Mrs Brenda Tapsell

The Granleys

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place over two days on the 16 and 22 August 2017. The Granleys provides accommodation and personal care for up to 17 people with a learning disability and a sensory or physical disability. At the time of the inspection there were 16 people living there.

The Granleys has a registered manager who was absent during our inspection. A representative of the provider was present. 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 the last comprehensive inspection, the service was rated as requires improvement. At this inspection we found the service was good and the service had made improvements to infection control systems and recruitment processes. They had also made improvements to the care planning processes and people were being treated with dignity and respect.

Quality assurance systems were in place to monitor the quality of care people received and to identify any shortfalls in the service. However, some improvement was needed to ensure all aspects of the service would be audited so that action would be taken to address these issues promptly. The representative of the provider took action during the inspection to ensure the appropriate pre-employment checks would be completed as part of their recruitment processes. They also made sure checks for fire systems and water temperatures were being carried out at the appropriate intervals. Quality assurance systems included feedback from people living in the home, their relatives and staff. Improvements made over the past 12 months to the environment, infection control systems, care records and staff support had been maintained.

People were supported by sufficient staff to meet their needs. Staff had access to training to acquire the skills and knowledge to support people. They had individual and group support to reflect on their roles and professional development. Staff had a good understanding of people's needs and treated them respectfully and with kindness.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People's care was individualised reflecting their individual needs, preferences and lifestyle choices. Their care was discussed with them and their care records were kept up to date with their changing needs. People were supported to stay healthy and well through access to health care professionals and a healthy diet.

People's rights were protected and they were kept safe from the risk of injury or harm. Any accidents or incidents were analysed and the appropriate action was taken to prevent them happening again. People who became anxious or upset were supported to manage their emotions. People's medicines were administered at times to suit them. Medicines systems were monitored closely to ensure they were

managed safely. People had access to a range of activities which were meaningful and reflected their choice and interests. They were actively involved with their local community using places of worship, the library, sports facilities and shops.

The registered manager and the representative of the provider were open and accessible. People and staff were confident talking with them about any issues or concerns. People knew how to raise concerns and complaints information was accessible to them. The management team were aware of the challenges of recruiting and keeping staff. The staff team spoke positively about their support and the care they provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People's rights were upheld and they were kept safe from the risks of harm or injury.

There were sufficient staff employed to meet people's needs. Recruitment processes were in place.

Medicines were safely managed and administered.

Infection control procedures were in place and a clean and hygienic environment was maintained.

Is the service effective?

Good

The service was effective. People were cared for by staff who received appropriate training and support to carry out their roles.

People's consent was sought in line with the essence of the Mental Capacity Act 2005. People deprived of their liberty had the appropriate authorisations in place.

People had a healthy diet which reflected their individual needs and preferences.

People's health needs were met through on-going support and liaison with relevant healthcare professionals.

Is the service caring?

Good

The service was caring. People had positive relationships with staff who treated them with kindness and sensitivity.

People had access to advocacy and kept in touch with those people important to them.

People were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive. People received individualised care and support which kept up to date with their changing needs. They were supported to take part in a choice of activities which

reflected their lifestyles and interests.

People had access to a complaints process. They raised concerns as they arose and action was taken in response.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led. Some improvements were needed to ensure quality assurance systems would always pick up areas that need improvement in the service. People's views and those of relatives and staff were sought to make improvements to the service provided.

The registered manager and the representative of the provider were open and accessible. They had worked with the staff team to ensure improvements to the service were sustained.

The Granleys

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 16 and 22 August 2017 and was unannounced. One inspector and an expert by experience carried out this inspection. The expert's area of expertise was learning disability and autism. Within the last 12 months the provider had 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 also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with seven people using the service. We spoke with a representative of the provider and six care staff. We reviewed the care records for three people including their medicines records. We also looked at the recruitment records for three staff, staff training records, accident and incident records and quality assurance systems. We observed the care and support being provided to people. We contacted health care professionals and local authority commissioners for their feedback.

Good

Is the service safe?

Our findings

People's rights were upheld. Staff had completed training in the safeguarding of adults and understood how to recognise and report suspected abuse. Records had been kept detailing any incidents and the appropriate authorities such as the local safeguarding team and the Care Quality Commission had been informed. Staff worked closely with a range of health care professionals to ensure people were supported to manage their emotions and anxieties. They followed their guidance and recommendations to reduce the impact they had on others living in the home.

