

SHC Rapkyns Group Limited

The Granary

Inspection report

Guildford Road
Broadbridge Heath
Horsham
West Sussex
RH12 3PQ

Tel: 01403219829
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
04 February 2019
05 February 2019

Date of publication:
01 August 2019

Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Requires Improvement ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

This focused inspection took place on 4 and 5 February 2019 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been reached. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and February 2019, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and have reported on what we found.

This inspection took place due to information shared with CQC about concerns around the management of people's care needs. However, this inspection did not examine the specifics of those incidents and focused on what the care experience was for all people living at The Granary. At the inspection we rated the Key Questions 'Safe', 'Effective' and 'Well-led'.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The Granary is a care home that provides nursing and residential care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

The Granary provides nursing and personal care for up to 41 people who may have learning disabilities, acquired brain injury and other neurological conditions. Most people had complex mobility and communication needs. At the time of our inspection there were six people living at The Granary and one person receiving short term care. The Granary provides accommodation across four ground floor units: Walnut, Pine, Yew and Alder. Each unit has a separate living room, dining room and kitchenette. At the time of this inspection, people were accommodated in Walnut and Alder, the other two units, which could accommodate 10 people each, were unoccupied. Rooms were of single occupancy and had en-suite facilities.

There was no registered manager at the time of this inspection. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who 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. A new manager had been employed since

December 2018 and had applied to become the registered manager.

The Granary has not been operated and developed in line with all the values that underpin the Registering the Right Support and other best practice guidance. The Granary was designed, built and registered before this guidance was published. However, the provider has not developed or adapted The Granary in response to changes in best practice guidance. Had the provider applied to register The Granary today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability should be operated to meet their needs. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

At the last inspection in September 2018, the service was found to be in breach of legal requirements and was given a rating of 'Requires Improvement'. The provider wrote to us after the inspection to inform us about the actions they were taking.

At this inspection we found that the quality and safety of care provided to people had deteriorated. We identified gaps in how the provider was managing risks on behalf of people. Care records did not consistently demonstrate people's care needs were being met. This included gaps in the management of epilepsy, hydration, weight loss and fire evacuation.

We found gaps in guidance and essential training to enable staff to support people who may display behaviours which challenge others safely and effectively. This was for both permanent and agency staff.

The provider was not consistently applying the principles of the Mental Capacity Act. We found conditions on one person's Deprivation of Liberty Safeguards was not being met.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured the delivery of consistent standards of care across the service. The provider had failed to ensure the necessary improvements had been made to the care provided since the last inspection. Most of the areas of concern we found during this inspection had already been highlighted to the provider following inspections of some of their other services. Learning had not been effectively shared to ensure that people living at The Granary received consistently safe, effective and well-led care.

Medicines were managed safely and registered nurses carried out this role with confidence. Infection control measures were adopted throughout the inspection. We received positive comments from people, their relatives and staff about the new manager. The manager was approachable and had taken time to get to know people and their needs and preferences.

The environment was spacious throughout and adapted to meet the needs of people who use wheelchairs. The home was decorated with pictures and photographs of people living at the home. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing.

Staff employed by the home underwent a safe recruitment process. Staff had attended safeguarding adults training and knew how to protect people from abuse.

There was enough food available and offered to people throughout our inspection at mealtimes. The menu offered flexibility to meet the needs of people and their specific dietary requirements. People had access to external health care professionals including GP's who visited the home weekly.

Some people were at risk of constipation. Staff and care records demonstrated the associated risks were being managed safely. Some people had enteral feeding tubes fitted (PEG) this was also being managed safely by the staff team.

We found four breaches of Regulation at this inspection and will publish information about our actions in response to these at a later date.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

There were aspects of unsafe care and treatment which held potential risks to people's safety and well being.

Risks associated with epilepsy, dehydration and weight management had been highlighted to the provider through other CQC inspections. Therefore, lessons had not been learnt to improve care practices at The Granary.

Fire Evacuation risks had not been properly addressed.

