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Grasmere Rest Home

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

This inspection took place on 6 October 2016 and was unannounced. At our last comprehensive inspection in July 2015 we found the service was in breach of regulations relating to safe care and treatment and good governance and rated it as requires improvement. This was because medicines were not managed safely, risks such as those relating to falls and people developing pressure ulcers were not managed safely and audits were not sufficiently robust. However, when we carried out a follow up inspection to check these areas in December 2015 we found the provider had taken appropriate action and the service was no longer in breach of the regulations. We did not change the rating of the service at that inspection because we wanted to see sustained improvements over time.

Grasmere Rest Home provides accommodation and personal care for up to 23 people, some of whom may be living with dementia. At the time of our visit, there were 20 people using the service. Although the service is required to have a registered manager in post, there was no registered manager at the time of our inspection because this person had recently left the service. 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.

We found some risks were not managed safely. Cleaning and laundry chemicals were kept where people could access them and potentially come to harm from contact with them. There were insufficient measures in place to manage risks relating to people's cigarette lighters where they did not have the mental capacity to operate and manage these safely. However, the provider promptly installed a lock on the cupboard where chemicals were kept and the acting manager told us they would review policies around use of smoking materials.

People had personalised risk assessments and these were up to date. Staff knew how to protect people from risks like falls and developing pressure ulcers and there was sufficient equipment in place to manage these risks. Measures were in place to protect people in the event of emergencies and the provider had taken action to help ensure people were protected from the risk of harm and abuse. Medicines were managed safely. Staff were familiar with medicines policies and arrangements were in place to store, administer and record medicines appropriately.

There were enough staff to care for people safely and so that people did not have to wait a long time for help. The provider carried out checks to ensure they did not employ any staff known to be unsuitable. Staff received the training and support they needed to do their jobs. They were able to obtain advice from healthcare professionals about supporting people's health needs. People had access to healthcare services when needed and were able to choose from a variety of nutritious food and drinks that met their needs.

Staff obtained people's consent before carrying out care tasks. Where people were unable to consent to their care, staff followed procedures to make sure they worked within the Mental Capacity Act (2005). This

included situations where people were deprived of their liberty within the care setting and ensured that the provider was meeting legal requirements in this area.

Staff were caring and showed respect, empathy and compassion in their interactions with people. They regularly checked that people were comfortable and whether they needed anything. They knew people well and took time to listen to them and talk about their experiences. Staff worked with people in a way that promoted their dignity.

People were free to choose how to spend their time and took the lead on deciding what their daily routines should be. People enjoyed trips and outings including a recent canal boat trip and there was an activities coordinator organising activities at the home. We saw people engaged in several activities during our inspection.

People had comprehensive care plans so staff had the information they needed to meet people's needs and preferences when delivering care. This included information about people's life histories and preferences in addition to their basic care needs.

Although people we spoke with were not aware of the formal complaints process, they knew how to raise concerns and felt confident doing so. The provider reminded people and their relatives at meetings about how to complain.

Staff felt they worked well as a team and the provider supported them to do so. There were clear lines of responsibility and accountability so staff knew whom to report to and the provider had appointed an acting manager to provide interim leadership while they waited for the new manager to complete the recruitment process. Staff, people and relatives had opportunities to express their opinions and give feedback about the service and the provider responded accordingly.

The provider had a number of systems to monitor and improve the quality of the service including surveys, audits and checks and an ongoing service improvement plan. Although they had not identified some of the concerns we found, they were aware of others and had begun taking action to address them.

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 consistently safe.

People were at risk of coming into contact with harmful chemicals because they were not stored securely, although the provider took action to address this during the inspection. There was no system in place to ensure cigarette lighters were handled safely and there was no evidence that personal emergency evacuation plans were regularly reviewed.

Personalised risk assessments were in place and there were systems to protect people from abuse and ill treatment. The provider monitored accidents and incidents to ensure they addressed any patterns or trends. There were enough suitable staff to keep people safe. Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff obtained people's consent before providing care to them. Where this was not possible, they worked within the requirements of the Mental Capacity Act 2005 to ensure decisions made on people's behalf were in their best interests.

Staff received the training, supervision and support they needed to perform their roles effectively. They were able to access guidance from healthcare professionals when needed. People had access to healthcare services as required.

