The Hospital of God at Greatham

Gretton Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 of Gretton Court commenced on 30 December 2016 and was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. Specifically the risks associated with the use of unsafe equipment, specifically the use of broken bed rails. This inspection examined those risks.

We last inspected Gretton Court in June 2016 and found it was meeting all the legal requirements we inspected against.

Gretton Court is a purpose built single storey nursing home which can accommodate 37 people. There are secured gardens which people who live at Gretton Court can access freely.

At the time of the inspection there were 35 people using the service.

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

We found health and safety checks of equipment and premises were not always completed in line with the providers own requirements. Premises related risk assessments were not signed or dated by the registered manager and not all staff accessed the documents. The control measures within the bed rails risk assessment were not being followed.

Individual risk assessments for bed rails identified the risk of people climbing over the bed rails but there was no information on how this risk was managed. There were inconsistencies in how information related to people's mobility needs was recorded. Some care plans had not been updated in relation to a change in people's needs which meant they were at risk of receiving inappropriate or unsafe care.

The concerns we noted during the inspection had not been identified through the provider's own quality assurance systems. Audits had not been completed in relation to health and safety.

You can see what action we told the provider to take at the back of the full version of the report.

Other audits and quality assurance visits were completed by the care services manager, the director and the proprietors. These had identified some areas for improvement and acknowledged some action had been taken.

Safeguarding concerns, accidents and incidents were recorded and investigated. Lessons learnt were evident.

There were enough staff to meet people's needs and safe recruitment practices were followed.

Medicines were managed safely, audits were completed and one of the nurses had a lead role as the medicines champion.

Staff training was up to date and where refresher training was needed this had been booked. Supervisions and appraisals were completed routinely and staff told us they felt well supported by the staff team and the management team.

Deprivation of Liberty Safeguards (DoLS) authorisations were in place and care plans provided detail to staff on any deprivations, such as people being unable to access the community without support. Staff understood the need to support people to make their own decisions but if this was not possible they made decisions in people's best interest.

There were warm, caring and compassionate relationships observed between staff and people. People often instigated affection with staff offering cuddles and hands to hold which was accepted and reciprocated in a respectful and appropriate manner.

Care plans were in place and reviewed each month. Care records included information about people's life history which had often been completed by family members.

We observed staff were engaged in activities with people and relatives told us there was plenty of things for people to do. A well-stocked activities room was available for people to use, there was an on-site hairdressers and a range of visiting entertainers attended the home.

There had been no complaints since the last inspection. Relatives told us they knew how to complain but had no reason to do so. A full procedure was in place to investigate any concerns or complaints.

Staff told us they found the management team to be supportive and approachable. They said the home had a culture which put people first.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Health and safety checks had not always been completed in line with the providers own requirements.

Risks had not always been mitigated against and there were some inconsistencies in the recording of information relating to risk management.

Safe recruitment procedures were followed and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff told us they had access to training and were well supported.

Deprivation of Liberty Safeguards (DoLS) authorisations were in place and associated care plans had been written.

People were supported with their nutritional needs and had access to healthcare.

Is the service caring?

Good

The service was caring.

We observed warm and attentive relationships between people and staff.

People instigated touch and closeness with staff which was appropriately reciprocated.

Relatives were complimentary about the care their family member received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records included personal information about people's life, their likes and dislikes.

Some care plans had not been updated to reflect people's current needs.

There had been no complaints since the last inspection but a procedure was in place.

Relatives told us there were lots of activities and entertainment available for people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance system did not include any audit to ensure health and safety checks of the premises and equipment were routinely completed.

Some records did not contain consistent information and some documents had not been updated following changes to people's needs.

Staff told us they thought the service was well-led and that the registered manager, care services manager and director were approachable and supportive.

Gretton Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 December 2016 and 6 and 20 January 2017. Day one of the inspection was unannounced; this meant the provider did not know we would be visiting. Days two and three were announced so the provider knew we would be returning.

The inspection team was made up of three adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We had contact with the coroner, the police, the local authority safeguarding team and the commissioning team during the course of the inspection in relation to the investigation into a serious concern involving the death of a person who lived at the home.

During the inspection we spent time in the communal areas with people living at the service and we spoke with four relatives. We also spoke with the registered manager, three care staff, the clinical lead, one nurse, the cook, the handyman and one domestic staff. We also spoke with the director and the care services manager and a visiting community matron.