Infection control measures were practiced by all staff and medicines were managed safely.

Staff had attended safeguarding adults training and knew how to protect people from abuse.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

There were some gaps in training to support staff in managing behaviours which might challenge.

The provider did not work consistently in accordance with Mental Capacity Act and DoLS legislation.

Pre-admission assessments regarding people's physical needs took place prior to them moving into The Granary. However, information was not consistently utilised to manage associated risks on behalf of people.

People were supported to access health care professionals when needed.

People were supported to have sufficient to eat and people's individual physical needs were met by the adaption of the premises.

Is the service well-led?

Inadequate 

The service was not Well-Led

Areas of concern highlighted during this inspection had been raised with the provider at some of their other services. This had not led to improvements to the safety and effectiveness of people's care.

The provider had systems in place to monitor care provided to people, however, they were not effective as they did not always identify and drive improvements to ensure safe and effective care standards.

There were missed opportunities to access support from the local authority regarding moving and handling people despite this being accessed in other locations owned by the provider.

The new manager was approachable and enthusiastic and responded to areas of concern. People, their relatives and staff spoke positively of what they had already achieved.

The staff team was open to developing further and understood their role and responsibilities.

The Granary

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 checked 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 4 and 5 February 2019. The first day was unannounced and the inspection team consisted of two inspectors, a specialist advisor 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. Their area of expertise included services for adults with a neurological care. The second day of inspection consisted of two inspectors and the same specialist advisor. The specialist advisor had specialist clinical experience in supporting people with complex health needs.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with two people who lived at the home to gain their views of the care they received. We also spoke with six people's relatives, during and after the inspection, about their views of the care their family members received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over the course of the inspection.

During the inspection we spoke with the clinical lead registered nurse, a registered nurse, the manager and the regional operation's director. In addition, we spoke separately with three care staff and the chef. During the inspection, we observed medicines being administered to people.

We reviewed a range of records about people's care which included seven care plans. We also looked at

three care staff records which included information about their training, support and recruitment records. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating to the management of the home. We provided feedback at the end of the inspection to the manager, regional operations director and the providers lead safeguarding manager.

Is the service safe?

Our findings

At the last inspection in September 2018 we found The Granary was providing safe care to people living at the home. At this inspection people and their relatives told us safe care continued to be provided. However, we found care standards had deteriorated and some health needs were not being adequately managed. This included a failure to mitigate risks for people with a diagnosis of epilepsy. The inconsistencies in support we highlighted held potential risks for some people and may have impacted their safety and well-being.

For example, one person with an acquired brain injury. A brain injury occurs through many possible causes such as an accident, tumour or stroke. As a health consequence, the person experienced epileptic seizures. Staff said these happened daily and described how the person presented at the time. However, records in place did not refer to that level of frequency. An epilepsy chart in place stated they had experienced a seizure once or twice a month and in some months no seizures, which contradicted what staff told us. The chart held no descriptive details about each seizure, which could have been used to highlight any changes in presentation (that may have needed to be referred to the GP/neurologist). We also read daily notes completed by staff. Seizure information had not always been transferred from the epilepsy record chart into the person's daily notes. This meant there was a lack of detail available about the seizures including how long they were lasting. Staff told us when a person had a seizure they would tell the registered nurse on duty who would complete the necessary records. One staff member said, "The nurse is in charge of paper work things." Therefore, the record was not completed by the staff member who observed the seizure. This meant important information about each seizure was being missed. We spoke to the manager about this who told us they would expect staff who witnessed the seizure to make entries in the person's care record.

The person's care plan referred to a history of a condition which occurred due to a lack of oxygen in the blood. The health condition meant their skin and lips might change colour. This meant there was even more importance placed on the monitoring of the person's health during and after the seizure to ensure a full recovery took place. As the records failed to match what care staff told us, there was a risk the records were not an accurate reflection of what was happening. The same person had access to appointments with their GP and a consultant neurologist where their seizure activity was discussed. At the last appointment with the consultant neurologist an increase in an epileptic medicine was agreed. However, as epilepsy records we read were incomplete there was a risk the consultant neurologist may not have been presented with all the information they needed to make an informed decision. We spoke to the manager and the regional operations director about the potential impact on the person's safety and well-being because of this. They told us they would review and speak to staff accordingly.