People were protected from the risk of harm or injury. Risk assessments described the hazards they might face and how these were minimised. For example, people at risk of falls had been provided with equipment such as handling belts or specialist chairs to keep them safe. Accidents and incidents were recorded into an electronic database which provided an overview of any developing trends or themes. Action could then be taken to prevent them happening again. There had been a significant decrease in accidents and incidents for people over the past 12 months because staff were supporting people effectively and in line with health care professionals recommendations. A person was observed talking with staff about how to stay safe in their room whilst an electrical socket was out of use. They understood not to use this and the socket was replaced during the inspection.

People were supported by staff who had pre-employment checks completed before they were offered employment to ensure they were suitable for their role. These included obtaining a full employment history and a satisfactory Disclosure and Barring Service check. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Other checks were in place but there was no recorded evidence they had been consistently completed for all new staff. The representative of the provider said this would be addressed.

People were supported by sufficient staff to meet their needs. One person commented, "The number of staff is good." The staffing levels had increased to reflect the changing needs of people living in the home. Each morning and afternoon a minimum of three but mostly four staff supported people. At times this increased to five depending on people's commitments and schedule of activities for the day. Agency staff were not used and the staff team managed to cover for sickness or annual leave between them. A cleaner had been employed but was on annual leave during our inspection. Staff had shared the cleaning duties between them.

People were safeguarded from the risks of potential harm due to emergencies. Each person had a personal evacuation plan which described how they would leave the building in an emergency. People took part in fire drills which recorded their reactions and whether they needed additional support. Servicing of fire systems, legionella checks and portable appliance testing were being carried out at the appropriate intervals. New fire extinguishers and fire signs had been installed after a recent service. Between January and May 2017 weekly and monthly tests for fire equipment and water temperatures had not been taking place. Arrangements had been made for these to be completed by named members of staff. There was evidence these were now being carried out. Maintenance systems were in place to deal with day to day

issues as they arose. On-call systems were in place should staff need help or support out of normal working hours. They said the management team were always available for advice or physical support.

People's medicines were administered at times to suit them and as safely as possible. Their medicine care plans detailed the medicines they were prescribed and any 'as necessary' medicines. Protocols were in place for medicines to be taken 'as necessary' stating the reason why this medicine should be given and the maximum dose. One person had been given this medicine once or twice a month when distraction techniques had not been successful to help them to manage their anxiety. It was evident other strategies were tried before administering this medicine. Systems were in place to monitor and audit the administration of medicines. Medicine administration charts (MAR) had been completed satisfactorily. Any gaps in these records were followed up with the staff member and further support provided to prevent errors occurring again. Stock levels were monitored and recorded on the MAR.

People were protected by the systems to prevent and control infections. The environment, including the kitchen, toilets and bathrooms were clean and had been well maintained. A visit by the local authority on behalf of the Food Standards Agency in 2017 had rated the home four out of a top score of five stars. This was a significant improvement on their previous inspection. There was evidence that standards and records had been maintained. The laundry had new washable flooring laid and laundry was being managed appropriately. An infection control audit had been completed in January 2017 confirming staff had completed training in infection control and there had been no infections in the home. This was in line with the Department of Health's code of practice on the prevention and control of infections.

Good

Is the service effective?

Our findings

People were cared for and supported by staff who had the opportunity to acquire the appropriate skills and knowledge. New staff completed an induction programme which included the care certificate. The care certificate is a set of national standards that health and social care workers adhere to in their daily working life. This incorporated training considered mandatory by the provider such as first aid, fire, food hygiene and moving and handling. Additional training was provided which related specifically to people's needs such as dementia awareness and epilepsy. The representative of the provider confirmed they would provide mental health training for staff with respect to the diagnosis of a person who had recently moved into the home. Training schedules were maintained electronically and prompted the management team when refresher training was due.

People benefited from staff who were supported to reflect about their roles and conduct through individual meetings and staff meetings. Staff said they felt supported and the registered manager was supportive and worked alongside them. They said, "We work as a team" and "Communication is really good between us." An electronic database confirmed staff had individual meetings every six to eight weeks. This would notify the registered manager when these were due.

People were supported to make choices and decisions in their day to day lives. We observed them being offered choices about how to spend their time, when to get up and what to eat and drink. People's capacity to make choices about their day to day care was considered in line with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who had been assessed as unable to make decisions for themselves had records in place to confirm when decisions had been made in their best interests. For example, helping them with their finances, medicines and personal care.

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 procedures for this in care homes 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. Applications had been approved to restrict people of their liberty when this was in their best interests. Any conditions, such as ensuring they were offered activities, were complied with.