We reviewed six people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records, including medicine administration records for four people as well as records relating to the management of the service.

We looked around the building. Due to the complex needs of the people living at Gretton Court we were not always able to gain their views about the service. We used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at the health and safety systems within Gretton Court. We found that not all checks had been completed to the timeframe specified by the provider. Window restrictor checks were recorded as monthly but the last check was completed 11 November 2016, this meant a check had not been completed in December 2016. We noted the last recorded fire alarm check was 16 December 2016 and prior to this there were periods of time when the test had not been completed. The handyman said, "Fire alarm checks are recorded weekly unless it's set off by people then its recorded as a drill." The director said, "Fire alarms should be checked weekly even if residents set them off."

Profiling bed inspections, including bed rails, were documented as needing to be inspected six monthly. It had been completed on 15 November 2016 but was overdue by one month as the previous check was April 2016. The comments on the checklists were recorded as N/A, ie not applicable. This meant we could not be sure if any defects or damage had been identified and noted for repair.

Monthly equipment checks of wheelchairs had not been recorded since 10 October 2016 and there was no record of monthly checks of walking frames, slide sheets and handling belts. The checklist for wheelchairs dated October 2016 stated for one wheelchair, 'both legs missing.' There was no record of what action had been taken to repair this nor was the check list signed. We checked the repair log and found no record of any repair.

Monthly health and safety checks of electrical sockets, switches, fire doors, extinguishers, hoists had been completed on 10 October 2016 and then not until 3 January 2017. This meant checks had not been completed for two months. A weekly door check was in place but it had not been signed and there were significant gaps with none having been completed in the period from 11 November 2016 until 3 January 2017. A fire safety audit was completed by the fire service on 19 January 2017 found Gretton Court to be broadly compliant with some areas requiring attention. This included finding a number of fire doors to be defective. This meant people may not have been appropriately protected in the event of a fire.

Risk assessments for the premises and equipment were stored as an online resource. The registered manager confirmed the templates were used as required and were personalised to the specific situation at Gretton Court. We asked how care staff had access to the risk assessments. The registered manager and care services manager explained that all nursing staff had a log on code to access the system and this log on could be used by the care staff. This meant care staff did not have direct access to the risk assessments themselves. Health and safety was also discussed in team meetings. One care staff member said, "No access to electronic risk assessment but we discuss health and safety in team meetings." Another said, "We have access to everything, it's all kept in the office and we are free to go into the office and read up on anything we need to." We noted the risk assessments included areas such as bed rails, first aid, slips and trips and were signed electronically by the director but they were not dated or signed by the registered manager.

The risk assessment for bed rails stated as an action to reduce risk, 'Dimensional requirements of bed rails MHRA checklist to be carried out.' MHRA is the Medicines and Healthcare Products Regulatory Agency. We

did not see any evidence that this had been completed. We spoke to the registered manager about this who said, "We have a zero tolerance on mechanical beds so don't do dimensions, we did used to carry tape measures and measure them. We would still do measurements if mattresses were changed to ensure safety." We asked where this was recorded and was told there was no record. The registered manager said they would raise it in the health and safety meeting. This meant one of the control measures which the provider had identified to manage the risk of people using bed rails had not been followed so we could not be sure the actions taken were effective in managing risk.

We noted the nursing staff wrote all risk assessments in relation to the care people used. They also reviewed risk assessments on a quarterly basis. However, we were told by a nurse that they had not received any training in risk assessment or care planning. We asked the registered manager about risk assessment training. They said, "We go through the files with nurses as part of induction, but we are looking at this in terms of clarity with regard to the things identified during the inspection."

Where people were using bed rails, we saw individual risk assessments were in place which identified the risk of climbing over the rails and the risk of falls from bed. One person had a risk assessment for bed rails which stated they were at medium risk of climbing over the rails and a low risk of falls from the bed. There was no detail as to how the risk of climbing over the rails was being assessed or controlled, which meant the person may have remained at risk of climbing over the bed rails. We found inconsistencies in the assessment and recording related to the use of bed rails.

For one person bed rails were mentioned in the moving and handling risk assessment but not in the mobility care plan. One person had a change in mattress but this had not led to a review of risk or an update to care records. This meant there was no consistent approach to the recording of information in relation to the safe use of bed rails.