The same person was also described as displaying behaviours which may challenge others. Staff told us they may become verbally and physically aggressive towards staff but not people they lived with. Staff spoke about the person with affection and told us the person may display physically challenging behaviour at some point each day. Their care plan referred to physically and verbally aggressive behaviour however no detail of how this presented. Also, the number of incidents recorded did not reflect those staff had referred to. Since the last inspection in September 2018 behaviour charts provided details of five incidents whereby

physical aggression had been displayed towards staff. We found there was no behaviour management plan or Positive Behaviour Support plan (PBS) which provided step by step guidance for such incidents. Including the support staff required after the incident. A PBS care plan is a document that promotes a set of strategies to ensure safe and personalised care is provided to a person if they become challenging to others. A failure to provide such an approach meant there was a risk staff may not always respond consistently and safely and using the least restrictive options.

Some people were at risk of dehydration if staff did not support them to drink. They had fluid charts in place and staff monitored what they drank. However, we found gaps within fluid records for one person. They had a learning disability, complex communication needs and they were reliant on staff for all their care. They were at risk of suffering with Urinary Tract Infections (UTI) due to a health condition. Their care plan stated that UTI'S may trigger epileptic seizures. Therefore, it was especially important staff monitored the person's fluid intake to ensure they did not become dehydrated to mitigate this risk. Staff completed fluid charts on the person's behalf. However, their fluid charts did not include a recommended daily fluid amount and there was no supporting documentation available at the time of the inspection to state what this was. Health professionals such as dietician's or speech and language therapists (SaLT) advise care staff teams on recommended fluid amounts. The fluid charts showed the amount of fluid the person received varied. For example, on one day there was a record of 800ml's squash and another day a total of 1200mls. However, due to the lack of associated guidance surrounding recommended fluid levels we were unable to check whether the person was receiving the correct amount or not. This meant the staff team had no reference to guide them about how much fluid the person needed. Therefore, the person was at risk of receiving incorrect amounts which may have impacted their health.

We also found information on four seizures the person had experienced. However, the date of the seizures had not been recorded on three out of the four. This meant staff supporting the person would not have known when all of the seizures had taken place. As their care plan stated a direct link between a UTI and seizures it was essential staff were able to monitor this aspect of care and pick up on links between what was recorded.

The same person had a nutrition care plan in place. It stated they needed support to maintain a stable body weight. Their food was pureed and thickening powders were added to their fluids. Other people's weight was being recorded monthly. However, this person's chart remained blank. Staff were also completing Malnutrition Universal Scoring Tools (MUST) on behalf of people. This is a method for applying a combined score to a person's BMI, weight losses and medical conditions to see if they are at risk of malnutrition. The MUST in this person's file also remained blank. We were unable to meet the person and observe their care being delivered. However, the gaps in the records we read meant the staff were not working in accordance with agreed care planning and there was a risk this was not being monitored effectively to ensure safe practices were being followed. The staff had not assured themselves the person was maintaining a stable body weight. We shared our findings with the management team for their review who told us they would address and ensure the person would be weighed.

The same person had been receiving care from staff at The Granary since March 2018. Prior to this they had received support from another service owned by the same provider. Shortly after the inspection, the manager sent us SaLT guidance which recommended the need for oral health care to reduce bacteria in case the person aspirated during seizure activity. Aspiration means inhaling food, fluid or other matter into the lungs. An oral health assessment and guidance was not in place at the time of the inspection. The manager told us they were putting this in place. They also confirmed the staff team had no access to guidance on how much fluid the person should be receiving each day and were in the process of speaking with the person's relative, SaLT and a dietician. As this information was an important part of the person's

care we were concerned it was not accessible for staff prior to this inspection visit.

