The Christian Care Trust

Grace House

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection that took place on 31 October and 9 and 22 November 2016. At our last inspection in March 2016, we found ten breaches of regulations. These included medicines management, risk management, care planning, embedding the principles of the Mental Capacity Act 2005 into practice, safe recruitment, and effective governance. Our overall rating of the service from that inspection was 'Inadequate.'

We undertook this comprehensive inspection to check on the progress made by the provider, and to consider whether the service could be removed from Special Measures, our framework to ensure a timely and coordinated response where we judge the standard of care to be inadequate.

Following the last inspection, we also took enforcement action. We imposed a condition on the provider's registration requiring them to send us monthly reports about auditing risk assessments of people using the service, medicines administration, and staff recruitment checks. This included any actions being taken to address any risks identified in those audits. The provider submitted these monthly. The reports indicated that progress was being made at addressing our previous concerns.

Grace House is a care home for up to ten people that specialises in the care and support of older people and people living with dementia. There was one vacancy when we inspected.

The service had a registered manager. 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 and associated Regulations about how the service is run.

People using the service and their relatives provided good feedback about the service's care and attentiveness. We found that the service was caring and respectful, and made efforts to improve the quality of people's lives. The environment was homely and welcoming, and the service helped people maintain community links.

Staff provided support in a kind, professional and attentive way. Staff worked to find the best outcomes for people they cared for, whilst valuing and prompting people's independence. There was good feedback about how well the service responded to people's requests and provided individualised care.

People's care plans had been reviewed and updated, and addressed their support needs. There were also better activities provided. People's health needs were addressed, including through the support of community healthcare professionals, and through nutritious home-cooked meals. The service was now working in line with the principles of the Mental Capacity Act 2005.

A management consultant had been recently hired to assist with implementing service improvements. We

saw their input, including the guidance of staff on appropriate care practices, as progress towards addressing our concerns.

However, we found insufficient improvement in the management of the service. Whilst criminal record checks (DBS) were now in place for established staff, recruitment checks of new staff were still not completed before the staff member started providing care to people. Audits of those checks were additionally inaccurate.

There were better overall risk management processes but they were not yet sufficient for falls prevention and management.

People's medicines were not always properly managed so as to maintain an audit trail that demonstrated that people were consistently offered their medicines as prescribed.

Auditing reports contained some inaccuracies that did not assure us of consistently effective governance at the service.

There were overall two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The condition on the provider's registration that we imposed therefore remains in place.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of 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?

Requires Improvement

The service was not consistently safe. Recruitment checks of new staff were still not in place before they started providing care to people, although recruitment checks were now in place for all established staff.

There were better risk management processes but they were not yet sufficient for falls prevention and management.

People's medicines were not always properly managed so as to maintain an audit trail that demonstrated that people were consistently offered their medicines as prescribed.

People were protected from abuse by effective safeguarding procedures. The service provided sufficient numbers of staff, and standards of cleanliness were good.

Is the service effective?

Good

The service was effective. All feedback we received indicated this, particularly for improving the quality of people's lives. Nutritious home-cooked meals were provided. People's health needs were addressed, including through the support of community healthcare professionals.

People received good care and support from trained staff. The service was now working in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People felt respected and were involved in decision-making about their care along with their relatives where appropriate. The environment was homely and welcoming, and the service helped people maintain community links.

Staff provided support in a kind, professional and attentive way. Staff worked to find the best outcomes for people they cared for, whilst valuing and prompting people's independence.

Is the service responsive?

Good

The service was responsive. People's care plans had been reviewed and updated, and addressed their support needs. There were also better activities provided.

There was good feedback about how well the service responded to people's requests and provided individualised care. Concerns were dealt with informally.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. We imposed a condition on the provider's registration, to send us monthly reports about auditing certain aspects of the service. These reports were regularly sent, although they contained some inaccuracies that did not assure us of consistently effective governance.

A management consultant had been recently hired to assist with implementing service improvements. We saw their input as progress towards addressing our concerns.

There was good feedback about the service providing an open and inclusive culture.