One person had a medicine care plan dated 4 October 2016 which stated the person did not take any medicines but their daily notes for 28 November 2016 stated they had been prescribed haloperidol as and when required covertly. A medicine administration record was in place but the medicine care plan had not been updated to reflect this change, the last medicine care plan review on 15 November 2016 stated 'no medication has been prescribed at this time'. This meant the person was at risk of not receiving the prescribed medicine as the care plan did not reflect the person's current needs.

These findings were a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Some risk assessments for mobility appropriately assessed the risk and identified how the risks should be managed. For example, for one person, who was assessed as at risk due to a history of climbing over bed rails, it had been agreed that the risk was too high to use bed rails. For another person this was a low risk, and as they were at risk of falls from bed it had been assessed that bed rails and a bumper would be used. Another person had a care plan for manual handling which detailed they were at high risk of falls. The reason for the risk was recorded, as well as triggers which could increase the risk such as feeling tired. The care plan identified how this was managed, such as by chair and bed sensors and one to one support.

Other risks were assessed, and appropriately recorded such as, behaviour, continence care and skin integrity, infection prevention and control, medicines and skin integrity.

Relatives told us they thought their family members were safe living at Gretton Court. One relative said, "[Family member] is definitely safe here." We asked what reassured them of this and they said, "The staff."

The provider had policies and procedures in place such as safeguarding and whistleblowing. All referrals to the local safeguarding team and CQC notifications were held electronically. During the inspection we viewed recent safeguarding referrals. The registered manager told us, "All safeguarding's are recorded and a copy is kept in individual files." Lessons learnt from safeguarding incidents were recorded with actions to be taken. We found these were not always signed off as being addressed. We asked the registered manager how they ensured staff were made aware of the lessons learnt. They told us, "Staff are spoken to straight away or they would be discussed at staff meetings."

The provider had a system in place to record and audit accidents and incidents. These were filed in monthly order with an overarching document recording each accident, time, date and location including what action had been taken. For example, contacted 111 or checked by the nurse and no injury noted so reassurance given. Monthly audits were completed which looked at whether the incident was minor, moderate treatment by nursing staff, hospital admission or a vulnerable adults referral. This demonstrated the provider was proactive in monitoring for patterns and themes. A bi monthly analysis was also completed to look at trends over a longer period of time to give a clearer picture of activity.

Routine surveys and certificates in relation to the premises were completed, such as an asbestos survey, fire risk assessment, gas safety certificate and electrical installation condition report. Lifting equipment, such as hoists, had been maintained and portable appliance testing completed. Routine checks of emergency lighting were completed.

A building fire plan and evacuation procedure was in place. Each person had a detailed personal emergency evacuation plan (PEEP) which detailed the support they needed in the event of an emergency evacuation. If people needed to use a hoist for transfer the location of their sling was detailed. Each PEEP was dated within the last 12 months and had been approved by the registered manager.

The registered manager used a dependency tool to ensure staffing levels were appropriate to people's assessed needs. We found all people using the service were entered as high dependency on the tool. We reviewed the current week's rota and recent weekly rotas. The service had enough staff on duty, depending on the people's assessed support needs and activities for the day. We found during the day there were two nurses and six or seven care workers, with one nurse and three care workers over night. Support plans set out the level of care each person needed. For example, two staff required for moving and assisting. Staff were visible in the service. We observed staff supporting people on a one to one basis during meal times. The provider employed a clinical lead nurse who was supernumerary; they provided the specialised nursing expertise in the service. The clinical lead told us, "I also do a day a week on the floor, that way it helps me see how things are going." During our inspection were found call buzzers were answered promptly.

Staff were recruited safely. The procedure included an application form, interview and the receipt of two satisfactory references and a disclosure and barring service check (DBS). DBS checks help employers make safe decisions as they provide information about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. Checks were also completed on nurse registrations to practice.

We checked to make sure medicines were being managed safely.

The clinical lead nurse told us, "We have just moved over to a new system of boxed medicines. Each person has a tray which holds their medicines with a photograph on the front. By having the photograph on the tray it makes identification easier." They went on to tell us, "I feel this is a much better system, easier to manage, we optimise medicines better by not ordering what we don't need."

Nursing staff were responsible for all the administration of medicines. The provider had a nominated medicines champion. This member of the nursing staff was responsible for checking medicine administration competencies. We found these were completed on an annual basis.

