Gracewell Healthcare Limited

Gracewell of Chingford

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

There are two registered providers for this service who are registered separately with the Care Quality Commission (Gracewell Healthcare Limited and Bayfield Court Operations Limited). The service is known both as Gracewell of Chingford and Bayfield Court and this report can be found under each location name. This service is a residential care home which provides personal care for up 46 older people some of whom may be living with dementia. The home is spread out over three floors. At the time of this inspection there were 44 people using the service.

The manager in post at the time of our inspection was in the process of applying to become registered with the Care Quality Commission. 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.

Staff knew how to report concerns or abuse. There were enough staff on duty to meet people's needs who were employed through safe recruitment processes. Risk assessments were carried out and management plans put in place to enable people to receive safe care. There were effective and up to date systems to check and maintain the safety of the premises. Medicines were administered and managed safely.

Staff received support through supervisions and training opportunities. Appropriate applications for Deprivation of Liberty Safeguards had been applied for and authorised. Staff obtained consent when carrying out care tasks. People were offered a varied and nutritious food menu and staff were knowledgeable about their dietary requirements. Healthcare professionals gave positive feedback about their joint working with the service. Records showed people had access to healthcare professionals as required to meet their day-to-day health needs.

People thought staff were caring and staff knew how to build positive relationships with people who used the service. Each person had a named carer who oversaw the care they received. Staff ensured people's privacy and dignity was respected and their level of independence was maintained. There was a calm and happy atmosphere throughout the home.

Care plans were written in a personalised way. Staff knew the people they were supporting including their preferences which helped ensure a personalised service was provided. A variety of activities were offered including visiting entertainers, a bistro service onsite and trips out to events in the community. The service dealt with complaints in accordance with their policy and timescales.

The provider was trying out holding separate meetings for people who used the service and for relatives but was considering returning to the previous system of holding them jointly. People and their representatives were given the opportunity to complete feedback surveys. The provider had quality assurance systems in place to identify areas for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and their relatives told us they felt safe. Relevant recruitment checks were done before employing staff and criminal record checks were up to date. There were enough staff on duty to meet people's needs.

Staff were knowledgeable about raising safeguarding concerns and whistleblowing. People had risk assessments in place to ensure risks were minimised and managed. The provider had carried out the necessary building safety checks to ensure people, staff and visitors were safe on the premises.

Medicines including controlled drugs were stored and administered correctly. Record keeping about the administration of medicines was completed correctly and was up to date.

Is the service effective?

Good

The service was effective because staff received support through regular training opportunities and supervisions to enable them to give care effectively.

The provider was knowledgeable about what was required of them to work within the legal framework of the Mental Capacity Act (2005) and staff were knowledgeable about when they needed to obtain consent from people.

People were offered a nutritious choice of food and drink. Staff were knowledgeable about people's dietary requirements. People had access to support from healthcare professionals as required and healthcare professionals gave positive feedback about joint working with the service.

Is the service caring?

Good

The service was caring. People told us staff were caring. Staff knew how to develop positive relationships with people using the service and were knowledgeable about their different needs.

Each person had a named carer who oversaw their care and was

their point of contact within the service.

Staff were knowledgeable about promoting people's privacy and dignity and about encouraging people to maintain their level of independence.

Is the service responsive?

Good

The service was responsive. Staff were knowledgeable about people's individual needs and preferences and about giving personalised care.

People's care plans were detailed, personalised and were regularly reviewed. People's rooms were personalised with pictures of their choice and family photographs.

There were a variety of activities on offer for people including visiting entertainers and trips into the community. The service had an onsite 'bistro' bar which served a variety of hot and cold drinks including alcoholic beverages to people who used the service and their visitors.

People and their representatives knew how to make a complaint and complaints were dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well led. There was a manager in post who was in the process of applying to become registered with the Care Quality Commission.

People who used the service and their relatives had regular meetings to enable them to raise issues of concern and to keep them updated on changes. The provider was trying out separate meetings for people who used the service and their relatives to see if this would be more effective.

Regular meetings were held with staff to keep them updated on service development and for the home manager to be updated on everybody's well-being.

The provider had a system to obtain feedback from people who used the service and relatives visiting the service. There were various systems in place to carry out quality checks of the service which were done by the manager and the provider.