People occasionally became anxious and upset. Their care records described how to support them and what the response of staff should be. For example, trying to distract or divert people by offering a different activity, a drink or space. Incident records and behaviour monitoring charts indicated there had been a substantial decline in the number of incidents for two people. Staff had a good understanding of how to support people and worked closely with health care professionals to monitor their health and wellbeing.

People were supported to have a healthy diet. They had access to snacks and drinks. Fresh fruit and cold drinks were provided in the lounge for people to help themselves. A person was observed making a hot drink and other people were able to help with cooking and baking. People were supported to attend a local club which gave them guidance about a healthy and nutritional diet whilst monitoring their weight. They were heard discussing with staff the healthy options they could eat as well as the treats they were allowed. People at risk of choking were provided with a soft diet which staff said they tried to make as appetising as possible. Staff discussed how they took equipment with them to mash or puree food when eating out. They said local pubs and restaurants now prepared soft options for them, ensuring everyone could eat out if they wished. People needing support to eat and drink had this provided at their own pace. They were not rushed and staff were attentive to their needs. People helped to plan the menu choosing the meals they liked best. During lunch each person chose what they wished to eat. A wide choice of meals was prepared including an egg salad, cheese toasties and beans on toast.

People's health needs were closely monitored to ensure they had access to health care professionals when needed. People were observed seeking reassurance about their health issues from staff. Staff provided this. They checked people's well-being and advised them that a GP appointment could be arranged for medicines to improve their condition. Each person had a health action plan describing their current health needs, any medicines they were prescribed and health care appointments. A hospital assessment had been completed to take with them in emergencies providing a summary of their health care needs and also how to communicate effectively with them. People were supported to attend a range of health care appointments with their GP, dentist and outpatient appointments at hospital.

Good

Is the service caring?

Our findings

People were cared for by staff with whom they had developed positive relationships. People enjoyed the company of staff seeking them out to chat with them and spend time with them. Staff were attentive and responsive to people. They treated people with kindness, patience and sensitivity. People happily joked with staff laughing and smiling. People told us, "I am happy here", "I like it here, nice place isn't it" and "I'm alright, I'm fine." Relatives commented, in response to the provider's quality assurance survey, "Staff are very helpful", "I get a good impression of how happy she is when she comes home" and "She is very happy at The Granleys."

People's diversity and needs in respect of age, disability, gender and religion were respected. People's religious preferences had been discussed with them and people were supported to attend places of worship of their choice. This meant people were able to visit one of three different venues each week. People's preferences, if they had any, about the gender of care staff supporting them had been highlighted in their care records. People were supported with meaningful and age appropriate activities. Their right to confidentiality was respected and information was kept securely and confidentially. People's right to a family life was supported and people visited relatives and friends as well as inviting them to come to their home.

People's preferences, likes and dislikes had been discussed with them and were referred to in their care records. For example, respecting some people liked to have a leisurely start to their day and some people's routines were really important to them. Staff understood people really well and knew their personal histories and what was important to them. They reassured people when upset or anxious, responding to them positively and quickly.

People and their relatives were involved in making decisions about their care and support. People met with their key workers each month to talk about the care and support they received. Their preferred form of communication had been highlighted in their care records. Information displayed around the home had been produced in an easy to read format using pictures and photographs. Some people used sign language to reinforce the spoken word. People expressed their views and opinions in resident's meetings such as what activities or holidays they would like and their choice of meals. People were observed chatting with staff about their care and support. They were listened to and the appropriate action was taken. For example, a person requested a visit to their family and this was arranged.

People had information about advocacy. They had both lay and statutory advocates. Advocates are people who provide a service to support people to get their views and wishes heard. People assessed as being deprived of their liberty had been appointed statutory independent mental capacity advocates.

People were treated with dignity and respect. Personal care was provided discretely in the privacy of their bedrooms or bathrooms. A staff meeting in April 2017 reminded staff to talk to people like adults and to treat them with dignity and respect. We observed staff treating people appropriately. People were supported to be independent helping around their home if they wished. Some people liked to help in the

kitchen and with the recycling and shopping.

Good

Is the service responsive?

Our findings

People received individualised care and support which reflected their needs, wishes and routines important to them. People's needs had been assessed prior to moving into the home to make sure they could be met. As people's needs changed their care records were amended and updated to reflect these. An electronic database was used which meant records could be changed immediately and staff would be informed by the messaging system. Daily records provided a log of people's care and support each day. Monitoring charts, such as accidents and incidents or body maps were also accessible on the database. The database identified when care records needed reviewing due to accidents or incidents. Six monthly reviews of care were also highlighted. We discussed with the representative of the provider two care plans which could provide more detailed information with respect to the risks of choking and the rationale for any restrictions. Amendments were made where possible during the inspection.