People received a variety of nutritious food and sufficient drinks to maintain good health.

Is the service caring?

Good

The service was caring.

Staff took time to listen to people and to make sure they were comfortable. People benefited from friendly, empathetic and respectful interactions with staff who knew them well.

People were involved in decisions about their care. Staff gave

them the information they needed and people were able to decide on their own daily routines and how to spend their time.

Staff supported people in a way that promoted their dignity and independence.

Is the service responsive?

Good

The service was responsive.

People were able to take part in a variety of meaningful activities that met their needs. Staff knew what was important to people and how they liked to spend their time.

People had personalised care plans that took into account their care needs, life history, relationships and other relevant information so staff could support them in a way that was responsive to their needs and preferences.

Although people were not aware of the formal complaints process, they knew how to raise concerns and were confident to do so.

Is the service well-led?

Good

The service was well-led.

There was an acting manager in post and staff knew whom they should report to.

The provider had systems to assess, monitor and improve the quality of the service. This included meetings to gather feedback from people, staff and relatives.

The provider had a plan to improve the service with clear targets so they could monitor progress.

Grasmere Rest Home

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 6 October 2016 and was unannounced. It was carried out by two inspectors and a specialist advisor, who was a GP by background.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports, feedback about the service that we received via our website, notifications from the service about significant events and a provider information return (PIR). The PIR is a document we ask providers to submit before our inspection about how they are meeting the requirements of the five key questions and what improvements they intend to make. We also spoke with two social workers from the local authority social services.

We spoke with seven people who used the service, one relative, seven members of staff and a director from the provider organisation. We observed staff interacting with people 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.

We looked at five people's care plans, three staff files and other records relevant to the management of the service such as staff rotas and audits.

Requires Improvement

Is the service safe?

Our findings

People and staff told us they felt safe living and working at the home. "I feel safe working here. There is always somebody to help you, to talk with."

Each person had an individual risk assessment, which covered falls and pressure ulcer prevention in addition to other risks relevant to them. Examples were moving and handling, nutrition and people administering their own medicines. Each person had a personal emergency evacuation plan (PEEP). A PEEP is a document to make staff and emergency services aware of the support each person needs to evacuate the premises in an emergency. However, the PEEPs did not have review dates on them so it was not clear if they contained up to date information. This meant there was a risk that people would not receive the support they needed to evacuate in an emergency, for example if their mobility had deteriorated and they needed more help than their PEEP described.

A recent fire safety inspection had found that curtains at the front door could pose a fire risk. However, by the time of our inspection the curtains had been treated with a fire-retardant spray. A fire marshal course was planned for the week following our visit. We noticed that some people who were smoking in a designated outdoor area were sharing cigarette lighters between them and this meant there was a risk that lighters could fall into the possession of people who might not fully appreciate the risks associated with these or use them safely. The acting manager mentioned one person for whom this was a known risk and told us they would review their policies around the safe use of smoking materials.

We noted that the laundry room door was left open and some hazardous substances, including a corrosive detergent, were left where people could potentially access them either on work surfaces or in a cupboard with no lock. These substances could cause serious harm to people if handled inappropriately. We spoke with a director from the provider organisation, who immediately notified staff of this risk and sent us photographic evidence the day after our inspection showing a lock had been fitted on the cupboard.

Windows were fitted with restrictors to prevent people from falling from height. Fire exit doors were easy to operate but were fitted with alarms. This meant that while people would be able to leave the home quickly in an emergency, they would not be able to leave the premises without alerting staff. We noticed that some of the individual tables and chairs people used were showing signs of wear and tear and could pose a risk to people especially if they used tables for physical support, as some of the surfaces were unsteady. We saw the provider's improvement plan, in which they noted a target of early 2017 to obtain new lounge furniture. We observed that staff made sure people were able to reach any mobility aids they needed, so they did not need to rely on furniture for support.

Staff were familiar with the home's safeguarding policy and procedure. They knew how to recognise and report suspected mistreatment or abuse of people and this helped to keep people safe from harm.

