Grace House Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 27 October 2016 and was unannounced. This was a comprehensive inspection.

Grace House is a residential home providing support to up to 21 older people, many of whom are living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in November 2014 we found breaches of the legal requirements. The provider wrote to us to inform us of the action they planned to take to address the concerns. This comprehensive inspection was conducted to check that the action had been taken by the provider and that they were now meeting their legal requirements. We found that measures had been taken to ensure breaches in regulation were met but we did identify other areas in which the provider was not meeting legal requirements.

People's rights were not protected as staff did not work in accordance with the guidance of the Mental Capacity Act (2005). Restrictions were being placed on people before their mental capacity had been assessed. Best interest decisions were also not recorded. MCA assessments were not taking place for day to day decisions.

At our last inspection, we recommended that the provider review their systems for assuring quality. At this inspection, we found that whilst some improvements had been made, there was a lack of robust quality assurance systems in place to ensure people received care of a high quality.

Accidents and incidents were recorded and measures were taken to prevent a reoccurrence. Staff routinely carried out risk assessments and created plans to minimise known hazards whilst encouraging people's independence. Staff understood their responsibilities in safeguarding people and knew what to do if they suspected abuse had occurred.

People had access to some activities. We recommended that the provider review the activities on offer to people.

Systems were in place to keep people safe in the event of an emergency. A contingency plan was in place to ensure people's care could continue in the event of evacuation.

People were administered their medicines safely and as prescribed by healthcare professionals. We saw evidence of staff working alongside healthcare professionals to ensure that people's needs were met.

People had care plans in place that reflected their needs and preferences. Where people's needs had changed, care plans were updated to reflect this.

There were sufficient staff present to meet people's needs safely. Staff had undergone checks to ensure that they were appropriate to be providing care to people.

People told us that they enjoyed the food and we saw evidence of people being provided with choice and also being consulted on food during meetings and reviews.

People were supported by kind and compassionate staff who knew them well. Staff demonstrated a good understanding of how to promote people's privacy and dignity.

Staff felt supported by management and had input into how the home was run. People's feedback was regularly sought and complaints were responded to appropriately.

During the inspection we found a breach 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 the 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?

Good

The service was safe.

Staff were aware of their responsibilities in safeguarding people and understood how to follow procedures to keep people safe.

Risk assessments ensured people were kept safe from known hazards. Accidents and incidents were recorded and actions taken prevented incidents reoccurring.

Contingency plans and emergency procedures were in place in case of emergencies and staff understood how to respond.

There were sufficient staff deployed to meet the needs of people. Checks were undertaken to ensure staff were suitable for their roles.

Medicines were administered safely by staff who were trained to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow the guidance of the Mental Capacity Act (2005). Where applicable, applications had been made to deprive people of their liberty but assessments of people's mental capacity had not been carried out

People were supported by staff who were appropriately trained and knowledgeable about their needs.

Staff knew people's food preferences and people were offered choices appropriate to their dietary requirements.

People had good access to healthcare professionals and staff worked alongside them to meet people's health needs effectively.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and got along with them.

There was an inclusive atmosphere at the home and people were involved in decisions about the home.

Staff provided care in a way that promoted their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had access to some activities but we recommended that the provider reviews activities to ensure that they meet the needs of everyone living at the home.

Assessments and care plans were person centred and reflected people's needs.

Systems were in place to ensure people received regular reviews and staff could identify where people's needs had changed.

People knew how to make a complaint and a system was in place for people to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor and assure quality were not robust.

Staff told us that they worked well as a team and felt supported by management. Staff were able to make suggestions to improve the lives of people living at the home.

The provider had links with the local community.

Grace House Care Home Limited

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.

The inspection took place on 27 October 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

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.

During the inspection we looked at a range of records about people's care and how the service was managed. We looked at seven people's care files, risk assessments, medicines records and the records of accidents and incidents. We looked at documentation relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

We looked at two staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and the result of surveys on people, relatives and staff.