Gracewell of Chingford

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 6, 13, 19 and 20 October 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. One inspector visited on the other inspection days.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the evidence we already held about the service. This included the last inspection report and notifications the provider had sent us.

During the inspection, we spoke with twelve staff including the interim manager, the new manager, two deputy managers, the administrator, the cook, the maintenance person, four care staff and a staff member who worked as a beautician and carer. We also spoke to eleven people who used the service, five visitors, a visiting optician and a visiting district nurse. We observed care and support in communal areas and 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 to us. We reviewed four care records, five staff files and records relating to the management of the service including menus, medicines, staff training, complaints and policies.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person said, "I've been here a long time and yes I feel secure. I'd do a runner if I didn't feel safe and content." A relative told us, "Here [relative] is safe and is well looked after."

The service had a recruitment and selection policy. We saw there was a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, we found staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. We saw that staff had criminal record checks carried out to confirm they were suitable to work with people and these were up to date. Staff were also required to complete a health questionnaire to check they were fit to carry out their role.

People who used the service told us they felt there were enough staff to meet their needs. We discussed the staff ratios with the interim manager and checked the staff rotas. We saw there were enough staff on each floor to meet people's needs and nobody had to wait long for assistance. The interim manager told us that regular agency staff had been used recently to cover staff vacancies but that the provider preferred not to use agency staff where possible. Staff rotas confirmed the same agency staff members were used and the interim manager told us they tried to use permanent staff to cover unexpected staff absences. The provider also employed two activities co-ordinators, a beautician, a hospitality manager who worked in the bistro room, a maintenance person, kitchen staff and administration staff to enable care staff to devote their time to carrying out daily care tasks. Some care staff told us they would benefit from having one extra carer on duty to assist with carrying out care tasks. We saw this issue had been raised at a recent staff meeting on 5 October 2016 and it was agreed a twilight shift would be introduced to help during the busy morning and evening times. We also observed the beautician helped care staff when short staffed.

Staff were knowledgeable about how to recognise and report concerns of abuse and about whistleblowing. Comments included, "If you see someone abusing a resident, you need to tell someone higher or CQC", "I would go straight to the manager or if it was the manager [abusing], I would go to the [director], CQC, head office or phone the internal support line", "When something happens, you have to tell the manager, go higher up to the director, safeguarding, the police or to you [CQC]" and "Report somebody that's doing something they shouldn't be doing to management or CQC."

People had detailed risk assessments as part of their care plans regarding their care and support needs. Risk assessments included clear actions for staff to mitigate the risks. For example, one person had a risk assessment for falls which included a falls prevention action plan and indicated the person had the involvement of the falls clinic. The action plan included using a sensor mat in the bedroom so that staff could be alerted if the person was moving around or had fallen. Records showed risk assessments were reviewed every month or sooner if needs changed or an accident occurred.

We saw building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, a gas safety check was carried out on 19 February 2016, lifting equipment

was serviced on 9 September 2016 and call bells were checked on 8 October 2016. The service had a book which staff used to report repairs needed which the maintenance person signed when the job was completed. The maintenance person had a list of regular checks they carried out, for example, monthly checks of all rooms which included checking the heating, electrics and décor.

We checked the medicine administration for people using the service on all floors. Appropriate arrangements were in place for recording the administration of medicines. Records showed that one person was being given their night time medicines at teatime. We raised this with the manager who explained this person had capacity and chose to go to bed early. The manager acknowledged this could be confusing. During the inspection, the pharmacist was contacted and in consultation with the GP changed the medicine administration record (MAR) chart instructions and the blister pack cover to indicate the medicines should be given at teatime.

There were guidelines in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. However one person's guidelines were not detailed enough and said, 'Give for constipation'. We noted this person was also prescribed a daily laxative. During the inspection we saw this had been amended to tell staff how many days to wait before administering this medicine.

MAR charts were fully completed and any reasons for not giving people their medicines were recorded. Medicines were stored appropriately in locked trolleys which were kept in a treatment room. Controlled medicines were stored and signed for appropriately and correctly. The provider had a medicines policy which gave clear guidance to staff about the storage and administration of medicines including controlled drugs and monitoring people who self-administer their medicines.

Good

Is the service effective?

Our findings

People told us they thought staff had the skills necessary to provide them with effective care. One person told us, "Depends on the carer. One carer is very good, who encourages me to get up, has been with the home a year. New carers have to learn but seem very good. I am happy with them."

