Gracewell Healthcare Limited

Gracewell of Edgbaston

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 and 13 April 2016. At this inspection we found that the provider was in breach of regulations related to failing to provide safe care and treatment; failing to provide care that was person centred to meet people's individual needs; failing to safely manage people's medication; failing to identify and respond to people's healthcare needs and an ineffective governance system to manage risks and make improvements. After that inspection we met with the provider to discuss the breaches and the provider completed an action plan stating what they would do to meet legal requirements in relation to these breaches.

We undertook this unannounced focussed inspection on 30 November 2016 to check whether the provider had followed their action plan and to confirm if they now met legal requirements. This report only covers our findings in relation to those improvements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Gracewell of Edgbaston on our website at www.cqc.org.uk.

At this inspection we found that improvements had been made and the service was no longer in breach of regulations.

The registered manager of the service was absent from work and there was an interim manager supporting the service. We had identified at our last inspection that there had been a lack of consistent management at the home and this continued to be the case. 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 that improvements had been made to the systems in place to identify and assess risks, although monitoring of risks needed further improvement. Medicine management had improved and people were happy with the support they received with their medicines. Further action was required to ensure new systems introduced were fully embedded into medicine management practice.

People received support from healthcare professionals to have their healthcare needs met. Information about people's healthcare needs had not always been updated when a person's needs changed and further improvement was needed.

People felt cared for by staff and were involved in planning their care. People were supported by more regular staff some of whom knew people well. Further improvements were needed to ensure all staff got to know people well to enable personalised care to be provided.

Improvements had been made to the quality monitoring of the service and a director of operations was overseeing improvements at the home. Some of the quality monitoring systems were not entirely effective and had not identified that records were not always up to date or that risks to care had not always been

monitored.

Further improvements were needed in all aspects of the areas we inspected to ensure that compliance with regulations would be maintained and that improvements made became fully embedded into everyday practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's care had been identified but had not been monitored consistently.

Medicine management had improved. The new medication systems needed embedding into practice to ensure continued improvement.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had made improvements to the information available about people's healthcare needs although this was not always current.

People were happy with the support they received with their healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff were able to tell us how people would prefer to receive their care.

People told us they felt cared for and information available to staff about people's likes and dislikes had improved.

Is the service well-led?

Requires Improvement

The service was not always well led.

There continued to be a lack of consistent management at the home.

Quality monitoring systems had improved although some had not been entirely effective.

Gracewell of Edgbaston

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We undertook an unannounced focussed inspection of Gracewell of Edgbaston on 30 November 2016. The inspection was undertaken by two inspectors. At this inspection we checked to see that improvements to meet legal requirements planned by the provider after our comprehensive inspection in April 2016 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, caring and well-led. This is because the service was not meeting some legal requirements.

As part of this inspection we reviewed information we held about the home, including notifications that had been sent to us.

At the inspection we spoke with six people, one relative, two nursing staff, five staff and an activities co-ordinator. We also spoke with the interim manager, deputy manager and director of operations. We spoke with the provider's quality monitoring team who were visiting the service at the time of the inspection. We sampled records including quality monitoring systems, two care plans and medication records.

Some people living at the home were unable to communicate verbally due to their healthcare conditions. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 12 and 13 April 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not taken appropriate action to reduce known risks to people. We had also identified that the provider had not ensured people had sufficient quantities of medicines and had not carried out safe management of medicines practice The provider had produced action plans detailing their plans to improve the management of risk and safe management of medication. At this inspection we found that some improvements had been made and the provider was no longer in breach of regulation.

The provider had taken action to improve the process of identifying and assessing of risks to people's care. We looked at two people's care plans and noted that initial assessments of risks took place with some detail of steps to take to reduce the risk for the person. We saw that monitoring of risks needed further improvement. For example, one person was a risk of developing sore skin and needed to be supported to move position to reduce this risk. Whilst the staff we spoke with knew about individual risks to peoples' health and well-being and how these were to be managed, we found peoples' care records and supporting documents did not provide evidence that risks had been monitored consistently. We found that further improvements were still required to ensure the risks associated with people's care were monitored and managed effectively.

Through our conversations with staff we identified that two agency staff were unsure of the action to take in the event of a fire. This placed people at potential risk should an emergency situation occur. We received evidence on the day of the inspection that agency staff had been provided with training about the fire procedure but also received assurance that the fire procedure would be re-visited with staff to ensure appropriate action would be taken.

Since the last inspection the provider had determined that only nursing staff would administer medicines and re-training and competency checks had been carried out for all nurses administering medicines. Assessing competency is a way of checking staff have the skills and knowledge needed. Since the last inspection the provider had carried out a recruitment drive to ensure there were sufficient permenant nursing staff at the service who would be more familiar with the systems in place for medicine management at the home and in turn reduce the risk of errors.

At the last inspection we had identified that the provider did not have systems in place to ensure people had sufficient quantities of medicines. This had led to people not receiving the medicines they needed. The provider advised that they had established that some of these errors had occurred due to the pharmacy supplying medicines to the home. Although this had been identified at that time little had been done to resolve this. At this inspection we found that the provider had made and sustained improvements ensuring that the home had sufficient supplies of medicines to meet peoples needs. The arrangements for the new pharmacy supplying the home had only commenced one month before the inspection so we were unable to gain sufficient evidence to determine if this solution had been entirely effective.

