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Graywood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Graywood Care Home provides accommodation and personal care for up to 13 people who need support with their mental health. The service is located in a residential area of Margate, near to shops, local amenities and the sea front. There is good access to public transport. The service is set out over two floors. The first floor could be accessed by stair lift if needed. On the ground floor were communal areas and bedrooms. Each person had their own bedroom which contained their own personal belongings and possessions that were important to them.

There were 13 people living at the service at the time of the inspection. The care and support needs of the people were varied. There was a wide age range of people living at the service with diverse needs and abilities. The youngest person was in their 40's and the oldest was over 90 years old. As well as needing support with their mental health, some people required care and support related to their physical health. People were able to make their own decisions about how they lived their lives. They were able to let staff know what they wanted and were able to go out independently.

There was no registered manager in post. This was because the service was registered to one person who is the provider and therefore the service does not require a registered manager. The provider was the registered person. 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. The registered provider had overall responsibility for this service. The provider was at the service every day and there was a deputy manager in post who gave support with the day to day running of the service. The service was a family run business and family members were employed by the provider. The deputy manager, staff and the provider supported us throughout the inspection.

The management and some staff knew how the Mental Capacity Act (MCA) 2005 was applied to ensure decisions made for people without capacity were only made in their best interests. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. At the time of the inspection no-one living at the service was subject to a DoLs restriction and everyone had full mental capacity to make the decisions they wanted to about how they lived their lives.

Before people decided to move into the service their support needs were assessed by the provider and deputy manager to make sure they would be able to offer them the care that they needed. The care and support needs of each person were different and each person's care plan was personal to them. People had been involved in writing the information in their care plans. In some care plans, but not in all, there was the information needed to make sure staff had guidance to care and support people in the safest way. People indicated they were satisfied with the care and support they received. When people's needs changed some care plans had not been reviewed and updated to reflect the changes. Other plans had been updated. Potential risks to people were identified but full guidance on how to safely manage the risks was not always

available. This left people at risk of not receiving the interventions they needed to keep them as safe as possible. People had an allocated keyworker who was involved in their care and support. A key worker was a member of staff who takes a key role in co-ordinating a person's care and support and promoted continuity.

People's medicines were not always handled and managed as safely as they could be. Some medicine records were not completed accurately. There was a lack of detailed guidance for medicine needed on a 'when needed' basis. People's physical and mental health was monitored and they had regular contact with specialist health care services. If people were unwell or their health was deteriorating the staff contacted their doctors or specialist services.

People said that they enjoyed their meals. People were offered and received a balanced and healthy diet. They had a choice about what food and drinks they wanted. If people were not eating enough they were seen by dieticians or their doctor and a specialist diet was provided.

Safeguarding procedures were in place to keep people safe from harm. On two occasions these procedures had not been followed by the provider. Management had not consulted with the local authority safeguarding team when incidents had occurred which they should have done as part of those procedures. People told us and indicated that they felt safe at the service; and if they had any concerns, they were confident these would be addressed quickly by the provider or the deputy manager. The staff had received training to recognise and report safeguarding concerns but this had not been updated since 2013 and staff were unsure about some aspects of protecting people and what constituted abuse. There was no available copy of the local authority's 'Adult Protection Policy Protocols and Guidance available for staff to refer to if they needed to. Staff were confident to whistle-blow to the provider or deputy manager if they had any concerns and were confident appropriate action would be taken.

On the whole staff were caring and respected people's privacy and dignity. There were positive and caring interactions between the staff and people were comfortable and at ease with the staff. On one occasion we observed that staff could have been more engaging and respectful when people were being given their medicines. Everyone told us their privacy was respected and they were able to make choices about their day to day lives.

