detailed action, responsibilities and timescales and shared this with families, involved professionals and the care quality commission. They provided regular updates to keep everyone informed of progress.

It was clear that the manager had worked hard with staff to identify and meet their training needs and to improve their understanding of their role and responsibilities. Staff we spoke with were knowledgeable about their roles and what was expected of them and were able to tell us of the values and vision of the service. One member of staff told us, "We assist people in their daily lives and promote their independence." It was clear that the manager promoted a person centred culture and this was reflected in the development of the service and the very positive feedback we received from families, people, staff and external professionals.

The management team were in the process of making improvements to the care delivery and monitoring systems used in the service. They recognised the need to ensure accurate records were kept and were developing a 'global chart' to enable staff to keep accurate records without being swamped with paperwork. The system enabled all essential day to day monitoring information to be recorded on one sheet of paper. Therefore information such as fluid and food intake and repositioning for people who remained in bed was easily noted in an 'at a glance' form. This system was new and staff were still getting used to it and we noted a few gaps in recording. When we raised this with the management team, they addressed this immediately by arranging staff development sessions to support staff to understand the purpose of the new system.

There was an effective quality assurance system in place. Weekly quality audits were completed by the manager and covered a wide range of areas, including audits of care plans, medicines, and infection control. These audits were then collated and submitted as a report to the head office where it was used to analyse patterns and trends in relation to shortfalls. Improvement plans were then sent to the manager and the actions were signed off when they had been completed. A quarterly monitoring visit was also carried out by a senior manager within the organisation.