Medicines were stored in two locked trollies and cupboards in a locked room. A fridge was available to store medicines that required cool storage. Records confirmed that temperatures were checked and recorded daily. The provider had a signature sheet in place with nurses' sample signatures for audit purposes.

Each person had a medicine file which contained the most current Medicine Administration Record (MAR). Records gave clear instructions on what medicines people were prescribed, the dosage and timings. The person's preferred method of taking their medicine was also in place. For example, [person] likes to take medicines with juice. The MARs were completed correctly with no gaps or inaccuracies. Where people were having their medicines administered covertly, the MAR detailed which medicine and how it was prepared. For example, crushed or empty capsule. People had care plans in place for covert administration along with records of best interest decisions.

During the inspection we were made aware of an outbreak of diarrhoea and vomiting. Appropriate notifications were made and visitors told us they had been informed and it had been recommended that they did not visit. This meant the registered manager was working to minimise the spread of infection. They explained they were in constant communication with relatives and friends of people to keep them informed of their loved ones well-being. Each person had a risk assessment and care plan in relation to infection prevention and control. We observed staff using personal protective equipment (PPE) correctly and appropriately. Cleaning regimes were followed as per infection prevention control guidelines.

Good

Is the service effective?

Our findings

We looked at the support and training staff received. Staff attended quarterly supervision meetings with a named supervisor. Annual appraisals had also been held which were used to offer praise, support and to develop plans for the forthcoming year. One care assistant said, "The support is good, supervisions with the nurses and an appraisal as well, we all have a named nurse for support."

We spoke with relatives about their views on the competency of staff. One relative said, "I'm confident staff are trained and know what they are doing."

During the last inspection we saw training was up to date and had been booked for new members of staff. During this inspection we noted the training matrix showed that not all nurses or care staff had received training in first aid. We spoke with the care services manager about this who provided assurances that there was a trained first aider on site at all times. They said they had spoken to the registered manager who had said there was lots of training that was booked and an updated training matrix would be forwarded.

We received the updated matrix and held a telephone discussion with the registered manager. All nursing staff had attended a three day first aid course except for one who had commenced in post in November 2016. The registered manager offered assurances that their training was booked. They said all nurses had attended dementia awareness training and some end of life training. The clinical lead said, "I've attended a degree level course in contemporary issues in palliative care which is a certificate for life." For other training such as infection control workbooks had been completed and there were positive links with the infection prevention and control nurse. For other training where there were gaps such as food hygiene and mental capacity this had been booked. Two nurses had not completed moving and handling training but this was because the trainer had cancelled the course, this had been rebooked. We will follow up the completion of this training outside of this inspection process.

The registered manager explained that additional training was provided on an as needed basis, for example if people had a catheter in situ. They said, "All nurses attended supra pubic catheter care with the NHS recently." One nurse said, "I've done suprapubic catheter training, end of life, medication. If a resident has a need we are trained to meet the needs of that resident. I did a three day first aid training."

Care staff training in areas deemed mandatory by the provider had been attended or was booked as were necessary. This included moving and handling, safeguarding, mental capacity and Deprivation of Liberty Safeguards (DoLS), health and safety and infection control. One care assistant said, "I've done all the mandatory training, fire, health and safety, COSHH (control of substances hazardous to health), first aid, it was a one day but it's good to know the basics as things change over time, moving and handling, safeguarding, mental capacity." They added, "I can bring training up in supervision or appraisal if I think I need it but it's quite up to date." They also said, "[Registered manager] is very receptive and tries to source training, they will ring and let us know about training."

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 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. We found the registered manager kept a copy of DoLS authorisation on file along with MCA assessments. We saw that people's care plans contained details of the authorisation. This meant that staff had guidance about how to support the person with a DoLS in place.

The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. The registered manager had followed the requirements and applications under DoLS had been authorised. Care plans were in place which described the conditions of DoLS authorisations and specific action staff needed to take in relation to the application of DoLS. One relative said, "They explained DoLS to me and went through it all."

Annual assessments of capacity, ability and decision making were completed. The assessments were not specific to decisions which needed to be made but covered activities of daily living, such as mobility, cognition and nutrition. This included a section titled, 'an assessment of illness, how the person's lifestyle has been affected by the illness.' For each activity such as mobility a decision had been made as to whether the person had capacity, lacked capacity or capacity fluctuated. We asked the registered manager about mental capacity assessments and best interest decisions. They said, "We do a capacity assessment when people move in which assesses whether we need to apply for a DoLS. After that if there was something decision specific we do a specific assessment." We saw best interest decisions were recorded for the covert administration of medicines.