There was a stable staff team working at the service, most had been there for many years. They knew people well and how they liked things done. There were enough staff available for people's care and support needs but staff had many tasks to complete throughout their shifts especially the morning shift. They had to clean, prepare meals, serve meals, and give people their medicines. They were so busy they had very little time to spend with people to support, encourage, organise and motivate people to do things during the day. People were left to their own devices about what they did and where they spent their time. This suited some people but other people would have benefitted from individual support and input from staff.

Staff had completed induction training when they first started to work at the service but all staff had not received all the continuous training and updates they needed to carry out their roles effectively and safely. Staff had received regular supervisions (one to one meetings with a senior member of staff) and there were regular staff meetings. Staff said that they supported by the management.

Staff were not always recruited safely. The provider had policies and procedures in place for when new staff were recruited, but these were not always followed. All the relevant safety checks had not been completed before staff started work. Some application forms did not show a full employment history and gaps in employment had not been explored when staff were interviewed. Some staff did not have two references on

their files and some of the references did not identify the person who had written the reference.

There was a complaints procedure but the complaints procedure was not easily available or accessible to people or others who visited the service. People told they knew who they would complain to within the service and felt they would be listened to but they had no information available to direct them to complain to anyone outside the service.

There were some quality assurance systems in place. Emergency plans were in place so if an emergency happened, like a fire the staff knew what to do. Checks were done to ensure the premises were safe, such as fire and health and safety checks. The checks for the fire alarms were done weekly and other fire checks were completed monthly. There were regular fire drills at the service so that people knew how to leave the building safely. Other health and safety checks were regularly carried out but some checks and audits had not been done. The management had not identified and taken action to make sure the all the systems used at the service were checked regularly and that shortfalls were identified and improvements made.

Staff and people told us that the service was well led and that the management team were supportive and approachable. They said there was a culture of openness within Graywood Care Home which allowed them to suggest new ideas which were often acted on. The deputy manager had formally sought feedback from people, their relatives and visitors. Their opinions had been captured, and analysed to promote and drive improvements within the service. Stakeholders had not been formally asked for their opinions of the service. Informal feedback from people, their relatives and healthcare professionals was encouraged and acted on wherever possible.

The provider is required by law to notify the Care Quality Commissions (CQC) of incidents that occur at the service. The provider had not notified CQC of some of the incidents that had happened at the service like serious injuries.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Risks to people were assessed but guidance was not always available to make sure all staff knew what action to take to keep people as safe as possible. Accidents and incidents were recorded and action taken, but these were not analysed to look for patterns or trends to reduce the risk of reoccurrence.

People's medicines were not always managed as safely as they could be.

People had not been fully protected from abuse and harm as safeguarding policies and procedures had not been consistently followed. Staff knew how to protect and keep people safe.

Recruitment procedures were in place but were not fully adhered to before new staff started to work with people.

Staff were not always suitable deployed to make sure people received the support that they needed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff had not received all the training they needed to meet the needs of people. Staff felt well supported by the registered manager and the staff team.

The management and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

When a people had specific physical or mental health needs and conditions, the staff had contacted healthcare professionals and made sure that appropriate support and treatment was made available.

People and their representatives were involved in making decisions about their care and support.

People were provided with a suitable range of nutritious food and drink.

Is the service caring?

Requires Improvement

The service was caring.

On the whole staff communicated with people in a caring and compassionate way.

People and their relatives were able discuss any concerns regarding their care and support. Staff knew people well and knew how they preferred to be supported. People's privacy was supported and respected and their independence was promoted.
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People were involved in reviews of the care being given.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's care and support was not always planned in line with their individual care and support needs.

People were involved in aspects of their care and support. People's choices and preferences were considered in all aspects of their care.

People said they would be able to raise any concerns or complaints with the staff, deputy manager and provider, who would listen and take action if required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Systems for monitoring the quality of care provided were not fully effective. Shortfalls had not been identified and some checks had not been carried out.

Staff were aware of the provider's vision for the service and this was followed through into their practice. The staff were aware of the service's ethos for caring for people as individuals.