We spoke to nine people who used the service and two relatives. We spoke to five members of staff and the registered manager.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe. One person told us, "I feel very safe living here. I feel as if I'm in my own home." Another person said, "I'm happy living here and I feel safe." A relative told us, "Yes, (person) is safe there."

At our inspection in November 2014 we found that people's medicine administration records (MARs) were not always up to date and important information such as what people were allergic to was not always recorded.

At this inspection we found that people's medicines were administered safely. The required improvement had been made and MARs were up to date and people's allergies were documented. MAR records were completed accurately and contained information about which medicines people were administered. Medicines records contained pictures of people which reduced the risk of errors occurring. Protocols were in place for PRN (as required) medicines so it was clearer when and how people should receive these medicines. Guidance from healthcare professionals was clearly documented and staff followed this. Medicines were stored safely and staff administered medicines to people safely and appropriately. We did note that some bottles of medicines did not have open dates on them. We also noted on one person's records, handwritten MARs had not been double signed. Due to the size of the home and the small number of people affected, the impact of these problems was low and people's safety was not compromised. The registered manager was made aware of this and took action to rectify these issues. However, audits of medicines had not identified these problems and therefore we have reported on this in the well led section.

After our inspection in November 2014, we recommended that the provider reviewed their systems to ensure that all risks to people were identified in order to keep people safe.

At this inspection, we found that the provider had introduced new assessment systems that identified different risks to people. A relative told us, "We talked about risks (regarding their family member) and they always keep us informed." Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Care records contained risk assessments that had been regularly reviewed and risk management plans were in place to keep people safe. One person was vulnerable to UTIs (urinary tract infections) and needed to drink regular fluids to prevent them. A risk assessment identified this risk and staff regularly offered this person fluids. We observed staff giving this person drinks throughout the day. Another person was at risk of falling. Their risk assessment identified why they were at risk, it stated, "I shuffle when I walk." Staff supervised this person when moving around the home and guided them with transfers to reduce the risk of falls.

People were protected against the risks of potential abuse. Staff demonstrated a good understanding of safeguarding procedures and knew their role in protecting people from abuse. All staff had attended safeguarding training. Staff were aware that a referral to the local Adult Services Safeguarding Team should be made, in line with the provider's policy. There had been no safeguarding incidents at the time of our inspection.

Accidents and incidents were documented and staff learnt from these to support people to remain as safe as possible. The accidents and incidents log included a record of all incidents, including the outcome and what had been done as a result to try to prevent the same incident happening again. One person had suffered a fall and had been admitted to hospital. Following this the person's risk assessment had been updated and staff provided more support at night time. The person's falls had reduced with these measures in place.

There were sufficient staff present to meet people's care needs. One person told us, "Yes I feel that there are enough staff working here." Another person told us, "Staff are always on tap!" The registered manager calculated how many staff were needed based on the needs of people living at the home. We observed that staff were able to take time to attend to people's needs. When people asked for help they were responded to. Staff attended people within a very short time which showed that there were sufficient numbers to respond to people. People told us that staff were unhurried and they had time to talk to people. One staff member told us, "It's not too rushed and night staff come in which means people can stay up late if they want to."

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. The staff files contained evidence that the provider had obtained a Disclosure Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also contained proof of identity and references to demonstrate that prospective staff were suitable for employment.

People could be assured that in the event of a fire staff had been trained and knew how to respond. Staff were able to explain what action they would take in the event of a fire. There were individual personal emergency evacuation plans (PEEPs) in place that described the support each person required in the event of a fire. The fire alarm system was tested regularly. There was a contingency plan in place to ensure that people were safe in the event of the building being unusable following an emergency.

Requires Improvement

Is the service effective?