People's changing needs were responded to quickly. Daily records evidenced changes in people's needs and any action taken by staff to address these. When needed referrals were made to health care professionals. A health care professional commented, "Staff have been very supportive and always ask for my advice." Staff took appropriate action when they noticed a person was very tired whilst taking a shower and at risk of falls. They made a referral to an occupational therapist for a shower chair to reduce this risk.

People had access to a range of activities which reflected their life styles and interests. They accessed activities in their local community and had developed ties with local people. Volunteers from a local church provided an activity session each week. We observed people taking part in an arts and craft session. The television was being watched by one person but most people were more interested in the activities. One person chose to do a jigsaw puzzle and another chatted with staff about the recent World Athletics competition. A group of people went out to a club where they met with other like-minded people who wished to lose weight. In the afternoon people had a choice of going out to the pub or shopping and recycling. An activities schedule was in place but people were observed changing their minds about which activities they wanted to take part in. People chose how to spend their time and with whom. They told us they liked going to church, to social clubs and to eat out. People said they had enjoyed a holiday to Blackpool. Other activities included pamper sessions, bingo and board games, going to the library, volunteering at a garden centre and swimming.

People had access to a complaints procedure which was displayed in their bedrooms and in communal areas. We observed people talking with staff about any issues they might have and they had been responded to at the time. For example, a person did not wish to go out on a scheduled activity and they were reassured this was fine. People were used to having access to the registered manager and would spend time with her in the office chatting through any concerns they might have. People were encouraged to talk about any concerns at their resident's meetings. Staff also took the opportunity at resident's meetings to prompt people to voice their concerns and talk about how to make a complaint. No formal complaints had been received by the provider.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to monitor the quality of care people received and identify any shortfalls in the service. We found the registered manager had made continued improvements over the past 12 months which included the embedding and maintenance of the electronic database for care records and staff records and the refurbishment of the environment. Previously highlighted concerns about infection control and food hygiene and been resolved and these improvements had been sustained. Staff had been given responsibility for monitoring medicines, training and health and safety systems. A member of staff talked through the auditing of medicines and how they made sure any errors were discussed with staff and the relevant support given to them.

However some improvement was needed to ensure all aspects of the service would be audited so that action would be taken to address shortfalls promptly. For example, the provider's quality assurance systems had not identified that some staff pre-employment checks had not always been recorded. These included the verification of staff's identity and the attempts that had been made to obtain a full employment history. A management audit tool had been completed in 2016 which monitored health and safety systems, fire systems, the environment, medicines, care records and infection control. No actions had been identified for improvement. Records for fire system checks had not been completed between January and May 2017 and then completed again in June 2017. There were gaps in the records indicating water temperatures had not been checked which had not been identified by the provider prior to our inspection. The registered manager might therefore not have taken the appropriate action to maintain a safe environment and to keep people safe. The representative of the provider took action to address these issues during the inspection. We have not been able to verify whether these actions have been sustained.

People's views and those of their relatives were sought to make improvements to the service. For example, a person had requested to eat in their room and a dining table and chairs had been provided. Annual surveys were sent out to relatives seeking their feedback about the service provided. Those who had responded to a recent survey were "very satisfied" with the service people received. People were able to give feedback at reviews of their care and at resident's meetings but also on a daily basis to the registered manager and a representative of the provider. Staff had a clear understanding of the whistle blowing procedures. Whistle blowing legally protects staff who report any issues of concern. They said they would raise concerns with the registered manager and were confident they would be listened to and the appropriate action taken.

There was a registered manager in place. 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. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.

People and staff found the registered manager open and accessible. Health care professionals said the registered manager kept in touch with them. The representative of the provider frequently visited the home

and was able to assess the day to day standards of care provided. During the inspection the representative of the provider took action to address any issues highlighted such as clarifying information in care records and following up shortfalls in recruitment and selection processes. The representative of the provider described the challenges of recruiting and keeping staff. They now had a staff team who worked well together. Changes had been made to the staff structure introducing three new senior positions. Senior staff said they enjoyed their additional responsibilities.

The representative of the provider and the registered manager had shown a willingness to work with CQC and commissioners to improve people's experience of their care and support. Over the past 12 month's there had been improvements to people's care and support and these had been sustained. The representative of the provider confirmed new policies and procedures had been put in place and would be updated as needed. The CQC rating for the home was displayed in the reception area.