People and staff said that they felt listened to and that they had a say on how to improve things. There was a commitment to listening to people's views and making changes to the service. However, stakeholders, such as professional bodies had not

been included in the survey to give them the opportunity to voice their opinions about the quality of the service.

Graywood Care 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 5 and 9 February 2016 and was unannounced. On the first day of the inspection there were two inspectors and on the second day there was one inspector.

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 included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or a serious injury.

We met all of the people living at the service and had conversations with ten of them. We spoke with four members of staff and the provider and the deputy manager. Following the inspection we spoke with a visiting professional who had regular contact with the service.

During our inspection we observed how the staff spoke with and engaged with people. We looked at how people were supported throughout the day with their daily routines and activities. We reviewed five care plans of the people living at the service, and looked at a range of other records, including safety checks, records kept for people's medicines, staff files and records about how the quality of the service was managed.

We last inspected this service on 19 July 2013. There were no concerns identified at this inspection.

Inadequate

Is the service safe?

Our findings

People did say, "I feel safe because I have people around me who help me if I need it". People were happy and relaxed. People had space to walk around freely. People told us they felt safe. People said, "They look after you well here I have never had any issues". "I feel safe and well looked after" and "It's the best home I've been in. The provider, she is a like a mum to us".

The provider and deputy manager had a lack of awareness and insight about their responsibility to report safeguarding incidents to the local safeguarding team and to the Care Quality Commission. Staff were not fully aware of the various types of abuse that needed to be reported. There were two incidents recorded which had involved people in potentially abusive situations. Staff told us what diversionary techniques they had used to de-escalate potential conflict. They said they would report concerns of a safeguarding nature to their manager. The manager and staff had dealt with the incidences but had not followed procedures by consulting with the local council safeguarding team who would have discussed the issue. A decision would then have been made on how to proceed to keep people safe in the way that suited them best. The provider did not have a copy of the local authority safeguarding protocol guidance which would have given guidance and information on incidents that may be safe guarding issues. There was a lack of awareness amongst staff with regards to knowing about the process of reporting concerns to the local safeguarding team.

Staff were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the provider had not followed the correct procedures to make sure people were as safe as possible. .

This is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from financial abuse. There were procedures in place to help people manage their money as independently as possible. This included maintaining a clear account of all money received and spent. Money was kept safely and was accessed by senior staff only. People's monies and what they spent was monitored and accounted for. People could access the money they needed when they wanted to.

Risks to people had been identified but the guidance on how risks should be managed varied. Some risk assessments contained the information needed to keep people as safe as possible but other risk assessments did not. One person had behaviours at times which may have posed a risk to others. The guidance for staff stated 'physical intervention'. There was no further information to tell staff what they had to do. Staff said that they did not use physical intervention and different staff told us about the different ways they would deal with behaviours. The interventions were not consistent and there was a risk that people would not be supported in a way that suited them best and keep them and others as safe as possible. The deputy manager told us they made attempts to explore the reasons for the unsettled behaviours and how the behaviours were being managed. They said they had made a referral to one person's GP and to other healthcare professionals which had resulted in a change of medication but the options explored were not always recorded, so it was not clear that the deputy manager was doing all they

could to mitigate potential risks.

When people had conditions like diabetes there was no guidance for the signs staff should look for if a person's diabetes was becoming unstable and what action they should take to try and prevent this from happening. There was no instruction on what they should do if this did happen. The manager and staff were unclear of the risks the condition posed, the signs they should be looking for if a person's diabetes was becoming unstable and what action they should take.

Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. This is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks had been assessed in relation to the impact that the risks had on each person. There were risk assessments for when people had conditions like epilepsy or if people were at risk of losing weight .These were detailed and explained how to support and care for people safely.

The provider had policies and procedures in place for when new staff were recruited, but these had not been consistently followed. All the relevant safety checks had not been completed before staff started work. Some application forms indicated that staff had gaps between their previous employments; the gaps had not been explored or questioned.. One staff file only contained one reference and the references came from someone not named as a referee, the reference was not signed or dated and there was no way of knowing who it was from. In some cases employment contracts had not been signed. The lack of full employment checks left people at potential risk of being cared for by staff that may not be safe to work with people.