Grace House

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 31 October and 9 and 22 November 2016 and was unannounced. The inspection team comprised of one inspector and one pharmacist specialist. There were nine people living at the service at the time of our visit.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned to us and was taken into account for this inspection. We also looked at the information we held about the service including any notifications they had sent us and information from the local authority.

As part of the inspection process, we spoke with six people using the service, five people's relatives, two other visitors, three health and social care professionals, four care staff, the cook, the registered manager and the office manager. In a few cases, the feedback was received by phone or email.

During our visits, we observed care delivery in communal areas, and looked at selected areas of the premises including some people's rooms. We looked at care records of four people using the service, everyone's medicines records, and personnel files of four staff, along with various management records such as quality auditing records and staff rosters. The office manager sent us some further documents on request after the inspection visits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service in March 2016, people using the service were not safe. This was because people were not safely supported with taking medicines, and records of this support were not properly kept. Additionally, actions were not taken to reduce foreseeable risks in relation to people's specific needs, including for nutrition, mobility, warmth and pressure care. Finally, staff were working without appropriate recruitment checks in place to assure that they were safe to provide care to people.

We imposed a condition on the provider's registration requiring them to send us monthly reports about auditing risk assessments of people using the service, medicines administration, and staff recruitment checks. This included any actions being taken to address any risks identified in those audits. The provider submitted these monthly. The reports indicated that progress was being made at addressing our previous concerns.

At this inspection, people and their relatives reported no safety concerns. Relatives' comments included, "We've never found any concern for her safety." We found that many foreseeable risks had been addressed. The service was now being kept consistently warm, and people reported no concerns in this respect. A relative said the temperature was "just right"; another that "They have overhauled the heating." The registered manager told us of professional radiator checks that had taken place, to help ensure a warm enough environment.

A relative told us, "I asked to see the report for a fall that my relative had and was satisfied that they were keeping my relative's records up to date." We checked on actions taken in response to records in the service's accident book. We found that some falls risk assessments had been updated and care plans changed to reflect this, to try to prevent further falls.

Staff were aware of precautions taken following falls, for example, that one person now needed a staff member to walk with them for reassurance, and that furniture in their room had been moved to minimise hazards. Another staff member told us of clearing up spillages quickly to minimise risk of anyone slipping.

However, one person's falls risk assessment following a second recent fall had not been reviewed and updated. This did not demonstrate that risks relating to the person's welfare following the second fall had been taken into account.

Another person had a recent fall. Their injuries included a small cut to the back of their head. Whilst staff provided first aid treatment at the time, health professional advice was not sought, which may have compromised the person's health and welfare. The office manager advised us that the person's falls risk assessment had not subsequently been updated, even though the accident had been investigated. The actions taken did not demonstrate sufficiently safe care.

The office manager informed us that the service did not have a falls prevention and management policy. This did not assure us that the service had an established and sufficient strategy for falls prevention and

management.

The evidence above demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff kept records of the temperature of the medicines cabinet. The records gave assurance that medicines were stored at the correct temperature to remain effective.

We saw running balances for medicines that were not kept in the blister pack. This meant that staff knew when medicines supplies were running low and could order more.

Staff managed the administration of warfarin well. A practice nurse regularly did blood tests for a person who was taking warfarin. The warfarin clinic sent regular communication to the provider, and the paperwork was filed in the appropriate person's folder.

The office manager liaised with a healthcare professional as a result of finding the quantity of a short-term medicine was smaller than anticipated. This helped to show that medicines were checked on becoming the responsibility of the service.

However, we found insufficient progress had been made with ensuring that people's medicines were properly and safely managed. Medicines for eight people were dispensed into multi-compartment compliance aids by their community pharmacists. One person's medicines were supplied in their original boxes, and a member of staff at the home used this supply to dispense the medicines into a dosette box. This practice is known as 'secondary dispensing' and adds additional risks to the safe management of a person's medicines. Staff were not trained to do this activity. We advised the management team to consider other options to reduce the risk of dispensing errors and risk to the person.

Medicines were ordered on a monthly basis for each person. We saw electronic records of this activity. Staff told us that medicines were also checked on arrival from the pharmacy. However, we did not see any records of this, which the office manager confirmed as correct. They undertook to start records from the next delivery.