Risk assessments for 'restraintive devices' were in place in relation to the use of any equipment such as bed rails which are considered to be a restraint. We spoke with a nurse about the process for assessing capacity to consent to the use of potentially restrictive equipment such as wheelchair lap belts. They said, "Lap belts and bed rails would need to be assessed. The 'restraintive devices' risk assessment gives consent for bed rails and wheelchair lap belts." For one person this assessment detailed that bed sides were not to be used due to the risk of the person climbing over them but as an alternative bed sensors were to be used at all times.

We spoke with care staff about their understanding of mental capacity and best interest decision making. One care staff member said, "It's about people making their own choice, if they can't do it we do it in their best interest, we try our best to see if people can do it first."

We asked staff about DNACPR (Do not attempt cardio pulmonary resuscitation records) and what their understanding was of these documents. One nurse told us, "They set out specific situations or medical needs where we would not attempt CPR (cardio pulmonary resuscitation)." They told us how the GP reviewed the DNACPR so it was up to date and that staff are made aware of who has one in place. We found care records contained DNACPR's which were up to date. One care assistant said, "When we did first aid we talked about them."

Nutritional assessments were completed regularly, along with care records to monitor people's food and fluid intake and weight. We reviewed food and fluid intake charts and found these were not always completed fully in relation to monitoring people's hydration. For example, for one person who needed to drink a certain amount of fluid, this was not recorded in measureable amounts. Records only stated 'tea or juice'. Amounts of food were entered, for example, half eaten or all eaten.

Dietary notification sheets were completed and kept in people's care files as well as in the kitchen. These detailed people's likes and dislikes as well as any specific requirements in relation to their diet, such as diabetic, eats independently with prompts from staff.

People were also supported to use any specialist equipment, such as adapted cutlery, plate guards and contrasting plate. A community matron was heard saying to a nurse, "Since you have changed the colour of the plates their intake is much better." They also told us, "They follow my advice to the word. They keep staff long term and invest in training which is reassuring." They added, "They make referrals in a timely manner and request reductions in medicines for people."

Communication between staff and healthcare professionals was evident in care records including social workers, dieticians, pharmacists, community psychiatric nurses and doctors. Letters from health care professionals were available following attendance to hospital or home visits. For example, one person's file contained letters following a medicine review by the memory nurse.

We spoke with staff about the procedures to follow if someone's health deteriorated. A care assistant said, "We would tell the nurse and the nurse would do blood pressure and observations, they might recommend bed rest or would contact the GP or ambulance if needed." A nurse said, "Care staff would seek advice from the nurse, we would then assess and seek further advice if required in terms of medical attention needed if it was immediate or the community matron, we use our clinical judgement about the action to take."

Good

Is the service caring?

Our findings

We spent time with people and relatives in one of the communal rooms. One relative said, "I'm really happy, couldn't fault it, they care for the family as well as the resident. Staff are approachable, if I have a problem I can go to staff." They added, "They pick the phone up and talk to me, I'm involved in everything, how [family member] should be cared for and how I want them cared for." They went on to say, "There's no place like home, it's lovely here." Another relative said, "Staff make us feel very welcome, I'm happy with the care. I'm very involved and I'm told what's going on. I'm happy with everything."

Another relative we spoke with said, "I'm very happy, it's the atmosphere, the friendliness, it's great, they know the family, it's relaxed, it's a good place. It's been the best thing, it has marvellous standards, marvellous. Every member of staff really cares, you couldn't ask for better care." They added, "I'm involved in care plans, sharing likes and dislikes, we are really well looked after, they are part of the family, marvellous."

A further relative said, "It's good in here, couldn't be any better, they are on the ball the nurses and everyone. This is the place, there's no better place in the town or the North East. It's a family atmosphere here, as happy as can be." A community matron said, "They have a very good standard in terms of dementia specific care, behaviour and guidance, it's always peaceful and people are never rushed."

We observed warm, engaging, compassionate and caring relationships between people and staff. Staff were attentive to people's needs, for example when one person left the dining table before finishing their meal. The person was approached in a gentle and calm manner, staff spoke to the person by name and asked if they had finished their dinner, they prompted, "Shall we go and have a look" and the person returned to the table with them and continued with their meal.