However, in other staff files all the safety checks had been completed. On the second day of the inspection the deputy manager had started to address these shortfalls.

The registered person had not ensured that all the information was available as required by Schedule three of the Regulations before new members of staff started work. This is a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

People told us that the staff were always very busy and had lots of things to do. Staff told us they did not have a lot of time, particularly in the mornings to spend with people. During the morning shift from 9:00 a.m. till 3:00 pm there were two care staff and the deputy manager on duty. We observed people alone in the lounge area for long periods of time. We did not see any staff come into the lounge to engage with or check on people. When we were in the office we observed staff come in and out to gather cleaning materials to clean the premises but they had very little time to interact with people. Staff told us, "In the morning we are very busy cleaning the lounge, kitchen and doing the laundry so we don't have much time to talk with the service users, but in the afternoon it is better and we have more time to engage with the service users". Staff had many tasks to complete, like cleaning, laundry, preparing meals, serving meals, and giving people their medicines. They were so busy they had very little time to spend with people to support, encourage, organise and motivate people to do things during the day. People were left to their own devices about what they did and where they spent their time. This suited some people but other people would have benefitted from individual support and input from staff.

There were not sufficient numbers of staff deployed to keep to meet the all the care and support needs of the people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

People told us that they always received the medicines they were supposed to. Staff said that they had received training in medicines and that their competencies in giving medicines to people were checked to make sure they were safe to do so. The service had a medication policy that covered the main areas about medicines but it did not contain all the information needed to make sure people received their medicines as safely as possible.

Some people were prescribed special drugs that needed to be counted every time they were given to a person. On the first day of the inspection we found that some of these medicines could not be accounted for. Staff told us that they had not been regularly counting the tablets when they gave them to people. The deputy manager was unable to explain the discrepancy. Audits and checks on the medicines had not been completed. Advice was given to the deputy manager about the action they should take as the policies and procedures did not contain this information. On the second day of the inspection the tablets could be accounted for and there had been miscommunication between staff and the deputy manager.

Sometimes people were prescribed tablets that had to be written by hand onto the medicines records by staff. When staff had received these tablets they had not entered the amount of tablets that had been received and they had not signed and countersigned to make sure there was the correct amount of tablets and that they were writing in the correct person's record. There was a risk that people might not receive their tablets safely and if errors were made the staff members would not be identifiable.

The temperature of the room where the medicines were stored was not checked. There was a risk that the room temperature may be above the recommended level. If this happened it could reduce the effectiveness of medicines. The staff did check the temperature of the room during the inspection, which was within the recommended level. The deputy manager told us that this check would be implemented daily.

There was risk that people were not receiving their medicines as safely as they should be.
This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The staff carried out regular health and safety checks of the environment and equipment. This made sure that people lived in a safe environment and that equipment was safe to use. These included ensuring that electrical and gas appliances were safe. Water temperatures were checked and regular checks were carried out on the fire alarms and other fire equipment to make sure it was working correctly. People had a personal emergency evacuation plan (PEEP) and staff and people were regularly involved in fire drills. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of a fire. People and staff were able to say what they would do in the event of a fire. They said they had practised lots of times and were able to say exactly what they had to do if the fire alarm went off.

Requires Improvement

Is the service effective?

Our findings

People told us the staff looked after them well and the staff knew what to do to make sure they got everything they needed. They said that staff were good at what they did. People told us they were "happy" and "liked" living at Graywood Care Home. We received feedback from a health care professional who was involved with the service. They told us that their experience of working with the people and staff at Graywood Care Home was a positive one. They had witnessed people being treated with respect and dignity. They said "The staff have a good understanding of people's needs and know how to support them".