We looked at how the service worked to prevent and manage pressure ulcers. One person had developed a pressure ulcer earlier in the year as a result of reduced mobility after a fall. Records showed, and staff

confirmed, that staff had followed the home's policy on dealing with pressure ulcers and it had since healed. Staff we spoke with were familiar with this policy. People had assessments about their risk of developing pressure ulcers and actions staff should follow to prevent them were noted. We saw evidence that staff followed these instructions and, where required, supported people to reposition themselves and use appropriate equipment such as pressure relieving mattresses and cushions. Staff filled in a daily checklist to ensure the tasks were complete.

The home had a policy on managing falls. Senior staff carried out a falls analysis to look for any recurring pattern that might show if falls were increasing or were linked to specific times. The acting manager told us this helped them identify who was at risk of falls or any triggers that might be causing people to fall. They then took appropriate action, such as referring people to a falls prevention team or providing equipment to reduce risks. For example, the provider had arranged for one person who had a history of falls to have a sensor mat in their bedroom. This meant staff were alerted if the person got out of bed without assistance, which was when they were most likely to fall. We observed people had access to frames and walking sticks to aid mobility. When one person wanted to go to the toilet, we saw staff supporting them to access their frame so they could walk to the toilet independently and safely.

Bathrooms, including en-suite facilities in people's bedrooms, were equipped with alarm pull cords so people could alert staff if they needed help in an emergency. Bathrooms had non-slip floor tiles and equipment such as shower chairs to enable people with reduced mobility to use the facilities safely. We also saw equipment that was designed to facilitate evacuation of the home by people with reduced mobility. Records showed that these, and other equipment such as call bells, were checked and serviced regularly.

Staff recorded injuries using body map diagrams to make it easier to identify any trends. We also saw staff recorded accidents and incidents and there was evidence that the provider responded appropriately.

One person said staff were "pretty busy but they make time for you. We're not neglected." Another person said, "There's plenty of staff." People told us staff attended promptly if they used call bells at night. Staff told us it could be difficult sometimes when colleagues called in sick but on the whole there were enough staff to keep people safe. We reviewed a sample of staff rotas and saw staffing was within the minimum levels set by the provider. We saw evidence that the provider used safe recruitment processes, including appropriate vetting of new staff. This helped to ensure there were enough suitable staff to keep people safe.

Medicines were stored in a locked trolley or refrigerator within a locked room and colour coded blister packs for different times of the day were used to reduce the risk of staff giving medicines at incorrect times. Staff checked the temperatures of the room and refrigerator daily to ensure medicines were not stored at high temperatures, which could damage them. Records showed that the temperatures were within acceptable ranges. We observed staff giving people medicines and saw they followed appropriate procedures, checking documentation to ensure they were giving the correct medicines to the right people. There were instructions for when and how staff should give people 'as required' medicines and we observed staff following these. We checked medicines records and found they were accurate and staff had signed after administering each medicine. This helped to ensure people's medicines were stored, administered and recorded correctly.

Good

Is the service effective?

Our findings

People told us they gave consent to decisions made about their care. One person told us their son had made the decision to come to the service, but that "it was quite right" that they were at the service.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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.

Staff demonstrated an understanding of the MCA and their roles in relation to this. The provider carried out assessments of people's capacity to make specific decisions about their care. We saw evidence that where people did not have capacity, the provider had followed processes in accordance with the MCA such as consulting people's families and others involved in their care, including GPs and advocates, to help ensure decisions were made in people's best interests. These decisions were reviewed regularly to help ensure care and treatment continued to be in people's best interests. People's files were colour coded so staff could see immediately whether they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in place. These forms indicate that an appropriate medical professional had made a decision that it would not be appropriate to attempt resuscitation in the event of cardiac arrest. Where people had the capacity to do so, the provider had involved them in this decision. People who had capacity signed consent forms to state they agreed to specific decisions about their care. We observed staff asking people before offering support and explaining to people what they wanted to do. This helped to ensure that staff obtained people's consent before providing care or, where this was not possible, made sure that people received care that was appropriate for them.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the provider had followed the required procedures when a decision was made to deprive people of their liberty. They used a DoLS checklist to ensure they were complying with the requirements of the MCA.

The home was equipped with staff training facilities, which staff told us they used regularly to keep their knowledge up to date as the provider offered four to five courses per month. There was a visiting nurse who offered training on a monthly basis. The provider also encouraged staff to enrol for courses at a local college in order to attain further qualifications relevant to their roles. Training records confirmed that staff took a variety of training courses appropriate to their roles. We also saw evidence that staff received one-to-one supervision and annual appraisals to support them in their roles.