We saw staff interacting with people in an encouraging and caring way. For example, spending time with people and speaking with a calm and gentle approach prompting and explaining. People were respected by staff and treated with kindness. Independence was promoted where possible. We observed staff members encouraging people to do small things for themselves such as eating and drinking, getting up and mobilising. We saw staff stopping to have a word with people as they passed.

Communication between staff and people took many forms such as touch, gestures and facial expressions. Some people were very tactile and staff appropriately responded to this by holding hands and providing hand massages. Other people sat with staff and placed their head on staff members' shoulders which was responded to with kindness and gentle words of reassurance. Other people instigated hugs and kissed staff on the cheeks or hands. This was accepted in the manner with which it was given, with respect and appropriate affection.

Since the last inspection a relatives' meeting had been held. All attendees had been welcomed and thanked for their contributions to the Christmas fayre. The clinical lead explained they were speaking with relatives to discuss their family member's preferred priorities of care. This is a document for people to record their wishes and preferences during the last year or months of life. It aims to help with the planning of care when

someone is dying. This means that everyone involved in the persons care knows what they want and how they wish to be cared for.

Future activities were discussed, including the offer to organise for the Father to visit and say prayers with people if it was requested. Attendees were invited to contribute and it was noted that relatives made positive comments about their family members care. For example, 'On a personal note you couldn't do anything better'. Meetings were arranged with family member's named nurse at their request and any queries were appropriately responded to. Relatives were reminded that the next survey for feedback would be issued in January and the next meeting was planned to include a presentation on end of life care and a discussion around dementia awareness.

We asked the registered manager if anyone had an advocate, they explained that no one did other than relevant person representatives in relation to Deprivation of Liberty Safeguards.

There was information on display about advocacy services, safeguarding, complaints, concerns, suggestions and compliments. A file containing dementia information sheets was also available.

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care records. As noted in 'Our findings – Is the service safe,' some care plans had not been updated to reflect people's current needs which meant they were at risk of receiving inappropriate care and support. Another person had a choking risk assessment and care plan which identified a need for a fork mashable diet and thickened fluids. A letter from the speech and language therapy team, received after the care plan had been written advised normal consistency liquids and diet. We spoke with the cook who checked their records and said, "They are on a normal diabetic diet." The cook confirmed that the diet notifications had been updated and the person was receiving the correct diet. This meant the person was receiving appropriate care but the care plan and risk assessment had not been amended in response to the healthcare professional's advice.

Another person had a care plan which stated they required two hourly positional changes through the day from their chair to their wheelchair and to have a specialised cushion, as well as positional changes at night. Records did state the person could shuffle and alter their position but staff were to assist with alternative seating. Although records showed positional changes at night, the same was not seen through the day. We discussed this with the registered manager who advised the person could alter their position themselves, so was not sure why this would be the case, and she would review the care records. This meant care records did not accurately reflect the person's needs.

These findings were a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Care records contained information about people's life histories, interests, likes and dislikes. 'This is Me' documents had been completed by people's family members and one page profiles described what was important to the person, what others liked and admired about the person and how best to support them. 'This is me' is a tool for people with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.
Care plans in relation to the management of behaviour were detailed and included information on potential triggers as well as strategies for staff to follow, such as specific topics of conversation which would distract the person or supporting people to move to a less stimulating environment. One person's cognition care plan stated that staff should introduce themselves by name on each occasion. Their care plan for emotional needs stated staff should approach in a cheerful manner, addressing the person by name. It went on to record that they responded well to friendly one to one interaction, liked singing and if offered a hand would often kiss it or shake it.
Other care plans included detail in relation to signs to look for which might indicate the person was feeling anxious or poorly and actions that should be taken to reduce distress. For example, one person's care plan for personal care stated, [person] becomes embarrassed, staff to minimise distress by having everything at hand to avoid delays. Another care plan for communication read, give plenty of time, and keep sentences short. Care plans were also in place for continence care, skin integrity, infection control, and cognition.

Monthly reviews of care plans were completed by the nursing staff. Care assistants explained that they had

access to the care plans and risk assessments and reported any changes to the nurse for documents to be updated. One care assistant said, "I do check it's been done but mainly it has been." They added, "We complete daily records on diet, fluid intake, bowels, room checks etc. any concerns go in the nurses notes which are more about how the residents have been that day."