Visiting professionals said that there was clear and effective communication with the staff. Regular reviews were held when people's care was discussed in full. They told us that the staff asked for advice and support if they are unsure how to manage certain situations in regard to more complex mental health issues.

The majority of the staff team had worked at the service for many years. The staff knew people well and knew how they liked to receive their care and support. The staff had knowledge about how people liked to receive their personal care and what activities they enjoyed. Staff were able to tell us about how they supported people on a daily basis to ensure they received effective individual care and support. They were able to explain what they would do if people became restless or agitated.

People had a wide range of needs. Some people's conditions were more complex than others. There were shortfalls in staff training especially related to people's specific needs. Some staff had not completed all the training they needed to make sure they had the skills, knowledge and competencies to meet all people's needs. For example, some staff had not completed mental health awareness; which was the main reason people were at the service. Some staff had not worked with people with mental health needs before and did not have a full understanding on how best to support people with their specific conditions. Others had not completed first aid training and Mental Capacity Act training. Some staff had not received training in diabetes; there were people with this condition. Staff did not know the signs and symptoms to look for if people's diabetes became unstable. There was a risk that people may not receive the care and support that they needed as staff had not completed the necessary training. These were important and relevant areas of training needed to support people safely and effectively. The deputy manager kept a training record which showed when training had been undertaken and when 'refresher training' was due. Regular training updates were provided in subjects, such as, fire safety, medicines and moving and handling and first aid. The deputy manager had identified the shortfalls in staff training and there were plans in place to make sure all staff received the training that they needed. The deputy manager said that training had been booked and was taking place a couple of days after the inspection.

The registered person had not taken all the necessary steps to make sure all staff were suitably qualified, competent skilled and experienced to work with people. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received inductions when they started working at the service. The induction consisted of time spent going over policies and procedures, getting to know the service and the people living there. As part of the

induction period, new staff shadowed existing staff to get to know how things were done. Staff member's personnel records showed that they were going through the induction which was being signed off by the deputy manager at each stage.

Staff had regular supervisions (one to one meetings) with the deputy manager. This was to make sure they were receiving support to do their jobs effectively and safely. Staff said this gave them the opportunity to discuss any issues or concerns that they had about caring and supporting people, and gave them the support that they needed to do their jobs more effectively. Staff had an annual appraisal to discuss their training and development needs. The performance of the staff was being monitored according to the company's policies and procedures. The staff were supported out of hours by the provider and deputy manager. Staff said they could contact the management team day or night and they were confident they would receive any support and help that they needed.

There were regular staff meetings that highlighted people's changing needs and other issues like health and safety, staff conduct and training. There were reminders about household tasks allocations and about the quality of care delivered. Staff had the opportunity to raise any concerns or suggest ideas. Staff felt that their concerns and ideas were taken seriously by the provider and deputy manager and acted on.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. People had regular health checks with their doctor. The staff actively sought support when people needed it and did not work in isolation. People were supported to make and attend medical appointments. People's health was monitored and care provided to meet any changing needs. When people's physical and/or mental health declined and they required more support the staff responded quickly. Staff contacted local community healthcare professionals and made sure that the appropriate treatment, care and support was provided. Staff closely monitored people's health and wellbeing in line with recommendations from healthcare professionals.

We observed a lunchtime meal. This was a social occasion when people sat together and chatted. There was a relaxed and friendly atmosphere. People had helped lay the tables. The tables were nicely laid with serviettes and condiments. Staff were aware of what people liked and disliked and gave people the food they wanted to eat. Staff respected people's choices about what they did eat. People were supported and encouraged to eat a healthy and nutritious diet. People could have drinks and snacks when they wanted to. Some people had coffee/tea making facilities in their rooms so they could be more autonomous and independent. Staff included and involved people in choosing and preparing their meals. People often went out to eat in restaurants and local cafés. When people were not eating their meals because their mental health was deteriorating or they were unwell the staff tried to made sure they had enough calories to maintain their weight to remain as healthy as possible. The amount of food and drinks they had was monitored to make sure they were having adequate amounts to keep healthy and hydrated. Staff contacted dieticians and supplement drinks were given to people when they needed it. Some people had specific health needs like diabetes and staff supported and encouraged them to manage their diets to make sure they were as healthy as possible.