One person said, "The food's very good." Staff were aware of people's dietary requirements. We saw staff regularly offering people drinks and when people requested a cup of tea this was provided to them promptly. One person said, "I always have it when I want it." We saw staff providing another person with fresh fruit when they requested it. We saw people ate several different things for breakfast, showing they were able to choose from a variety of options, and staff went to each person asking which of two choices they wanted for lunch. There was information about people's dietary needs in their care plans and staff recorded what they ate and drank. This helped to ensure people's nutrition and hydration needs were met.

There was information in people's files about medical conditions they had and signs staff should look for that might indicate the person needed medical or specialist attention. For example, people with diabetes had information about how staff could tell their diabetes was not being well controlled. Staff recorded relevant information regularly as directed by care plans, such as testing blood sugar levels and weighing people. There was also information about other services involved in caring for people, such as mental health professionals and other healthcare specialists.

One person told us their dentures did not fit well and were uncomfortable. We spoke with staff, who told us they would arrange a dental appointment. We saw evidence, and people confirmed, that other people received healthcare appointments when needed, for example with nurses, chiropodists and dentists. This helped to ensure people's healthcare needs were met.

Good

Is the service caring?

Our findings

People told us the service was caring. One person said, "I like it here. It's very nice indeed." Another person told us, "I have a better chance here of happiness." A visitor said, "It's a good home. The staff are kind to them. The staff care for them. It's a little family really. No hesitation in recommending Grasmere and that's down to the staff."
We observed staff interacting with people in a friendly, respectful and compassionate manner, demonstrating patience when supporting people. Staff smiled and joked with people, which helped create a happy atmosphere for people to live in. When a person requested a pain relief tablet they could take either one or two of, the member of staff administering medicines checked with the person that they only wanted one tablet and said they would return in an hour to check the pain relief had worked. On another occasion we saw staff quickly going to a person when they started coughing to see if they needed anything and staff regularly asked people "are you OK?" making sure they were comfortable. When a person became frustrated during an activity and said, "I'm stupid," the member of staff supporting them responded, "No, you're not stupid. You have dementia and that sometimes makes things difficult." They proceeded to discuss with the person how dementia affected them and how staff could best support them. This showed staff had a caring, empathetic attitude and consideration for people's comfort.

We saw staff had gathered information about people's personalities and what was important to them. This included information about how to communicate with people. Some people used hearing aids and we observed staff providing people with these if they did not have them in already. Interactions we observed between people and staff demonstrated that staff knew people well and people we spoke with knew the names of the staff who were on duty. This helped to show that staff had formed good caring relationships with people.

People confirmed they were able to spend their time how they liked and they were able to get up and go to bed when they liked. One person said, "You do what you want" and, "You get up when you want and order [breakfast] when you come down." During the inspection, we saw staff giving people information and asking for their choices about several other things such as where they wanted to sit and what they wanted to eat and drink. We observed people eating breakfast at different times showing people did not have to stick to a particular time or wait for others to get up before eating their meal. There was information recorded in people's care plans about their preferred routines. One person was in their dressing gown at breakfast. They said they were having a lazy day and did not want to get dressed yet. This showed how staff supported people to make choices about their daily routines.

People told us staff respected their privacy and dignity. People's appearance was clean and neat. They were wearing clean and well-maintained clothing and some people had their nails painted. This helped to maintain people's dignity.

Good

Is the service responsive?

Our findings

People spoke fondly of their recent trip on a horse drawn canal boat with afternoon tea. They had also been to visit the lavender fields, Hampton Court and the seaside. Staff confirmed there were two day trips a month. One person told us, "I like to spend time in my room but if I come down there's always something going on. They encourage you." Another person said, "We all have a sing song." One person said "The activities person is very good."
There was an activities timetable displayed, which showed that one-to-one activities were due to take place during our inspection, and we saw the activities coordinator engaging with people individually and offering a choice of activities. A variety of activities equipment was available including games, DVDs and a computer with large keys to make it easier for people with reduced movement in their hands to use. We saw some people engaging in different one to one activities in the morning, including doing jigsaw puzzles with care staff, colouring and reading magazines or newspapers. One person's care plan stated that they liked dancing and we saw the activities coordinator encouraging that person to dance, which the person appeared to enjoy. This showed that the service provided appropriate activities that met people's needs.