We also read care records for another person who had complex health needs. They had a learning disability and relied on staff to meet all their health needs and communicate on their behalf. Their epilepsy care plan and protocols provided staff with the information they needed to know how to support the person. However, an epilepsy chart highlighted they had experienced seizures in August, September and October 2018 but there was limited information within daily notes about how they had presented at the time. One record had no date so staff would not have known when it took place. This meant important health information may have been missed. We were told the person's seizures were now controlled by the medicines they were taking. However, the person had complex communication and health needs. Therefore, it was essential staff recorded what they observed to ensure information could be shared with external health care professionals such as a GP or neurologist so further actions could be taken if deemed necessary, such as a change in medicines. It was also a concern because information in relation to the person's epilepsy would not be shared between staff on different shifts including agency registered nurses.

Staff had received fire safety training. However, on the second day of the inspection the fire alarms were set off. Inspectors gathered with staff and one person in the main reception area. The manager led the group and established the fire alarm had been activated, however there was no fire. We asked the manager why other people who lacked capacity to make such a decision did not join the evacuation. They provided some reasons on behalf of some people, however agreed they would look into what happened to others by speaking with staff and people.

We checked people's risk assessments and found all had Personal Emergency Evacuation Plans (PEEPs) in place. This is an 'escape plan' for individuals to reach a place of safety in the event of an emergency, such as a fire. PEEPs lacked detail regarding where staff were to support people to as it said, 'place of safety' on behalf of three people. Another person's PEEPs stated an evacuation point, however no clarity as to which one. As people were reliant on staff to support them in the event of an emergency we fed back our findings to the management team.

The CQC and partner agencies had already highlighted concerns about risk management at other inspections at homes owned by the same provider since July 2017. This had included inconsistencies within epilepsy management and ensuring people at risk of dehydration and weight loss were adequately monitored. We had also expressed concerns at other inspections about a lack of guidance available for staff when supporting people who may display behaviours which may challenge others. Considering there was only six people living permanently at The Granary and one person receiving short term care, we were concerned the records in place failed to demonstrate all health needs were being met safely. There was a failure to apply lessons learnt from this across the organisation. We have explored this further in the Well-led section of this report.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other incidents and accidents had been recorded and reported by staff to the manager who then shared the information with external agencies such as the local authority safeguarding team. When an incident did occur, it was also sent to the quality team for their review. We were told this was to ensure shared learning could be taken from how a situation was managed by staff.

Staff we spoke with demonstrated they understood the importance of protecting the people they supported and were knowledgeable about different types of abuse. One staff member said if they were concerned

about a person, "I would go to the manager or maybe the nurse first." They also knew they could approach external partner agencies outside of the provider if needed. Relatives provided examples of incidents which had been managed well by the staff team and expressed confidence concerns would be responded to in the future when issues arose. There was a copy of the West Sussex Safeguarding Adults policy on display within the home which provided information for staff on who to contact if they had concerns about the people they supported.

Some risks to people were being managed safely. This included those at risk of constipation. Guidance was in place and bowel charts were completed when required. This meant the correct action could be taken, such as administering medicines if the person needed it to reduce any discomfort. Three people required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tube fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. We observed registered nurses carrying out this aspect of care confidently, working in accordance with people's care plans and best practice national guidance. Most of the people at risk of choking were supported appropriately. We observed people at risk of choking were supported appropriately at mealtimes in line with guidance and risk assessments. This included those that required thickening powders to ensure fluids were at the right consistency. We observed safe moving and handling practices were used throughout the inspection and staff supported people to move using the correct equipment, such as a hoist. One person had a wound which was being monitored by staff who were working alongside a tissue viability nurse for additional advice and support.'