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 make 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 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. At the time of the inspection all the people had the capacity to make their own decisions and no-one was deprived of their liberties.

Requires Improvement

Is the service caring?

Our findings

One person said, "I like living here, we all get on most of the time". Another said, "I love it here". The staff are very helpful and they look after us". A lot of the people had been living at the service for many years. People told us that they wanted to be independent and do as much as possible for themselves; they said the staff supported them to do this but 'stepped in' if they did need any support or help. They said they were very happy living at Graywood Care Home and would not want to be anywhere else. People told us, "I am helped by staff to get my things for my bedroom". People looked very comfortable with the staff that supported them. People chatted and socialised with each other.

On the whole people were treated with dignity and respect. Most of the interactions between people and staff was positive, caring and inclusive. However, on one occasion when people were receiving their medicines at lunchtime, staff went to them and put their medicines down in front of them. They did not engage with the people and just waited till they had taken their medicines and walked away. On this occasion people were not fully considered and were not treated with respect and dignity. This is an area for improvement. The deputy manager agreed with this observation and addressed it with the staff team.

Staff were very busy during the inspection and had little time sit down and speak with people about what they wanted to do and what they had done. Staff did chat with people as they went by and carried out their duties but there was little quality time spent with people. Staff said that they were able to spend more time with people in evening. This is an area for improvement

People were independent and could come and go as they pleased. If they wanted to, people had a key to the front door to let themselves in. People decided when they went to bed, when they got up and how they wanted to spend their time. People said there were opportunities to express their views about their own support and about the running of the service. There were regular 'house' and individual meetings. People told us their opinions were acted upon. They said that they enjoyed their lives at Graywood Care Home. Staff considered people's views and took action in line with people's wishes. One person said, "I have made my bedroom how I want it".

Staff said that they kept themselves up to date about the care and support people needed by reading people's care plans and from the handovers at the beginning of each shift. The key worker system encouraged staff to have a greater knowledge, understanding of and responsibility for the people they were key worker for. Staff involved people in making decisions about their care. People said that they were involved in planning their care. They told us that staff sat with them to discuss what care and support they wanted and what they did not want. They said they were involved in what happened at the service.

Staff took care to ask permission before intervening or assisting. Staff spoke with people in a friendly and pleasant manner. Staff respected people's privacy and knocked on people's doors and waited to be invited in. When staff wished to discuss a confidential matter with a person they did not do so in front of other people but asked the person if they could speak to them in private. Everyone said their privacy was always respected.

Requires Improvement

Is the service responsive?

Our findings

Visiting professionals told us that staff contacted them promptly if there were any concerns and acted on their advice and made changes to people's care and support.

People had assessments before they came to stay at the service. People said that they were involved in planning their own care. They told us that they talked with staff about the care and support they wanted and how they preferred to have things done. Assessments reflected their previous lifestyles, backgrounds and family life. It also included their hobbies, and interests, as well as their health concerns and medical needs. These assessments helped staff to understand about people and the lives that they had before they came to live at Graywood Care Home. The assessments also included information about how people wanted to remain independent with specific tasks and the areas where they needed support. Staff asked people and their family members for details of their life so they could build up a 'picture' of the person. This gave the provider, deputy manager and staff additional information about the person and how to care and support them.