Medicines were administered by staff who had received medicines training. Each person had a photograph in their Medicines Administration Record (MAR) chart folder to enable staff to identify who they were administering medicines to. However, two people did not have their allergy status documented on the MAR.

For medicines that were taken when required, we found that there were no protocols to guide staff on when to give these medicines. Staff relied on memory for this information. For one person who was on pain killers prescribed 'when required, up to four times a day', they were given the pain killers regularly each morning. We were told that the pain was always bad in the morning so that was the usual routine, but there was no record of this information. For people on laxatives (medicines that treat constipation), we were told that staff looked at the information on people's bowel charts to decide when to offer laxatives. There were no instructions available to guide staff on when to offer these medicines.

For one person, their evening dose of prescribed cream had been signed for in error as it was not yet evening when we viewed the MAR. There were missed doses of this medicine on four occasions across the month. For another person, one dose of medicine was not signed for across the previous month. Nothing was documented to explain these omissions.

One person was self-administering some of their medicines. They were provided with lockable box in their bedroom to store their medicines securely. However, there was no system of assessing people who wanted to self-administer their medicines to ensure that they were competent to do so.

When liquid medicines were opened or reconstituted staff did not write the date on the bottle. We advised staff that it would be good practice to include this information on the bottle.

We were told that unwanted medicines were returned to a local pharmacy for disposal; however there were no records of this activity. In addition, a member of staff was witnessed placing expired medicines into a domestic bin.

There was a medicines policy; however we found that it did not reflect current practice in the service. For example, it said that staff did not use homely remedies, which are over the counter medicines that are available to people living in homes for the short-term management of minor ailments. However the registered manager told us that she would give cough mixture or tea tree oil to people when required.

We found that established staff now had appropriate and timely criminal records disclosure (DBS) checks in place, and that where some established staff had previously been employed without suitable references, references had now been acquired.

There was one new staff member working at the service since our last inspection. Their file showed that recruitment checks took place in respect of them being safe to work with people alone. The checks included application form, reasons for leaving previous jobs, identity documents, and a DBS disclosure. However, whilst written references were applied for, this did not start until the staff member's first day of providing care to people. The office manager informed us, after our visit, that a reference from the staff member's most recent care employer had now been received. This was over two months after the staff member's first working day.

Additionally, the staff member's DBS pre-dated their employment by almost a year, when the DBS guidance states a three-month maximum length of portability. The service's DBS policy had been updated since our last inspection. However, it did not stipulate how old a new staff member's DBS check could be for it to still be acceptable.

As some of the above recruitment and medicines concerns were identified at our previous inspection but repeated at this inspection, effective governance was not demonstrated.

The evidence above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and staff told us they thought there were enough staff working to meet the needs of people using the service. One person told us that staffing levels were "slightly higher than recommended levels." Relatives' comments included, "There's more than enough staff." Our observations confirmed this, as there was usually a staff member interacting with people in communal areas and staff available to check up on people in their rooms. The numbers of staff on shift during the inspection matched those on the staff rota. This supported staff to meet people's needs in a safe and unhurried way.

The service was using occasional agency staff. We saw one such staff member working during our visits, with no obvious detrimental impact on people using the service. Staff and the management team praised that particular agency staff member's abilities.

The service had policies and procedures for protecting people from abuse and harm which staff had signed to show they had read them. Records showed that new staff learnt about safeguarding and whistle-blowing in their induction process, and that established staff had received further safeguarding training. Staff could give us examples of what could be seen as abuse, and were aware of responsibilities to raise a safeguarding alert with a member of the management team. The management team told us of making recent safeguarding referrals for unexplained injuries to people.

We saw that the premises were clean throughout our visit. We heard people being encouraged to wash their hands before meals, and saw risk assessments relating to this. Care staff had responsibilities for maintaining these standards. We saw that staff had easy access to personal protective equipment, by which to help control infection risk when supporting people with personal care. We noted that the kitchen and food hygiene systems received a five-star rating from the Food Standards authority in the autumn of 2015.