One relative said, "There's plenty of things for people to do, quizzes, sing songs, entertainers, they have some really good ones, dominoes, pie and pea suppers." Another said, "They do all sorts, there's lots of entertainment, they come in all the time." We spent time with people and their relatives whilst they enjoyed a karaoke afternoon. This brought lots of smiles and some people sang along and danced to the music. It was also an opportunity for visitors to reminisce with their family members about favourite times and special events prompted by the music.

A new activities co-ordinator was being recruited. The registered manager explained that the handyman continued to support with activities during afternoons. We observed him engaging people in a karaoke, sing along session which people and their visitors and staff were joining in with. We saw a record was kept of activities such as entertainers, the celebration of peoples' anniversaries and special occasions. The local school had led a carol service over Christmas and there had been a Santa's Grotto.

The activities room was well equipped and staff were able to use this to engage people in activities. The hairdresser's salon continued to be used by people. One care assistant said, "We are waiting for the activities coordinator to start so we try to fit things in between one to ones, each person is different, we have dominos, books, colours, things to feel, (handyman) does musical bingo and karaoke, it's really good." They added, "Some people like to walk, talk, or want to be on their own."

We spoke with relatives about the complaints procedure. One relative said, "If I needed to complain I would go straight to [registered manager] but I'm more than happy, couldn't fault it, it's second to none." Another relative told us, "Complaints are in the information you get on first admission, but I've no complaints, if I did I'd see [registered manager]."

A complaints policy and procedure was in place which was accessible to people, relatives and staff. The procedure included a record of the complaint, the investigation, outcome, action taken and confirmation that the complainant was happy with the outcome. There had been no complaints or concerns raised since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found routine health and safety checks had not been completed in the timeframe specified by the provider. This included checks of equipment used by people as well as checks in relation to premises safety. We spoke with the registered manager in relation to the completion of health and safety audits. They explained they did not complete audits to ensure the health and safety checks were up to date. They went on to say the system used by the maintenance person had been changed recently and they needed to revert back to this system as they used to be able to see at glance if checks had been completed or not. The director said, "The registered manager needs to do health and safety checks, audits."

Electronic risk assessments in relation to the premises had not been signed and dated by the registered manager. This meant we could not be sure that the risk assessments had been reviewed and agreed to by the registered manager. We spoke with the registered manager about the control measures in relation to the risk assessment for the use of bed rails and they were unable to provide evidence of the stipulated checks. The risk assessments were not accessed by all staff so we could not be sure the care staff were aware of how risks relating to premises and equipment should be managed and mitigated.

We also found the management of risks, predominantly in relation to mobility and bed rails were not consistently recorded nor were all risks mitigated against, especially the risk of climbing over the bed rails, as there was no detail on how this risk was being reduced or managed.

An audit file was in place which included care plan audits which had been completed by the care services manager and the director. The care service manager's audit from November 2016 had identified one person's care plans as needing 'urgent attention, no evaluations since October 2016. Communication care plan not reviewed since August 2016, mobility requires urgent update as resident does not mobilise on their own and requires two people. Care plans written in 2015 should be updated to 2016. Personal hygiene needs updating to identify the number of staff required to assist this person, ie two.'

We found some people's care records had not been updated following a change in need. One person's risk assessment and care plan in relation to their nutritional needs had not been updated to reflect the advice of the speech and language therapy team. Another person's medicine care plan had not been updated following the prescribing of a medicine nor had their care records or risk assessments been updated following a change in mattress. This meant an accurate complete and contemporaneous record in respect of people's care and treatment had not been maintained.

We also saw audits of beds and mattresses and a falls audits. A falls audit from November 2016 noted as a key indicator a recommendation that there should be 'regular audits of the use of bedrails against the policy and embed changes to ensure appropriate use.'

These concerns meant the provider had failed to ensure that effective systems were operated to assess, monitor and improve the quality and safety of the services provided.