Each person had a care plan. These were written to give staff the guidance and information they needed to look after the person in the way that suited them best. The information and guidance in the plans varied. Some parts of the plans contained clear directions and guidance for staff on how to care and support people safely and effectively. The care plans gave the information on the support people needed with their personal care. The care plans clearly stated the signs staff should be observing for to detect if people's mental health was deteriorating and the action they should take. Other parts of the care plans did not contain the guidance staff needed. People on occasions had problem behaviours and could be threatening to others. One plan stated use 'physical intervention'. The staff did not use and had not been trained to use physical intervention techniques. There was no guidance in place to explain what action they should take. There was a risk that staff would not use the right techniques to deal with these types of situations. Another care plan stated that a person was receiving supplement drinks to help them maintain their weight. Staff said that the person had the drinks every morning. We checked if the person was receiving the drink and found that it had been discontinued. The staff were not aware of this and the reasons why the drinks had been discontinued. The care plan had not been reviewed and updated to reflect that the staff now needed to monitor the person's diet and encourage them to eat adequate amounts of nutritious food and not rely on supplements. There was a risk that people may not be receiving the support that they needed with their diet.

People had monthly meetings with their key workers. At these meetings people talked about what they had been doing, how they were feeling. If they had any concerns and if there was anything specific that they wanted. These meetings did not identify people's goals and aspirations and what they wanted to do and achieve in the short and long term. People were not receiving consistent person –centred support and encouragement to live more fulfilling and interesting lives.

People decided what they wanted to do and when they wanted to do it. Information was included in people's care plans about their preferences about how they wanted to be supported. Staff were familiar with

people's likes and dislikes in regards to their personal care, hobbies and interests, outings, holidays and activities in and outside the service. Throughout the days of the inspection people decided how they spent their time, the food they wanted and what social activities they wanted to do. Some people went out to visit family; others went to meet up with friends. Others liked to go shopping. People were able to do these activities on their own. Some people had specific interests and hobbies. In some care plans we saw that people liked animals, going to football matches and photography. One person had a special interest in aeroplanes. People said that they would like to take part in activities that involved these interests. There had been little support and encouragement from the staff to support people to organise and access these interests. People could have been living more fulfilling and interesting lives if they were helped to do this.

The provider was not ensuring that person centred care and treatment was meeting the needs of people and plans had not all been reviewed and updated. This is in breach of Regulation 9(1) (a) (b) (c) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People said that they felt listened to and their views were taken seriously. If any issues were raised they said these were dealt with quickly. There were regular meetings for people and staff. There was a commitment to listening to people's views and making changes to the service in accordance with people's comments and suggestions. Sometimes people decided to remain in their rooms for periods of time. Staff encouraged them to come to the communal areas to socialise and eat their meals but respected their wishes if they chose not to do this. If people wanted to be on their own staff respected this.

The staff encouraged and supported people to keep in contact with relatives and friends. People who were important to people like members of their family and friends were named in the care plan. This included their contact details and people were supported to keep in touch. Relatives came to visit and people went to visit their families. People often went out to meet up with their friends in local cafés and pubs.

People and their relatives were confident that the provider, deputy manager and staff would listen to them if they had any concerns and would take action to resolve the issues. People said they would have 'no problems' complaining but did not have any complaints. People were asked regularly if they were 'happy' with everything. During residents meetings people were asked if they had any complaints, issues or concerns. There was a written complaints procedure. There had been no formal complaints made in the past 12 months. Any complaints would be logged and investigated and responded to by the provider. The complaints procedure was not produced in an accessible or easy read format that may be more suitable for people's needs. This was an area for improvement.

Requires Improvement

Is the service well-led?

Our findings

People and staff told us they thought the service was well led. They said that the provider and deputy manager were approachable and supportive. They said they could speak to them whenever they wanted to. People told us the provider and deputy manager listened to what they had to say and 'sorted things out' if there were any problems. The staff said the provider dealt with issues in a fair way. On the day of the inspection people and staff came in and out of the office whenever they wanted to. There was clear and open dialogue between the people, staff and the provider and deputy manager. Despite the constant demands, the provider and deputy manager remained calm and engaged with people and the staff. A staff member said "You can contact the manager at any time. Even if they are not at work they are always there at the end of the phone to give advice and support".