Training records showed that staff had regular opportunities for training. We saw that staff were required to complete core training such as dementia, manual handling, infection control and health and safety. Staff were also required to complete the Care Certificate which is training in an identified set of standards of care that care staff must receive before they begin working with people unsupervised. The training matrix showed that all care staff had completed the Care Certificate except for two members of staff who were in the process of completing it.

The service had a supervision policy which stated the minimum amount of supervisions employees should expect was four times a year. Supervision records showed these were up to date and topics discussed included training, sickness policy, care plans and housekeeping. The new manager told us they were spending time getting to know staff through supervisions and planned to start appraisals with the staff in January 2017 to plan their goals and what personal development they wished to achieve in the coming year.

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

People can only be deprived of their liberty to receive care and treatment 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. At the time of inspection, nineteen people had DoLS authorisations in place. These applications had been made because the individuals needed a level of supervision that may amount to their deprivation of liberty. For example, the provider used a key code lock to keep people safe. People who had DoLS in place were not given the key code and needed a staff member to be with them when they left the premises. The provider did not use bedrails and found alternative ways to keep people safe in bed. For example, one person had their bed set to the lowest level near to the ground and a mattress on the floor in case they rolled out of the bed.

Care files showed people had consented to their photographs being on their records and for sharing their information with other professionals involved in their care. When asked about obtaining consent, one staff member told us, "You ask consent for personal care or coming to the table and by asking them what they would prefer." Another staff member said, "When you are about to do [a care task], show them what you

want to do." A third staff member told us, "Ask them. The first thing I do when I go into someone in the morning is to ask if they want to get up and if they want a shower or a wash. If they can't answer my question, I will show them the choices and they can answer 'no' to what they don't want so I will try again with another thing." A fourth staff member said, "We ask them [before carrying out a task] and get the consent from them."

Staff told us people had choices of food and drink. One staff member told us, "Show people the food who cannot say. There are two choices on the menu on the table." Another staff member said, "We take two plates [of the food on offer] up to show them, so they can choose." A third staff member said, "If their choice isn't on the menu, we offer something else." This showed people who used the service had a choice around the food they consumed.

We spoke with the chef who showed us the four weekly menu offered to people who used the service. The menu consisted of a choice of cooked and continental breakfast including a choice of hot and cold cereals and fruit. There were two choices of hot food at lunch and dinner but people could choose other options and could have sandwiches instead. The kitchen was well stocked with nutritious food and drink. Each person who used the service had a card displayed in the kitchen with their dietary needs. The chef and staff were knowledgeable about meeting people's dietary needs and how to fortify food to increase calorie intake for people who were at risk of malnourishment. Fridge, freezer and food serving temperatures were recorded, up to date and within the accepted range.

People were weighed monthly to ensure weight loss or weight gain was monitored and those who were at risk of malnutrition had their weight checked on a weekly basis. Food and fluid charts were completed for people who used the service who were at risk of malnutrition or dehydration and these were up to date.

Staff confirmed that they supported people to healthcare appointments when family members could not go. For example, one staff member told us, "Sometimes a carer goes, sometimes family takes them." Staff also told us the service had a visiting chiropodist, dentist and optician. One visiting healthcare professional told us, "Staff are amazing, they're very helpful. I think this is the best one [care home] I visit." Another healthcare professional told us, "With commitment and communication, they are the best. We have a very good relationship with them."

One person who used the service told us they needed to go for regular hospital appointments and a named staff member accompanied them, "Just as well as I never remember what they say and my carer writes it all down about my treatment to be done back here. My [relative] and I are very satisfied with this."

Care records confirmed that people were able to access support from healthcare professionals when needed and referrals were made in a timely manner. For example, one care record showed the person had been referred to the district nurses.

Good

Is the service caring?

Our findings

People told us staff were caring. Comments included, "The staff are encouraged to care for us one to one so that we have a real ongoing relationship with them. We grow fond of each other, all of us, not just me", "The carers here understand [our] predicament and are very patient and caring, with so much gentleness", "I've had all the gentle and caring support that I need" and "I feel supported by the staff and my friends and nothing is too much trouble."