Our findings

People told us that staff gave them freedom to make decisions. One person told us, "I make all my own decisions." Another person said, "I am able to make my own decisions and pop out sometimes." Another person told us, "On the whole, I make my own decisions." We found that generally people were receiving effective care but improvements were required to the way people's mental capacity was assessed, regarding specific decision making.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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 staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's rights were not protected as staff did not work in accordance with the MCA. Where restrictions were being placed upon people, the provider had submitted an application to do so to the local DoLS team. However, they had not assessed the person's mental capacity to make the decision to stay at the home and they had not recorded a best interest decision before applying for the restriction. One person was being administered medicines covertly, without their knowledge as healthcare professionals had advised that this was in their best interests. There was not a mental capacity assessment in their file regarding this decision. MCA assessments were carried out for DNAR (Do Not Attempt Resuscitation) orders, but the registered manager was not aware of the need to complete decision-specific mental capacity assessments as stated in the MCA. Staff demonstrated a good understanding of the MCA and the registered manager showed us evidence following the inspection that they were looking to improve their knowledge in this area.

The lack of mental capacity assessments and records of best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt staff were well trained. One person told us, "The staff are skilled and experienced enough to look after us." Another person said, "They (staff) are good and know what they're doing." A relative told us, "I am very impressed with the staff."

Staff had access to training to provide people with the care that they needed. One staff member said, "Sometimes professionals come in to train us which is good." Staff files contained a record of training courses completed and induction. All staff completed a period of induction, including mandatory training units, before starting work at the home. Staff were up to date in their modules and had been offered further

training where training needs were identified. For example, one person living with dementia had been displaying behaviours that presented a challenge to staff. Staff had training to support them in managing these types of needs. One staff member told us, "I'm doing a dementia course which helps with one person who has some challenging behaviour."

All staff received regular one to one supervisions and records showed they could discuss training needs as well as to discuss the care that they were providing to people to ensure that they were always following good practice. One staff member told us, "I get supervision every three months or so." Records showed staff discussed training they needed and also feedback issues to management. One staff member had discussed how best to support one person who was at a high risk of falls. Another staff member had used supervision to feedback that they felt one person was not getting along well with another person living at the home. Following this, staff monitored the people to ensure that it did not develop into a problem.

People told us that they liked the food prepared for them. One person told us, "I like the food very much, it's good." Another person said, "Oh the food is good here." Another person told us, "The food is good for me and I get enough." On the day of our inspection, food was brought in from a local market. Staff prepared food freshly and people had menus to refer to and were able to make choices on the day in relation to their food. People's food preferences were in their care records and staff had a good understanding of people's likes, dislikes and dietary needs.

Staff told us they had all the dietary information they needed and were aware of people's individual needs. Staff knew where one person was not able to reat gluten. They showed us the alternative ingredients used to provide meals suitable for this person. The kitchen contained information on people's allergies and where they needed to avoid foods due to their medicines. We did note that one person who was living with dementia had diabetes. Staff had problems encouraging this person to eat. There was no plan or risk assessment in place for this person in relation to their diabetes. The registered manager was made aware of this and ensured appropriate guidance was in place for staff following the inspection.

People's healthcare needs were met and staff supported people to access healthcare professionals quickly. One person told us, "If I'm not well, staff get me a doctor." Staff worked alongside healthcare professionals to meet people's healthcare needs. One person required dressings on their leg ulcers. District nurses visited regularly to change their dressings and where staff noticed problems they had called district nurses to share these. People's records contained information from healthcare professionals and visits were logged with care plans updated where necessary.

Good

Is the service caring?

Our findings

People told us that the staff were caring. One person told us, "It is very caring here." Another person said, "The fact that I feel so at home shows caring and kindness to me." Another person told us, "It is brilliant here, its like home. The staff are brilliant." A relative told us, "They (staff) are very patient."

Interactions between people and staff showed kindness and compassion. People were supported by staff who interacted with them warmly and with good humour. One person living with dementia was becoming confused and slightly agitated. A staff member came to them and tried to establish what was wrong. They eventually placed a gentle hand on the person's arm and said "Do you want a cup of tea?" The person was happier following this. Staff came down to people's eye line when speaking to them and used touch appropriately when engaging with people.

Staff knew the people that they were supporting. One person told us, "The staff know us, they're consistent." Staff were knowledgeable about people's preferences and life histories and the information they told us clearly matched with the information recorded in people's care records. A staff member told us, "What they need is very clear. We get to know people as we chat to them every day." One person had recently come to the home and was adjusting to moving from their home. Their background information was not yet fully completed in their records, but staff demonstrated a good understanding of their needs and their background.