Services that provide health and social care to people are required to inform the Care Quality. Commission, (the CQC), of important events that happen in the service like serious injury and safeguarding incidents. This is so we could check that appropriate action had been taken. The management were aware that they had to inform CQC of significant events, in a timely way but we had not received some notifications from the service. They had not identified some events as significant and had not informed us.

The provider had not notified the Care Quality Commission of significant events that occurred at the service. This is a breach of Regulation 18 Registration Regulations 2009.

Quality assurance systems were in place but these did not cover all the systems used at the service. There were no audits and checks to make sure care plans were up to date and relevant for people, medicines had not been audited to make sure people were receiving their medicines as they were supposed to. Not all the staff files had been checked to make sure they contained all the information required to make sure staff were safe to work with people. These shortfalls were identified at the inspection but had not been identified by the provider.

Accidents and incidents had been recorded and action had been taken to reduce the risks, however these were not analysed to identify any patterns or concerns to reduce the risk of them happening again.

Satisfaction surveys had been sent to people, their relatives and staff. The last surveys had been done in August 2015. The deputy manager said they formally asked people for their comments and views every six months and relatives and staff annually. When people had made comments or suggestions these had been responded to and action taken. For example, people had wanted different and more varied meals. This had been addressed and people were now able to choose from a more varied menu. The provider had not sent surveys to stakeholders who had contact with the service including visiting health care professionals. The deputy manager said they would include stakeholders in their next survey.

The registered person had failed to identify the shortfalls at the service through regular effective auditing. Feedback was not being gathered from all stakeholders to improve the quality of the service. This was a breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The deputy manager carried out monthly health and safety checks of the environment including the water temperatures, the stair lift and fire safety equipment. All bed rooms were checked monthly for any repairs or replacements needed for fixtures and fitting. Safety of electrical equipment was checked, cleanliness and décor. These checks were recorded. If any shortfalls or issues were identified then action was taken to rectify them.

People and staff said that the provider and deputy manager were available and accessible and gave practical support, assistance and advice. Staff handovers between shifts highlighted any changes in people's health and care needs. Staff were clear about their roles and responsibilities. They were able to describe these well. The staffing structure ensured that staff knew who they were accountable to. Regular staff meetings were held where staff responsibilities and roles were reinforced by the management team. The management clearly stated in the minutes of meetings the expectations in regard to staff members fulfilling their roles and responsibilities.

Our observations of people and discussions with staff at the service showed that there was an open and positive culture between people, staff and the management. The service's visions and values were to give people the care and support that they needed while keeping them safe. The management and staff were clear about the aims and visions of the service. When staff spoke about people, they were very clear about putting people first but said that they often did not have the time to do the things people would benefit from as they had so many tasks to complete. The provider and deputy manager knew people well, communicated with people in a way that they could understand and gave individual and compassionate care. The staff team followed their lead and on the whole interacted with people in the same caring manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission of significant events that occurred at the service. This is a breach of regulation 18 (1) (2) (a) registration Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring that person centred care and treatment was meeting the needs of people and plans had not all been reviewed and updated. This is in breach of Regulation 9(1) (a) (b) (c) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk of receiving care or treatment that was inappropriate or unsafe People were at risk of not receiving all their medicines safely and consistently. Regulation 12 (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to protect people from abuse by not responding to allegations of abuse appropriately. Regulation 13(1) (3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not identify and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity. The systems in place to quality assure the care being provided were not fully effective. Feedback was not being gathered from all stakeholders to improve the quality of the service. 17 (1) (2) (a) (b) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not obtained all the information as stated in Schedule 3 for each member of staff. Regulation 19 (3) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were times when there were staff on duty that were not suitably qualified, skilled and

experienced to meet the needs of service users.

Staff were not always sufficiently deployed to make sure the care and support needs of service users were consistently met.

Regulation 18 (1) (2)(a)