At our last inspection we had identified that information was not always available for staff about when a person may need their as required medicines. At this inspection we saw that the provider had ensured this information was available.

Daily checks had been introduced to check that medicines had been given as prescribed. At the end of each shift nursing staff were required to check each persons medicines to ensure they had all been administered. We saw that these checks had not been completed consistently and this monitoring system was not entirely effective.

Due to the number of concerns raised at the last inspection around medicine management the provider had carried out an evaluation of all systems involved in medicine management and had produced a dedicated action plan to improve medicine management. The provider carried out monthly monitoring checks based against this plan to identify if they were on target in making the improvements they had planned. We saw that progress had been made in all areas of the action plan although further progress was still required in certain areas.

We sampled and checked the medicine records for two people living at the home. We saw that both were completed accurately and completely. We saw that medicines were stored safely.

People we spoke with told us they were happy with the support they received with their medicines. One person told us, "I get my medicines on time," and another person commented, "My medicines are dispensed on time and closely monitored."

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 12 and 13 April 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured people were supported appropriately with their healthcare needs. At this inspection we found that some improvements had been made and the provider was no longer in breach of regulation.

People told us they received support to have their healthcare needs met. People told us that they received support with healthcare checks from professionals such as optician's and chiropodist and one person told us, "Staff will phone the doctor when I need one." Another person told us the service had sourced further advice from healthcare professionals to enable their independence to be promoted and told us, "I'm having physio. They're trying to get me more mobile."

Staff we spoke with told us there were systems in place to share information about changes to people's healthcare to ensure staff were aware of people's current needs. One staff member told us, "Handovers are vital for the well-being of service user's. It's here we discuss people's individual health needs."

We saw that the information available about people's healthcare needs had improved. However, we noted that where people's healthcare needs had changed, information in people's care plans had not always been updated. This meant there was some risk that staff would not have access to information about people's most current needs.

Although outcomes for people had improved in most cases, the monitoring systems in place had not become fully embedded into everyday practice.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 12 and 13 April 2016 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured people received personalised care that met their individual needs. At this inspection we found that some improvements had been made and the provider was no longer in breach of regulation.

People told us they felt cared for. People's comments included, "Staff are kind," and "The staff are wonderful I can't speak highly enough of them." People told us they felt involved in their care and one person told us, "I make my own decisions." Another person told us, "The care is very personal to me and my needs."

At our last inspection we found that many of the staff working at the service were agency staff who did not know people well. Since that inspection the provider had reduced the numbers of agency staff working at the service significantly by carrying out recruitment drives and employing permanent staff. Where agency staff continued to be used the provider had ensured that known agency staff were used to support people.

Some of the permanent staff we spoke with knew people well and could described what people's interests were. One staff member told us, "Person centred care is a must." However other staff were unable to tell us important information about how individual people would prefer to have their care delivered. Further improvements were needed to ensure people received personalised care from staff who knew them well.

We saw that improvements had been made to the information available in people's care plans about their likes, dislikes and family histories. This additional information would aid people in being able to state how they wanted their care to be delivered and would ensure staff had access to important information.

We carried out a SOFI [Short Observational Framework for Inspection] observation to capture and reflect the experiences of people who couldn't verbally tell us their experience of care. During the observation we saw that despite staff being present in the lounge there were long periods of time where staff did not interact or engage with people. This lack of interaction failed to benefit people's well-being. We received assurance after the inspection that this issue was being addressed and additional training was due to be carried out with the staff team.

A number of people living at the home chose to spend their time in their bedrooms. There were systems in place for people to summon assistance by using call bells which were in each person's room. We observed one instance where a person was not responded to promptly. We found that one person's call bell was not accessible to them despite this being the only way for them to seek assistance. Although some improvements had been made people may not have their individual needs met. We spoke with the director of operations about this who said they would investigate into these concerns.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 12 and 13 April 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have effective systems in place to fully monitor the quality and safety of the service. At this inspection we found that some improvements had been made and the provider was no longer in breach of regulation.

At our last inspection we had identified that the quality of the service had not been monitored consistently since the home opened. There had been a number of management changes leading to a lack of consistent management within the service, with four registered managers leading the service since April 2015. Since our last inspection a new registered manager had been recuited and became registered in June 2016. At this inspection we found that this registered manager had been absent from work. However management cover at the home was being provided by interim managers. There continued to be a lack of consistent management at the service and one staff member summarised this when they commented that: "Our only problem is a lack of a manager."

Oversight of the quality of the service was being carried out by the director of operations who visited the service once a week to oversee the management of the service and to monitor improvements. The director of operations informed us that the service was under close monitoring due to the last inspection report which had highlighted a number of areas that required improving.

Quality audits had been introduced which monitored key aspects of the service such as the number of accidents that had occurred. These audits were completed monthly and were monitored by the provider. We found that audits had not been entirely effective in identifying that some care plans did not always contain up to date information and that monitoring of risks had not been carried out consistently.

Focussed quality monitoring systems had been introduced around key aspects of the service such as medication. We saw that progression had been made although further improvements were still required.

Staff told us about some of the improvements that had been within the service following the last inspection.

Following our last inspection the provider has been open in their communication with the Commission and had updated us on improvements that have been made within the service. The provider had ensured that statutory requirements, such as notifying the Commission of specific events that occurred in the home, had continued.