Staff demonstrated their knowledge about developing caring relationships with new people who began using the service. For example, one staff member told us, "If it's someone new, I go in and present myself to them. We will have been given information about them. I will talk to [person who used the service] and tell them about the other [people who used the service]." Another staff member said, "Try to make them feel welcome, get to know their likes and dislikes. Chat to them about their past and what they used to do as a living." A third staff member told us, "When they first come here, we do a life book about what they like and what they prefer, build trust, consistency and listen to them." This meant staff were knowledgeable about how to build up positive relationships with people.

The provider had a keyworker system in place where each person using the service had a named carer. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life.

There was a calm and happy atmosphere throughout the home, people who used the service were smiling and staff were seen chatting to people as they carried out their care tasks. During the inspection we saw that people were treated with respect and in a kind and caring way. People who used the service and staff chatted and laughed together. One staff member told us, "Sometimes it is very happy, like a birthday which we all celebrate together and other times not, when a [person who used the service] who we have all loved and respected dies."

The provider had a policy which gave clear guidance to staff about people's rights to choice, dignity and respect and staff were knowledgeable in this area. One staff member told us, "Close the door, draw the curtains and if they need help to go to the toilet, I come out to let them go on their own." Another staff member said, "Make sure the door is closed. Ask them if I'm allowed to give personal care. Make sure they are covered. Knocking on doors before going in." A third staff member told us, "Before I go in, I knock on the door. It's very important to ask them how they want everything. If they want to go to the toilet, when you know people you can leave them in privacy. If they might fall, I will close the door but leave a slight gap so I can see."

Staff were knowledgeable about assisting people to maintain their independence. One staff member said, "Let them do as much unassisted for as long as they can, while they can." Another staff member gave an example of, "I ask [person who used the service] if he wants help and give him the flannel to wash himself." A third staff member told us, "For a start we look at their care plan and we try to let them do what they possibly can. Try to promote them to do for themselves."

Good

Is the service responsive?

Our findings

Staff were knowledgeable about personalised care. For example, one staff member told us, "Care for one individual. They are all different and they all have different needs. Treat [people who used the service] how you would want to be treated." Another staff member told us, "When someone has their own personal routine, you support them the way they like it." This staff member gave an example of one person who used the service who preferred to use different soaps and sponges for different parts of their body. A third staff member told us, "Giving support one to one with [person who used the service]. For example, one [person who used the service] likes a teddy bear and feeds it but you would not give a teddy bear to everyone on the floor. For that [person] it works."

Care plans were detailed, personalised and included basic details about the person, personal histories and choices over care. Each person had an assessment of their needs before they began to use the service. Records included people's preferences of food and drink, how they wished to take their medicines and details on their communication needs. We saw evidence that care plans were reviewed every month or more frequently sooner if a person's needs changed and these were up to date.

People's rooms were personalised with pictures and family photographs. One person who used the service told us, "I have my paper and my TV Guide plus I like my room watching all the people go by [in the street] and their dogs." There was a wide choice of daily newspapers placed on a table in the reception area and people who used the service were seen sitting in this area reading one of the newspapers at various times throughout the inspection period.

People and their relatives confirmed there were various activities available. For example, one relative told us, "There is a lovely beautician, chair exercises and the Rotary Club put on a show about twice a month." The service employed a staff member who provided hairdressing and a nail salon service. This staff member also assisted with care if any of the floors were short staffed and received the same training as the rest of the staff team.

The activities timetable showed weekly activities included baking, gardening, a memory café, quiz morning, arts and crafts, flower arranging, bingo, charades, reminiscence and exercise sessions. There was a church service on Sundays and also a time slot for sherry time. Trips out were organised and the timetable showed trips planned for October included a local tea dance, dog racing at a local stadium and a pantomime. Outside entertainers visited the home two or three times each week including an organ player, pan music and reptiles.

During the inspection we saw one staff member reading out a quiz to a group of people who used the service. On one inspection day we saw a visiting entertainer playing music in one of the lounges. Staff encouraged people to sing and dance along to the music and the enjoyment that people had from this activity was evident from the laughter that came from the room. Several people who used the service chose to sit in the bistro room to have their lunch or with their visitors. This room was furnished as a café/bar where a wide range of hot or cold drinks and alcoholic beverages were served.

People who used the service and their relatives confirmed they were aware of how to raise concerns. Staff were knowledgeable about the complaints procedure. One staff member gave an example of how they handled a complaint and said, "You should always make a note of it and write it down and go to the manager." Another staff member told us they would, "Have them put it in writing and give it to the manager."