These findings were a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

An established registered manager was in post. We spoke with them about quality assurance. They said, "We want things to be right, we have to demonstrate safe practice at work, rights and choices in care, if people are deprived we try to provide something else. We don't deprive people of going out, they can access the community with support and have free access to garden space. The doors between units are only closed at medicine time or if a person was targeting another person. There would be an action plan in place as an interim measure." We asked specifically about the audits process and they said, "Care plan audits are done by [clinical lead] and I go over the findings. [Director] and [care services manager] do sample audits, and the proprietors do the 'Mums test' and some document checks. [Nurse] audits medicines with [clinical lead] and I oversee. Problems are brought to me but they are normally rectified beforehand." They also explained a new procedure was being introduced in relation to health and safety to ensure an effective audit system was in place. This involved the registered manager auditing health and safety once a month, the care service manager completing a bi monthly audit which would include a sample check of the registered manager's audit. They also explained that they would be completing a physical sample of checks such as water checks.

The care services manager audit in December 2016 identified some actions were needed such as documents needing to be reviewed and one person's care file included no information in relation to choking. We noted there were no comments recorded in the section for the registered manager's response. The care services manager had commented on care record audits completed by the registered manager. They noted that all actions had been completed. They also wrote, 'Noted huge improvements in the detail of care plans, extremely person centred and reflect the needs of individuals. Following training on 13 December care plans to be formulated to reflect risk/aims/care interventions.'

Members of the board of trustees, such as the proprietors, also completed bi-monthly visits to Gretton Court to assess the quality of the service. The director described this as being, 'the Mum's test.' These included observations and speaking with staff as well as checking records and commenting on significant events. It was noted that one trustee had commented that access to health and safety records was restricted if the registered manager or maintenance person weren't available. We spoke with the registered manager who said this had been resolved and there was now access. We noted the reports produced by the proprietors had not been signed by the registered manager although on some reports the proprietor had noted that the registered manager had addressed the concerns they had raised previously.

Medicine audits took place on a regular basis, with 'when required' medicines being audited on a weekly basis. Running totals of when required medicines were kept. The clinical lead told us, "This way we know what the stock is, making sure we order more to prevent us running out. We complete a weekly audit on each unit, looking at half the MAR, then the other half the week later." We asked how staff were made aware of any issues with the audits and how actions were addressed. The clinical lead told us, "I raise the issue in staff meetings as well as speaking to the individual nurses, if issues continue then I would have a supervision with them."

We found evidence of accidents, incidents and allegations of abuse being reported. The registered manager audited these to identify if there were any trends or patterns. If any concerns were found then action had been taken to minimise these.

Each nurse took a lead role in relation to medicines, dignity in care, end of life, wound care and infection control and were known as champions.

Records showed the registered manager held meetings with staff and relatives. A relatives' meeting held on 8 December 2016 showed positive comments had been about the service. Comments included, 'staff are very approachable, concerns are taken seriously, you couldn't do anything better.' Staff meetings were held regularly. Minutes identified agenda items as, health and safety, staff, activities infection control and meals. A policy of the month was discussed during each meeting to ensure staff understanding.

Management team meetings and health and safety meetings were attended bi-monthly and agenda items included safeguarding's, language in relation to dementia. Health and safety meetings included new risk assessments, nutrition and hydration, accidents and incidents and lessons learnt.

Staff were complimentary of the registered managers approach and said they thought the service was well led. One care assistant said, "We have a good manager, approachable, supportive, spends time with residents. There's been a lot of improvements over the years, the grounds are safer, people are free to walk wherever." They added, "[Care services manager] and [director] pop in, they are approachable too, I see more of [care services manager], they always ask if everything is ok." Another care assistant said, "It's a nice place, relaxed, a good team, everyone is approachable, the nurses, [registered manager], are always there for you, they always have time for me." They added, "It's a well-run home, we all know our jobs and make sure (everything's) done. The nurses give a hand and it all runs smoothly."

A nurse said, "We all work well in the team, everyone is focused on the residents. The company ethos and philosophy, if we want something we get it as long as we can justify why, if it will benefit the resident or our week."

One relative said, "[Registered manager] comes and says hello, I see the chief exec [director] wandering about. There's no improvements that I can think of." One care assistant said, "It's a good place to work, it's a lovely place, lovely team, I'm settled, it's like home."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the equipment used by the service for providing care to service user's was safe for such use and used in a safe way. The provider failed to assess the risks to the health and safety of service users and failed to do all that was reasonably practicable to mitigate such risks. 12(2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that effective systems were operated to assess, monitor and improve the quality and safety of the services provided. There was a failure to ensure accurate, complete and contemporaneous records in respect of each service user. 17(1); 17(2)(a)(b)(c)