There was equipment and fittings around the service to help maintain safety. This included handrails for the stairs, a passenger lift, restrictors to prevent windows opening too far, and covers for radiators so that people would not get scalded against them. There were locks to the inside of people's doors for privacy, but which could be overridden in case of emergency. People assessed as needing pressure care equipment had equipment in use.

There were individual risk assessments for people in respect of matters such as falls, pressure care management, and behaviours that challenged the service. These indicated what action was being taken to reduce identified risks. For example, where someone was at risk of falling, they were to be reminded to use both hands when walking with their frame, and to avoid carrying additional items with them. Care plans reminded staff of the support to provide, such as to check on water temperatures before helping people to shower. The risks were kept under review and updated when people's needs changed.

We saw a recent written review of environmental risks in the premises. The service had a protocol for dealing with emergency situations such as flooding or significant injury to people using the service. We checked that there was an accessible emergency first-aid kit that contained in-date items.

Good

Is the service effective?

Our findings

People's relatives told us the service was effective and that they recommended it to friends and family. One relative told us, "I'd give it 101 out of 100." Another said, "When other friends or family visit they all say how lucky we were to find this place." A person using the service told us that the service was "extremely good" and that "it got me back on my feet." A staff member told us that one person had "come out of her shell" since moving into the service, as they joined in more and more with what was going on. This all helped demonstrate the effectiveness of the service.

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).

At our last inspection of the service in March 2016, people using the service were not consistently receiving effective care. This was because the service had not embedded the principles of the MCA into its practice. Whilst some people were being deprived of their liberty for their protection, applications to undertake this lawfully had not been made. The provider sent us an action plan to address these concerns.

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 that the management team had applied for the formal deprivation of liberty of some people using the service on the basis of them needing more care and supervision than the individuals appreciated. The office manager told us that these had been granted by the 'supervisory body' and that having read them, no conditions were attached. We saw that people's care files now included information on who had legal rights such as Power of Attorney status in relation to them, and that care plans reminded staff to gain consent for care delivery.

The office manager said that the local authority had provided staff with further training on the MCA since our last inspection. Staff told us of respecting people's right to refuse care but trying to balance this with care duties. For example, where one person was recognised as tending to refuse personal care, different strategies were used to encourage them to accept sufficient support. A relative told us that their family member "is never forced to do anything she doesn't want to." This all assured us of appropriate care in line with MCA principles.

We received professional feedback that the service had supported one person to be more settled despite their behaviours which caused challenges. A staff member confirmed the approach to this person, explaining that staff consistency was important, but that different staff supported the person where needed so as to uphold their duty of care. One person told us about a scenario with another person that impacted on them, but clarified that staff dealt with it well. We saw this to be the case, as the staff member reassured

the person without attracting attention to their behaviour. This helped to demonstrate effective care and support.

People were supported to eat and drink well. They told us they enjoyed the meals provided. Comments included, "It's all good food" and "The food is so good." Relatives told us about "excellent food", that "all the food is freshly made, home-baked biscuits, bread etc." and "From day one my relative's eating and drinking has improved." We also overheard people praising the lunch of roast dinner with seasonal vegetables. It was well presented, nutritious and hot. Starters and a dessert were also routinely provided.

People's specific preferences and needs around diet were addressed. The cook could tell us of people's specific dietary needs. Whilst one home-cooked main meal was served at each sitting, adjustments were individually made. There was also recognition of when people preferred to eat. People's care plans were specific to their nutritional needs and preferences, for example, on what they liked to eat, how much they typically ate, and where they liked to sit for meals. One relative confirmed that what was written in the care plan was accurate. We saw that people were supported to eat their meals where needed. This included checking on the few people who did not want to leave their rooms for the meal and sitting with someone in a friendly but encouraging manner.

The service supported people with their health needs. This was confirmed by two healthcare professionals we liaised with, who added that the service followed their advice. One person told us how the service had helped them regain health, adding, "They believe in looking after people." People's relatives were also positive about support with health matters. For example, one relative told us, "My relative's physical health has improved due to great nutrition and hydration and being kept mobile." The registered manager told us of one person where medicines had been reduced, which relatives were happy about. A staff member told us of concerns with someone's health, which resulted in healthcare professionals visiting and closer monitoring of the person, both of which we saw during our visits.