Medicines were managed safely. We observed registered nurses administer people's medicines as prescribed. Guidance was in place to support staff to carry out this role safely including information about any allergies a person may have. Medicine Administration Records (MARs) held necessary information such as whether a person received their medicines via a PEG or orally. Registered nurses referred to the MARs for guidance and made the appropriate entries onto the MARs after they had administered what was prescribed. Registered nurses practiced safe infection control when carrying out medicine administration and spoke to people sensitively whilst doing so. People were able to have access to 'when required' medicines such as pain relief if needed. Additional stocks were stored securely and separately from the medicines trolley. We noted some higher stock levels than were needed within the medicine room. We were told this was due to a handover from one pharmacy to another as the provider was changing its pharmacy shortly after the inspection. Therefore, this would be addressed as any medicine stocks not needed would be sent back to the pharmacy the provider was moving away from.

The Granary had a clean and well-maintained environment. Over the two days of the inspection domestic staff ensured the home remained clean, free from offensive odours and tidy. Equipment was seen to be readily available that promoted effective infection control such as antibacterial hand wash, disposable gloves and clinical waste bins.

We observed there were enough staff working across each of the units to ensure people's needs and requests were responded to. The manager told us they used a dependency tool to establish safe staffing levels. We were told and records confirmed, there were two registered nurses and five care staff across each area throughout the day. Three care staff provided one to one support to people. The manager said this increased when they were supporting the person on short term care. We saw that staff responded within a reasonable time to those who required assistance. In addition to care staff the provider employed an activities co-ordinator, maintenance, domestic and kitchen staff. This meant care staff could focus on providing care to people.

The manager told us agency registered nurses were used to fill in any gaps, which was mainly for night shifts.

They told us and rotas confirmed the same agency registered nurses were used who knew people and their needs well. One person presented as happy with the care they received and said they received safe care. They told us, "Yes, not bad, I haven't been here long, but it's not bad." The same person told us, "Yes, there is enough staff." A staff member told us, "We have agency nurses at night time but they have been working sometime for the company."

Is the service effective?

Our findings

At the inspection in September 2018 we found effective care was being provided to people. At this inspection we found this was not consistently the case.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found mental capacity assessments were completed on behalf of people. These included areas such as people accessing the community, using transport, the use of bed rails and how a person should be moved from one area to another such as a chair to a bed. We also observed staff seeking consent from people prior to providing support to them.

According to the manager, no relatives had Power of Attorney for health and welfare for people living at The Granary. There were no documents in people's care records to state this. The manager told us some relatives might have Power of Attorney for people in relation to finances. However, we found people's relatives had given consent for decisions over their health and welfare. For example, we found one person's relatives had made the decision for a person not to have routine health screening. Yet the provider had not checked whether they were able to make this decision legally on the person's behalf. This meant there was a lack of understanding about the process that needed to be followed when making a decision in a person's best interests.

We spoke with the care staff about whether any people had DoLS authorisations in place and whether any conditions applied and were being met. The three care staff we spoke with had attended training on both MCA and DoLS and had some understanding of the importance of this legislation for people they supported. However, they were unaware of how many people had authorised DoLS and if any had conditions. We checked people's DoLS status. Two DoLS had been authorised and a further two had been applied for by the provider and were waiting an outcome from the local authority. Conditions were in place for two people living at the home. This showed a significant gap in staff knowledge about DoLS in relation to the people they support.

One person's DoLS was authorised in August 2018. Their condition stated the provider needed to make more efforts to explore activities in the community. We checked the activities planner and record. This showed that from the 11 December 2018 to the present day the person had only had two outings in the community. Other activities recorded included indoor sessions such as watching a movie and listening to music. The manager told us they had plans to ensure more personalised activities took place, however, at

the time of this inspection this part of the person's DoLS condition, which was authorised in August 2018 was not being fully met.

Concerns about DoLS conditions had been raised with the provider at inspections of some of their other services. Learning from this had not been effectively shared to improve staff knowledge or people's care at The Granary.

The provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had its own training academy. The training academy facilitated an extensive rolling training programme throughout each year. Some training sessions were face to face sessions, whilst staff could achieve other courses through an on-line process. The provider's website describes The Granary as offering neurological care. Therefore, at this inspection we checked to see what training staff had attended to carry out their role effectively. We found whilst some staff had attended all the necessary training they needed to support people, there were inconsistencies.