People had comprehensive care plans and these were reviewed regularly to ensure they were up to date with people's changing needs. The care plans included information about people's interests, likes and dislikes, religious beliefs and family members they were in contact with. People said their family often visited. There were a number of visitors on the morning of the inspection. One person told us their son came to visit them every day. We saw staff welcoming visitors and offering hot drinks. There was information in care plans about what might cause people to become upset or worried and what staff should do to reassure them under these circumstances. People had documents entitled 'Map of Life' and 'Life Story Book' that staff had completed with them to gather information about their life histories and relationships. This helped staff provide person-centred care that took into account people's individual circumstances and preferences.

Care plans covered people's individual needs in terms of the support they needed and how much they could do for themselves. For example, care plans specified what aspects of people's personal care they could do independently, what staff should prompt them to do if they did not do it independently and what they needed full support with. This helped to ensure people received the care they needed whilst remaining as independent as possible.

Staff recorded the care they provided to people daily and other significant information such as changes in people's health or mood. Each month, an assigned member of staff reviewed this information for each person and noted any trends or changes in people's care plans, such as whether people were losing or gaining weight, and whether people continued to enjoy the same activities and foods. This helped ensure that staff had up to date information about people's needs and preferences.

People we spoke with had no complaints or concerns. One person said, "It's my home really. No complaints. It's lovely." We saw information displayed about how to complain and the home's code of conduct, although people we asked were not aware of the formal complaints process and the information displayed was not in an accessible format. The people we spoke with said they felt comfortable speaking with staff. We

saw some positive feedback relatives had left in a comments book about the care their loved ones received. There was evidence that the provider used residents' and relatives' meetings to remind people and their relatives about how to complain.

Good

Is the service well-led?

Our findings

People told us they were happy with the way that the service was led and staff said they enjoyed working there. At the time of our inspection, there was no registered manager in post as the last manager had recently left the service and the provider was in the process of recruiting a new manager. The deputy manager, who had worked at the service for several years, had taken on an acting manager role in the interim. Although they acknowledged that several changes in management over recent years had been challenging for the service, staff told us they worked well as a team and felt the acting manager led the service well in the absence of a registered manager. The provider had recently created team leader posts, which assigned specific responsibility to senior staff for certain areas of their work such as medicines management. Staff told us they felt well supported by the provider and by each other.

At the time of our inspection, the provider was in the process of rolling out a new set of organisational values. The director we spoke with told us this was designed to ensure staff worked consistently towards the same values and provided high quality care. There was a group manager working across homes within the provider organisation whose role included carrying out quality assurance visits and audits at the home. We saw evidence including safety checks and records of the monthly provider visit. This included people's feedback, action taken in response and monitoring of whether any issues raised had been resolved. The provider had an improvement plan for the service, which took into account changes people said they would like to see and had completion dates so the provider could track their progress. Although the provider's audits and checks had failed to identify some of the issues we found, such as the unsafe storage of harmful chemicals, they were aware of others and working on improvements. The provider also took immediate action to address concerns we raised.

We saw that a pharmacist had carried out an audit of medicines management at the service the month before our visit. The audit had identified some minor issues to follow up and the provider had carried out their own audit the following week, which demonstrated these concerns had been addressed. The provider had recently appointed a pharmacist to work part-time at the service to ensure a high standard of medicines management.

There was a regular staff meeting that managers used to ensure staff were aware of action they needed to take to improve the quality of the service, pass on feedback and hear any concerns staff wanted to raise. We saw evidence that staff had acted on suggestions and action points from the meetings.

The provider used a variety of methods to gather feedback about the service from people and their relatives. This included cheese and wine evenings as an informal way of gathering views. We saw minutes from a cheese and wine evening that took place four months before our inspection. These showed that the provider had used the meeting to inform people and their relatives about changes to the service and to gather feedback. The meeting was also used to introduce people and their relatives to healthcare professionals working alongside the service, including a nurse specialist in end of life care. The provider had appointed a resident/relative representative, whose role was to liaise with people and their relatives and pass on their comments to the provider. This helped to ensure that people and their relatives felt involved in

the running of the service and helped to maintain an open, inclusive culture.