People told us that they lived in an environment that was inclusive of everyone. One person told us, "The atmosphere here is very pleasant." Another person said, "It's a real family affair." Another person told us, "The atmosphere is good. It is very friendly, we help each other. It is very close." This was evident in our observations. Groups of people sat together and laughed and chatted. Staff chatted to people and engaged in and encouraged conversations between people. People told us that they had formed friendships in the home and visitors were very welcome. One relative told us, "They're always very welcoming when I visit." People were involved in decisions about the home and we saw evidence that people were able to make changes to menus and request activities.

People were supported to remain as independent as possible. One person told us, "I remain independent with personal care and getting dressed." A staff member told us, "(Person), for example, is very independent and gets dressed and we just help with reminders." People's records contained information on what they could do, and they told us that staff allowed them to do what they were able to. One person's records stated, 'I can wash my hands and face if you run me a sink.' Staff were aware of this person's needs and gave the appropriate level of support to this person to allow them to be independent...

People's privacy and dignity was respected by staff. One person told us, "If I wanted the door shut, the door would be shut. I'm quite happy with the door open though." During our inspection staff were sensitive to not discuss confidential information in front of people and where people needed support with personal care this was done discreetly. Staff understood the need for promoting people's privacy and dignity and demonstrated a good understanding of how they would do this. One staff member told us, "I always make

sure curtains are closed and the door is shut. I use a towel to cover people and do not ever rush."

People's religious and cultural needs were taken seriously by staff. Initial assessments included questions on people's religion and culture so that staff could support the person in a personalised way. One person's records stated that their religion was important to them. They benefitted from visits from a local priest who visited weekly to carry out communion. Information about people's religious needs was gathered before admission.

Requires Improvement

Is the service responsive?

Our findings

People had different views on the activities on offer at the home. One person told us, "My activities are reading and television." Another person said, "I enjoy watching television and chatting with my friends." Another person told us, "There's things to do, people come in and do things with us. However, one person told us, "I get bored. There's not much to do. The television is on all the time and there is nothing showing that is of a particular interest to me."

People had access to a range of activities. A timetable covered games, music and story telling activities. We did note on the day of our inspection that two television sets were playing different channels in the lounge areas. This provided stimulation for those who wished to watch television, but would be a nuisance for people who did not enjoy it. The sounds from the televisions created a confusing environment for people living with dementia. However, people told us that they were happy with this as they wished to watch different television channels. Following the inspection, the registered manager submitted evidence to show activities specific to the needs of people living with dementia were available. These included reminiscence activities and exercises. A 'resident profile' allowed staff to get to know what people enjoyed doing and how staff can support them to engage in activities.

People told us that they did not get taken out regularly by staff. Records showed that trips took place roughly once a month and only a small number of people were able to go. A staff member said, "It would be nice if they (people) could be taken out more." A relative told us, "In an ideal world it would be lovely if (person) could go out, but it's difficult." The registered manager was aware of this feedback and was finding ways for people to be taken out more regularly.

We recommend that the activities on offer cater for all people and the types of activities and environments created are sensitive to the needs of people living with dementia.

Care plans were person-centred and information on what was important to people was clear. Information for staff was personalised and specific to people's needs. In the care plan for one person living with dementia it stated, 'I will sometimes get dressed myself and will have several jumpers on or clothes over my night dress. Help me back to my room to start again.' Staff were aware of this need and supported this person with personal care in a way that matched their needs and routine.

Assessments were undertaken before people moved into the home to make sure their needs could be met. In their PIR, the provider told us, 'a full admission assessment is carried out over a period of time to ensure we have taken into account personal choices and a preferred routine.' Examples seen were thorough and picked up important information about people's needs, routines and preferences. One person who had recently come to live at the home had an assessment that informed staff that they liked to have a bath, what time they got up and how they liked their tea.