One staff member who had been working for the provider for five years and at The Granary for one year supported people with epilepsy, however, they had not attended training on the subject. When we asked them about the support they provided they said, "You have to keep an eye on [named a person]." They did tell us they would alert the registered nurse on duty if a person had a seizure. However, they also described the seizures as being very short so they may have been finished by the time the registered nurse arrived. Due to our concerns about the lack of seizure records and monitoring we spoke to the manager about this. On the second day of inspection they told us the staff member had commenced the on- line epilepsy awareness course. They also sent us further training information after the inspection. This confirmed 64% of the staff team had attended epilepsy awareness training. As staff supported four people with epilepsy it was essential all staff were suitably trained to keep people safe.

In the Safe section of this report the lack of guidance for staff to assist in managing risks on behalf of a person who displayed behaviour which may challenge others is raised. We checked to see whether all staff had been provided with training about managing behaviour which may become challenging. This type of training is sometimes called Positive Behaviour Support (PBS) training. PBS training aims to provide staff with an understanding of why a person may behave in a certain way and enhances their skills and competencies to manage incidents effectively and safely. Training records showed that only five out of 25 staff had completed this training. This included only one registered nurse. There were missed opportunities to explore why a person may behave in a certain way which may have added the person's frustrations.

We were told and rotas confirmed agency registered nurses worked mostly night shifts. Five out of seven agency registered nurses had not completed PBS training. This meant when an incident occurred care staff were seeking advice from both permanent and agency registered nurses who may not have had not attended behavioural management training; and therefore may not have the skills to advise appropriately. This may have contributed to the gaps in behaviour monitoring which we found during this inspection.

Our reports of inspections of some of the provider's other homes have highlighted inconsistencies and gaps in essential training specific to the people staff are supporting. This demonstrates that learning has not been effectively shared by the provider to make improvements at The Granary.

The above evidence shows that staff had not always received appropriate training and support to enable

them to carry out their duties effectively. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager sent us information after the inspection regarding the training staff had completed. They also responded to the concerns we raised about gaps and inconsistencies. They told us the provider's PBS specialist was now providing a workshop on PBS for all staff. This would include how to record and report an incident accurately. We will follow this up at our next inspection.

Staff had received training in other areas such as tracheostomy, emergency first aid, moving and handling, fire safety, health and safety, food hygiene and safeguarding. They also received regular supervision and appraisals from their line manager and the opportunity to attend staff meetings. One person told us, "Yes, they (staff) are pretty good." A relative said, "There has always been plenty of staff and they know what they are doing." The deputy manager who was also a registered nurse provided clinical supervision to other registered nurses. We were told they were supported by the providers clinical lead.

New staff were provided with opportunities to shadow experienced staff members until they were competent to work independently. New staff were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. To achieve this, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff were also encouraged to complete Health and Social Care Diplomas (HSCD). These are work based qualifications that are achieved through assessment and training. One staff member told us, "I need to develop my skills, always happy to do more training."

The provider carried out assessments regarding people's physical needs prior to them moving into The Granary. However, information was not always utilised in how risks were being managed at the time of this inspection. We have discussed this further in the Safe section of this report. We also found some gaps in care plans in relation to people's personal life histories. This is important as it informs the development of a care plan and supports staff to deliver a personalised and effective service. The manager told us care plans were in a transition stage and some information may have been removed in the process into another filing system. The initial assessment processes in place considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability. However, throughout the inspection we found examples whereby people's human rights were not consistently respected. For example, not meeting the condition in one person's authorised DoLS as discussed earlier in this inspection report.

People that were able to communicate verbally told us they were happy with the food that was offered. One person said they ordered a take away regularly with the support of the staff including the manager. Another person told us they were provided with choices and said, "The food is ok. I don't do breakfast, but I like Shreddies." Three people were supported by registered nurses to receive all their nutrition and fluid via a PEG. We observed this was carried out in accordance with care planning and PEG management guidance.