There was ongoing training for staff. Alongside the recent completion of the national Care Certificate, staff told us of receiving further training on some role-specific topics such as shift-leading and person-centred care. One staff member felt this was helping staff to interact more with people, "to help them feel good." They cited dancing with some people at the service, which we saw other staff doing. As such the training was having a positive impact on people's welfare.

Records informed us that further training on dementia was planned. A new staff member had completed an eight-standard induction booklet alongside showing evidence of previous care experience and qualifications.

Records also showed that most of the staff had certificates of completing national training courses in care such as NVQs, including some at advanced levels, which staff confirmed to us. Staff were therefore able to demonstrate care knowledge, for example, on person-centred care.

Staff reported occasional supervision sessions and team meetings, but that formal supervision sessions were about to take place now with the newly-hired management consultant. They all reported sufficient support to do their work.

Good

Is the service caring?

Our findings

Our last inspection of this service found it to be caring. This continued to be the case. People's comments included, "Lovely staff", "No problems at all" and "It's very pleasant here." A relative said, "There's a lot of affection, you feel they really care." Another stated, "The genuine personal care my relative is receiving and the support given to my family have allowed my relative to have the quality of life that one can truly hope for as one's memories disappear." The management team told us that visitors were welcome at any time with the agreement of the person using the service.

We heard staff talking politely and encouragingly with people. For example, "Would you like to come with me to wash your hands?" and "That's lovely" in response to being shown a jigsaw nearing completion. Staff were friendly in their approach, and used appropriate touch to reassure and communicate. Staff communicated at people's head-height, sitting down with them wherever possible. We also saw a staff member spontaneously dancing which brought a smile to the face of someone whose communications challenged the service. This all enabled positive and trusting relationships to develop.

Attention was paid to supporting people with their appearance, such as through a few people being encouraged to wear cloth aprons for lunch so as to protect their clothing. A hairdresser visited during the morning, and so we heard people being complemented on their hair at lunch. We also overheard staff knocking on people's doors before entering. People were treated respectfully.

People's independence was valued. We saw people being encouraged to do what they could at mealtimes, but being given enough help where needed. Two staff members told us that the service had supported one person to regain confidence with walking when using mobility equipment. The person's care records confirmed the gradual improvement.

A relative told us that staff understood their family member, someone living with dementia. Another said that despite the dementia, "They always ask my relative's opinion," which was good practice.

Staff demonstrated concern with finding the best outcomes for people they cared for. For example, one person's behaviour had recently started challenging the service. A staff member told us about actions that had been taken to help the person, and that feedback to help with this was provided to the management team verbally and in writing.

Some staff had been working at the service for many years, and so were well-known to some people using the service. People's care files included a summary of their life histories including what was important to them. This helped staff to connect to the person and potentially understand their behaviours.

We noted that the environment was homely and welcoming, something which staff, relatives and people using the service commented positively on. One relative told us, "We feel like family"; another that there was a "very home-like atmosphere." Communal areas had many pictures and items of interest. Most people's rooms were similarly furnished and reflected them as individuals. We were shown the extensive out-house

that had been recently built at the end of the garden. Staff and the management team told us that it had been used for morning coffee for people using the service, that a Jazz band had recently played there, and that it was also used for staff training purposes.

The service adhered to Christian beliefs and had strong connections with a local church. One person told us of appreciating the community that this created, for example, through a few additional visitors for lunch on some days. The office manager told us that a few people were supported to attend a local church service on Sundays, and that a monthly ceremony took place at this premises. People's religious support needs and preferences were clearly documented within their care files.
One staff member told us that the service invited people to the care home for activities such as Bible studies, in line with the ethos of the service. A complement card from a relative praised that Bible sessions took place which their family member appreciated. The service was helping people to retain a community presence regardless of individuals' increasing needs.

The management team told us about considering ways in which people and their relatives could be more enabled to express their views and make decisions about the care provided. There had not been much interest in holding individual review meetings, so instead a summer gathering was staged using the service's outhouse at which informal feedback from people's relatives was sought. This had been more effective at eliciting people's views, and so a similar event was being planned for the festive season. Relatives confirmed that their views were sought and that they were kept promptly informed, for example, about health concerns.