People's care plans were kept up to date and adjusted when things changed. One person had recently been in hospital and their needs were reviewed before coming home to ensure staff could meet their needs. They

were less steady on their feet so staff supervised all transfers. We noted that not all care plans were being regularly reviewed. However, care plans were updated when things changed. People and relatives told us that their needs were met well by staff, who responded to changes in need. Staff knew people well and worked with them regularly which meant staff could identify changes in needs. The registered manager told us that they participated in local authority placement reviews, but these did not always happen annually.

People told us that they knew how to complain but they hadn't had to. One person said, "I've got no need to make a complaint." Another person said, "If I had to complain, I would tell them but have no need to do so." Another person told us, "I cannot imagine having to complain but I would say something." At the time of our inspection there had been no recent complaints. Information on how to complain was available to people. People and relatives told us that they felt comfortable raising concerns with management. The registered manager sought feedback from people and relatives in order to identify areas for improvement.

Requires Improvement

Is the service well-led?

Our findings

People told us that they felt that the service was well led. One person told us, "The home is managed very well." Another person said, "I don't know who the manager is but I think the home is running very well." Another person told us, "Without a doubt, this home is well led."

After our inspection in November 2014, we recommended that the provider reviewed their quality monitoring procedures to ensure that any shortfalls were identified and received an appropriate response.

At this inspection we found that the recommendation had not led to significant improvements in the way the quality of the service was assessed and monitored. The quality assurance processes were still not robust enough to identify issues and improve the quality of care. After the last inspection, some additional detail had been added to existing audits. Audits were in place for areas such as medicines, care plans and call bell response times but the records of the audit did not offer much detail and did not identify what had been looked at. Medicines audits did not document details such as which areas of medicines management had been audited or how many MARs had been reviewed for their quality. For each audit, comments were written such as, 'tick boxes signed' or 'everything seems in order' without documenting what had been seen. There was no policy in place for how regularly audits should take place and the time between audits varied. Audits being carried out did not identify the issues that we had found. For example, information and reviews were missing from some care plans. A recent audit did not identify this. Medicines audits had also failed to identify that some open bottles of medicines had not been labelled. Whilst this had not impacted on people, there was no evidence that medicines audits could identify more serious concerns. An audit of Mental Capacity Act compliance had been started but had not identified the lack of MCA assessments and best interest decisions in place.

Failing to complete effective monitoring of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that management was not always visible in the home but they were always contactable. The registered manager was at the home daily but often left in the afternoon. Staff told us that they could always reach the registered manager by telephone if there were problems. Staff told us that they worked well as a team when management was not present. Staff did tell us that they felt supported by management. One staff member told us, "They (management) are supportive." Where incidents had happened out of hours, the registered manager had visited or spoken to staff over the phone. This demonstrated that management were contactable and approachable for staff, even when not present at the home.

People were involved in the running of the home and felt that management were approachable and responsive. One person said, "Ideas and suggestions are just naturally given within a discussion. It's a very open door policy from management." Surveys of people and relatives provided an opportunity for people to make suggestions and the registered manager acted upon them. One person had asked for more fish to be on the menu, the registered manager arranged this. Two people had mentioned they needed larger televisions in their rooms due to visual impairments. New televisions were put in place for these people.

Staff were able to make suggestions to improve the home. Staff meetings took place and staff suggestions or concerns were acted upon. One staff member told us that they had raised concerns in a meeting that staff were too stretched in the mornings. In response to this, the registered manager added another member of staff which meant staff could spend more time with people. Minutes of meetings demonstrated that staff also used these to share examples of good practice. Staff had recently discussed how best to monitor blood sugars for one person who had diabetes.

The registered manager had links with the local community. In their PIR, the provider told us that they had formed links with local charities such as Alzheimer's society and Age UK. They were also taking part in a local Hydrate project with a local community nursing team. Staff received specialist training in how to promote good levels of hydration for people and fluid charts were completed and sent to healthcare professionals to analyse. People's fluid intake had increased and the registered manager saw a fall in UTIs and falls following implementing the project.

The registered manager was aware of their responsibilities to notify CQC where appropriate. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events. At the time of inspection, there had been very few events that required a notification.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not undertaking decision specific mental capacity assessments before placing restrictions upon people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to assure the quality of care that people received.