The other three people required varying levels of support. The chef was aware of any specialist diets and shared information with us they kept on file about the consistency of people's foods. Staff described how one person's physical health was deteriorating and they needed additional one to one support from staff throughout their meal. The manager told us they had introduced the use of an adapted beaker, however, the wrong one had been delivered so they were waiting for the new one to arrive. Mostly staff presented as caring and attentive in their approach at mealtimes. However, on the second day one person was offered and given fish for their lunch. We read their care plan which stated they did not like fish. Staff supporting them seemed unaware of this. The person refused to eat the fish yet instead of being offered an alternative as a main meal staff offered them their pudding, which they ate. Routine weight records showed there were

no concerns about the person's weight. However, as staff had not worked in accordance with the person's preferences we shared our observation with the management team.

Efforts had been made by the provider to ensure the environment and adaptations of the premises met people's needs in relation to their physical disabilities. People living at the home used wheelchairs. Corridors and doorways were wide enough for people who used wheelchairs to move around the shared areas. Where required, bedrooms were equipped with an overhead tracking hoist to assist with safe moving and handling.

People's healthcare needs were recorded in 'My care passport'; this is a document which details what healthcare staff need to know about a person's care and support needs should they be admitted to hospital. The manager told us they invited all new care staff and agency staff to read this document as they felt it gave a good profile of the person's main health needs and wishes. Care records documented the input people received from healthcare professionals. People and their relatives confirmed they had access to health and medical professionals when they needed. GP's visited the home and any changes to people's health needs were discussed and any actions to support people carried out.

Is the service well-led?

Our findings

In December 2017 we found the provider was in breach of Regulations and The Granary was rated as Requires Improvement. In September 2018 we inspected The Granary again. Whilst we found there had been some improvements in the safety of care provided further work was required in ensuring care records were completed accurately. At that inspection the provider also remained in breach of regulations associated with person-centred care. Therefore, they continued to be rated as Requires Improvement overall. After both inspections the provider wrote to us to inform us about the actions they were taking.

At this inspection we found concerns regarding risks to people's safety. This included how risks were being managed on behalf of people in relation to their diagnosis of epilepsy, hydration, weight management and staff training. We found some associated health monitoring records were incomplete and therefore did not provide an accurate assessment of a person's current health. We also found the provider was not always effective in implementing legislation. For example, there were inconsistencies with how the provider applied MCA 2005 principles and DoLS when supporting people. Prior to this inspection, we had raised similar concerns with the provider in our reports of inspections at others of their services. Despite this, the issues we have repeatedly highlighted had not been used to check the safety and effectiveness of care being provided at The Granary. As a result, people were exposed to risks which had already been identified as themes to the provider; and which could therefore have been prevented. In addition, the provider had not identified the gaps and ensured improvements in PEEPs on behalf of people which we referred to in the Safe section of this report.

As this was a focused inspection we did not inspect all areas of care provided. However, we found the provider remained in breach of regulations and the quality and safety of care had deteriorated. Considering there were six people out of a possible 41 living at the home we were concerned that all their needs were not being met.

The provider had systems and checks in place to audit care being provided. This included an audit carried out by the provider's quality team in October 2018. The team had devised a 'service improvement plan' with a list of 43 areas/points which needed addressing. The new manager told us they had been working through this list since December 2018. Some of the actions had been completed and some were marked as 'in-progress'. It also identified some of the areas of concern we found on this inspection. For example, one point focused on behaviours which may challenge others due to an entry the auditor had read in a person's daily notes. However, this finding had not led to the introduction of behaviour management guidelines. Neither did it ensure training on behaviour that challenges, or PBS training for the staff team was sought. This meant the system for checking this area of care was ineffective.