The provider had a clear complaints policy that explained the process that was followed if a concern was raised. We reviewed the complaints records and saw three complaints had been made in 2016. These complaints had been dealt with in accordance with the provider's policy and the outcome recorded including whether the complainant was happy with the resolution.

The provider also kept a record of compliments received. For example, an email from a relative stated, "I have to write to let you know how impressed I have been by the staff. The words 'Thank you' seem inadequate."

Good

Is the service well-led?

Our findings

The service had a manager who had recently joined the staff team and had applied to become registered with the Care Quality Commission. People who used the service told us they were aware of the recent management changes but did not elaborate on how they felt about this. Staff spoke highly about the interim manager. For example, one staff member told us,"[Interim manager is] always happy and you see the [people who used the service] love him." One staff member told us, "All the staff, we work so well together."

The provider held regular meetings with people who used the service and relatives. Records showed the most recent meeting for people who used the service was on 22 June 2016. This meeting was the first attempt at holding these meetings separate to meetings for families. Topics discussed included the recruitment of a new manager, quality of care, activities and hospital appointments for people who used the service. The interim manager explained that the meeting was not very effective because it was not well attended but they were going to try again to hold another meeting with people who used the service and if still ineffective they would return to combining with relatives meetings.

We reviewed the minutes of the most recent relatives meetings held on 30 July 2016. We saw topics included an update on the appointment of the new manager, health and safety and staffing. The interim manager and the new manager told us these meetings were normally held monthly but there had been a gap when waiting for the new manager to take up post. The new manager said they planned to hold their first meeting with relatives on 26 October 2016.

The provider carried out a feedback survey in July and August 2016 with families and people who used the service. At the time of the inspection, the analysis of this survey had not yet been given to the service. The initial analysis of this survey was sent to us following the inspection and showed there were thirteen respondents and they were happy with the service overall. Comments included, "The carers and seniors are excellent. They are patient, courteous and kind", "Very good and excellent care home. Very caring staff" and "I am impressed by the attitude of the staff and the support." We noted two respondents felt communication could be improved. The manager planned to share with the staff team the results of the full survey analysis when they received it and resolve any concerns that had been raised.

The provider had a system of meeting with staff every month. One staff member told us, "Yes, usually [staff meetings] on a Wednesday. I think it's really good. We talk about how things work and how we can make more changes." Records of these meetings were up to date and showed topics of discussion included hospitality, laundry, meal times, infection control and teamwork. Senior staff meetings were held every three months and the record of the most recent meeting held on 21 September 2016 showed discussions included medicine administration, completion of fluid charts, falls and health and safety. The manager told us they planned to introduce in the near future a weekly meeting with senior staff to discuss high risk areas such as falls, weight loss and pressure wounds.

The provider also held meetings every three months with all managers and following the inspection, sent us the record of the most recent meeting held on 23 September 2016. The record showed discussions were

held on the overview of operations, reducing the use of agency staff and Christmas preparations. The provider had a system of holding a conference call with managers every two weeks to provide support and share information.

Records showed the provider visited every two weeks and did a quality check every 2 months. For example, the report of the care and quality team support visit on 16 August 2016 showed checks were carried out on falls records and noted that people did not have an individual falls tracker and records did not evidence referral to external resources. The provider used a traffic light scoring system and these checks had been scored as amber because there were areas that needed improving. Targets with actions identified were set for the manager to resolve issues in time for the next quality check visit.

Records showed the manager held a "Daily Huddle" meeting each morning whereby they could be updated on the general care and wellbeing of people who used the service and the staffing arrangements on the day. We saw notes from these meetings also highlighted which staff member or person who used the service had a birthday on the day.

The provider had systems in place to check the quality of the service provided. Clinical governance team meetings were held monthly and records showed these were up to date. For example, records showed at the meeting held on 16 August 2016 topics discussed included pressure damage, infections, complaints, compliments and training. A health and Safety meeting was held every three months. Records of the most recent meeting held on 25 June 2016 showed topics discussed included action from regulatory authorities, an overview of accidents and incidents, risk assessments and training.

The manager carried out care and quality baseline audits which were based on a theme. Records showed these were done every two months and we reviewed the audits carried out in May, July and September 2016. The manager used the provider's traffic light scoring system and we saw the most recent check done on 29 September 2016 looked at care records and medicines management with each given a green score which meant there were no concerns.