Good

Is the service responsive?

Our findings

At our last inspection in March 2016, people using the service were not always receiving responsive care. This was because people's care plans did not consistently address all their support needs and sometimes contained contradictory information. The provider sent us an action plan to address these concerns.

At this inspection, we found there to be ongoing work in respect of ensuring care plans were comprehensive. Most people's care plans had been recently updated based on an extensive needs assessment review. The plans gave staff clear guidance for supporting the person with identified needs, such as for mobility, encouraging independence, addressing health matters, and what their typical routines during the day and night were. The plans reflected people's individual needs and preferences, for example, how the person usually liked to dress, and what their bedtime routines were. There were also reviews every few months of how the person had progressed.

The registered manager told us that one of the newly-hired management consultant's roles was to ensure that the care planning and delivery process was embedded as a means of continuously reviewing and improving on individual care delivery. We noticed that care plans did not always capture all relevant needs comprehensively and provide current guidance, for example, by clearly documenting all recent healthcare professional input. However, we were now confident that this process would be completed with the ongoing work of the consultant.

A person using the service confirmed that their needs and preferences were understood and acted on. Staff demonstrated good knowledge of the individual routines of the people they supported, which we saw were clearly documented within people's care plans. For example, we were told of staff gender being important to one person. Relatives felt the service was meeting needs, for example, "The care home knows my relative's needs better than me" and hence "I feel Grace House goes above and beyond to respond to my family's requests for her care."

Relatives praised the activities, one telling us that their family member was becoming gradually more involved. One person told us about helping the provider to maintain their website. The registered manager told us of further work undertaken to develop more engagement with people using the service. Staff also told us of activities such as dominoes, jigsaws and board games. This was linked to both the keenness of some newer people using the service that was having a knock-on effect on other people, plus recent training on person-centred care. We saw activities taking place that involved a number of people, which provided a better sense of involvement opportunities than at the previous inspection. The service also had a small dog and fish, both of which provided some people with comforting interactions.

One person told us that people moving into the service was based on "word of mouth recommendations." They felt that the service was responsive to their needs and preferences, citing for example that they could phone downstairs for a cup of coffee that was both quickly provided and exactly how they liked it. Relatives also told us how responsive the service was, for example, "The staff all are approachable and respond promptly to any requests I make for my relative." A staff member told us of reporting things people wanted,

and that the management team "do it" as requested. For example, if someone's hearing aid battery was flat, it was quickly resolved.

In respect of concerns and complaints, one person said, "If anything needs doing, they will attempt to do it" and that people were not "shown the door." A relative told us, "If there has been any issues, hard to think of any, they were dealt with." One relative explained a minor concern that was addressed, adding, "The actions taken gave me confidence that Grace House listens and responds to the family's requests and preferences." The registered manager told us there were no complaints about the service since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service in March 2016, we found that the service was not well-led. This was because there were few governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed. The provider had not kept us notified when significant events occurred at the service, contrary to legislation, which prevented us from monitoring the service effectively. Care and management records were not consistently up-to-date and complete. This undermined appropriate care practices and meant information could not always be easily accessed.

We imposed a condition on the provider's registration requiring them to send us monthly reports about auditing risk assessments of people using the service, medicines administration, and staff recruitment checks. This included any actions being taken to address any risks identified in those audits. The provider submitted these monthly. The reports indicated that progress was being made at addressing our previous concerns.

By the time of this inspection, we had been notified of significant events occurring at the service.

The registered manager told us of hiring a management consultant for the last couple of months to assist with implementing service improvements. This person told us that their role included staff training sessions, organised two days a week so as to enable all staff to attend. It was also to enable the implementation of training so as to ensure its effectiveness. They helped ensure that handovers between staff leaving and arriving covered relevant information relating to everyone using the service and any other key information. We saw this to take place. The consultant observed care and staff practice, and provided feedback to staff around what was working and how better practice could be implemented. The consultant told us there was ongoing work to embed better practice and more effective team working. We saw, for example, that more formalised staff supervisions meetings were about to begin. Whilst it was of concern that formal staff supervisions had not been re-established since our last inspection, we saw the consultant's input as progress addressing our concerns.