We found other examples whereby the improvement plan referred to areas of risk we found but had not driven improvements to take place. This included reference to daily health monitoring records, including the need for staff to complete fluid charts accurately. However, this had not prompted checks to ensure all people at risk of dehydration had the correct guidance in place for staff. The audit also commented on MCA and DoLS, but had not reported that one person's condition within their DoLS authorisation was not being

met. It was not the audit findings but feedback from Inspectors which prompted the provider to take actions in the areas discussed throughout this report.

One person had a neurological condition and the manager explained how their physical health had deteriorated in recent weeks. They spoke about the support they were receiving from SaLT and a dietician. They told us and records confirmed, at a recent meeting in January 2019, they had discussed the next steps to support the person with their food and fluid intake. The person was also experiencing involuntary movements in their arms. One staff told us they found this difficult when supporting them to move safely. Inspectors suggested to the management team they might benefit from the support of the local authority Occupational Therapist team. Considering this support had been utilised in other services owned by the same provider, inspectors were concerned the provider had not shared this aspect of partner agency working with the new manager.

The above evidence demonstrates that the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not maintained complete and contemporaneous records in respect of each service user, including a record of their care and treatment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings people and their relatives presented as happy with the care they received. The last manager deregistered in July 2018 and the new manager came into post in December 2018. The deputy manager had consistently supported the home guided by senior management, in between changes of manager. The new manager had applied to be registered with the Commission. They were open and transparent and approachable to both people and staff. They were knowledgeable about a recent safeguarding concern and had made efforts to ensure any recommendations had been acted on. They provided assurances to inspectors about the action they would take to protect people living at the home. They told inspectors they would escalate any new concerns to the local authority safeguarding team for their review.

The manager had taken the time to get to know people, their likes and dislikes. They told us they recognised there was the need to improve activities and occupation offered to people. They had started to support people to access their own Motability cars so personalised community activities could be pursued. One person told us, "The new Manager, he's good, you know, he's sorting out my transport. I'll be going out anytime, in the evening going out for a meal or picking up a Chinese. We have a meeting and we sort it." The manager told us as he had been new to the home he had been meeting with people and their relatives separately to try and establish their needs and wishes and ensure they were involved with their care rather than in a group meeting. Relatives provided positive feedback, one said, "The new manager is pretty on the ball."

We discussed what other systems were working well with the manager. This included checks on medicines and equipment. They were also carrying out observations and interactions between staff and using this to inform discussions in supervisions with staff members. The manager had held two meetings with the deputy manager, lead clinical nurse and another registered nurse. These meetings had promoted discussions relevant to the people they were supporting. This included requests for any equipment which was needed and any current safeguarding concerns. The provider had introduced the National Early Warning Score (NEWS) which is a clinical assessment tool. NEWS determines the degree of illness of a person using physiological findings and observation. We found the NEWS was being completed as intended and was used as a method of assessment when a person became unwell.

The manager told us they had taken action on the areas of risk we identified at this inspection. They contacted us after the inspection with the progress they were making in people's best interests. This included carrying out one to one supervision meetings with staff and organising additional training and support for staff. They said they had also taken action to assess and mitigate the risks to one person. We will follow this up at the next inspection.

Staff were aware of their responsibilities and presented as happy in their role. They said they appreciated the support the manager had provided so far. The provider was promoting, 'A star of the month' for any staff member who had shown extra commitment. A poster displayed the staff member who had won the accolade during the time of the inspection. They were described as, 'friendly, supportive and hard-working'. One staff member told us their job was all about, "Helping people."

All notifications that were required to be sent to us by law had been completed and sent to the Commission as needed. The Commission's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to work consistently in accordance with MCA and DoLS legislation.

The enforcement action we took:

Imposed conditions on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with service users health care needs were not consistently mitigated.

The enforcement action we took:

Imposed conditions on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality and safety of care provided to service users were not always effective in mitigating risks to services users and ensuring improvements were made.

The enforcement action we took:

Imposed conditions on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found gaps in essential staff training and support to ensure they were able to carry out their role and responsibilities effectively.

The enforcement action we took:

Imposed conditions on the provider