We found that whilst there were improvements with the auditing at the service, processes were not consistently effective. Records showed that the registered manager was conducting a monthly medicines audit. However, we found that these were not consistently accurate. Whilst the audit for October identified a reason for gaps on one day in someone's medicines administration record (MAR), it did not identify a gap on two other days that we subsequently found, or gaps in another person's MAR. The audit was also ineffective as specific issues were identified but without a statement of actions being taken to minimise the risk of reoccurrence. This did not meet part of the condition we imposed on the provider after our last inspection.

The registered manager told us that no medicines incidents had occurred. However, there was no system for reporting incidents and sharing learning from highlighted issues. There was no system to deal with medicines alerts.

We saw a recent external pharmacist's audit report that identified some action for improvement but which

did not highlight serious concerns. However, the office manager could not find any records of a health and safety audit of the service when asked for.

There was one new staff member since our last inspection. Our checks of their recruitment file found no references in place, and a recruitment audit form that had not ticked off that references had been acquired. The office manager showed us that the reference from a recent care employer had been obtained but recognised that the second reference request had not been responded to. The audit form for this staff member's recruitment had not therefore been effectively completed so as to ensure all appropriate checks had been undertaken. This new staff member was referred to on the two most recent monthly audits sent to us. However, these both stated that both references were in place for them. These inaccuracies demonstrated that those audits were not undertaken effectively.

The monthly audits considered the health and welfare of eight people using the service but not the most recent person to move in. This person was using the service from at least August 2016, but the October and November audits did not monitor their welfare. Whilst the November audit correctly considered changes in weight of most people, it incorrectly recorded one person as having stable weight at 74.03kg. Their entry on the service's weight monitoring chart recorded them as refusing to be weighed in November, and so their last weight on that chart was from August at 74.3kg. It was not therefore accurate to conclude that their weight was stable.

We also noted that some concerns that we had previously identified did not get addressed until we visited. A new medicines cabinet was in place on our first day of visiting, and we noted that it was not lockable although we were told a lock was available for fitting. On our second day of visiting, the lock was not fitted until later in the day. A number of medicines concerns were repeated at this inspection despite the concerns being stated in our last inspection report. This included a lack of documenting what medicines the service had taken responsibility for when delivered from the pharmacist, and no individualised guidance for people's as-needed medicines. However, we noted that the registered manager had documented the feedback that we provided on our first visit, and was able to discuss it with us, indicating recognition of some further action being needed.

The evidence above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives fed back positively on the management of the service. Comments included, "The service is extremely well-led and managed." One relative told us that the registered manager was very "astute", and hence staff were changed where needed, which another visitor confirmed.

One person told us, "Their main concern is keeping people (using the service) happy." Feedback we received and the most recent written compliments in the service's compliments folder provided good evidence that the service was achieving this aim.

The registered manager showed us that surveys of the views of people using the service, relatives, and some staff were recently received. There was no analysis on the findings of these, but they provided mainly positive feedback about the service.

Staff told us they were pleased that people using the service were happy and that they could help meet needs. One staff member said that a strength of the service was that it was for a small number of people, which allowed more individualised care and support to be provided. Staff gave examples of how people who had recently moved in were now healthier and more confident. They found recent training positive as it

was helping them to understand the legal basis for various aspects of their care work. They all said they would recommend the service to friends and family needing care.

Staff told us that the registered manager and office manager were approachable and helped to address any concerns they or people using the service had. One staff member told us of having weekly conversations with the office manager that reviewed the services provided to the person they worked with. Another spoke of team meetings taking place regularly.

There was a new system of recording care delivery records electronically. On our last day of visiting, we found that accurate records had been made of the care provided to people that we saw at our previous visit. There were detailed records of care where people's behaviour was challenging the service, which helped to inform subsequent service delivery. The records also indicated that people were provided with regular support for showering, which improved on records from the last inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care of service users was not provided in a consistently safe way. This included failure to assess the risks to the health and safety of service users of receiving care and do all that was reasonably practicable to mitigate any such risks. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to assess, monitor and improve the quality and safety of the services provided, and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. Regulation 17(1)(2)(a)(b)