Workington 2014 LTD

Gregory House

Inspection report

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Workington
Cumbria
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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

This was an unannounced inspection on 10 March 2016.

Gregory House is a modern, purpose built nursing home specialising in the care of people living with a learning disability or a mental health problem. Accommodation is in single, ensuite rooms. The home can take up to 24 people in four units of six bedrooms. Each unit has a small kitchen and lounge and dining areas. There are some shared areas that can be used for activities and meetings. There is suitable outside space in the secure garden. The home is situated in a residential area of Workington and is near to local shops and good transport links.

The home has 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 2008 and associated Regulations about how the service is run.

People in the service were protected from harm and abuse because suitable arrangements were in place to safeguard them.

The premises and the working practices in the home ensured that people in the home and the staff team were as safe as possible at all times.

Accidents and incidents were carefully monitored and risk management plans were in place.

The home was staffed with a mix of experienced and suitably qualified staff who could meet the needs of people in the home. Staffing levels were suitable for the needs of people in the home.

Staff were recruited appropriately. The service had policies and procedures related to disciplinary and grievance matters.

Medicines were well managed in the service. Individuals had regular medicines' reviews and the nursing staff monitored any side-effects of medicines.

The house was clean and orderly with good infection control measures in place.

Staff in the service were suitably trained. Staff received training in basic skills and in the specialist skills used in the home. Nurse training was on-going.

Supervision, both formal and ad hoc, had commenced. Staff competence was being checked on and appraisals planned.

The staff team had a good knowledge and understanding of relevant legislation. Where staff felt concerned about necessary restrictions they applied for a Deprivation of Liberty authority.

All staff in the home were trained in the management of behaviours that might challenge. Restraint was only used as a last resort but the staff team had received suitable training to do this.

People in the service were happy with the meals provided and some people enjoyed preparing meals for themselves.

Gregory House was a purpose-built home that had been open for less than a year. The design of the building allowed people to be safe in a homely setting.

We observed staff approach, we looked at training and we asked people about how staff treated them. We judged that this team had a caring, non-judgemental approach to care delivery that paid good attention to matters of equality and diversity.

People were encouraged to be as independent as possible because the long-term aim was to move people to more independent living.

Care files contained detailed risk assessments, person centred care plans, contingency plans and recovery plans. These were of a good standard and people told us that they had been involved in drawing these up.

People were encouraged to engage in activities both inside and out of the home. Plans were in place to support people back into education or to become more involved in the local community.

The service had suitable policies and procedures in place to deal with any concerns or complaints. There had been no concerns and no formal complaints made since the service opened.

We saw evidence to show that both admission and discharge were planned in a suitable way so that transition between services was managed well.

The home had a suitably qualified and experienced manager who was registered with the Care Quality Commission. He had developed had an open and transparent culture in the service.

A quality monitoring system was in place and we saw evidence to show that this was being used on a daily basis. We saw that detailed records were in place.

The service worked closely with other professionals to ensure people received the best possible treatment.

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 in the service said they felt safe and supported.

Risk assessments and risk management plans were in place.

Staffing levels met the assessed needs of people in the service.

Is the service effective?

Good

The service was effective.

The staff team had been suitably inducted and trained into their roles.

The service managed the issues of restraint, consent and deprivation of liberty appropriately.

The building was designed and adapted to support the needs of people in the service.

Is the service caring?

Good

The service was caring.

We observed appropriate care delivery from staff.

Staff understood the issues of equality and diversity and care delivery reflected this.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Assessment and care planning was of a high standard.

People were being encouraged to engage in activities and education where appropriate.

The service had suitable arrangements in place to manage concerns and complaints.

Is the service well-led?

Good

The service was well-led.

The home had a suitably qualified and experienced manager who was registered with the Care Quality Commission.

The home had a quality monitoring system in place.

Recording systems were effective and easily accessed.

Gregory 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 10 March 2016 and was unannounced. This was the first inspection of this service since it was registered in April 2015.

The inspection was conducted by an adult social care inspector and a specialist advisor. The specialist advisor was a trained mental health nurse with experience of caring for people living with mental health needs and people living with learning disabilities.

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. This was completed in detail and gave us a good understanding of the service.

We met all of the eleven people who were in residence on the day of our visit. We observed how staff interacted with people and we spoke to four people. We read seven care files which included risk assessments and care plans.

We met with seven members of the care and nursing staff team, the psychologist and the psychology assistant, the cook, one of the housekeeping staff and the maintenance person, the registered manager and one of the directors of the company. We looked at six staff files. These included recruitment and induction information. We also saw a matrix of training received and a training plan. We looked at four weeks of rostered hours.

We looked at quality monitoring documents. These included checks on care and nursing support, staff training and development and maintenance of the property. We looked at food safety and menu planning documents in the kitchen. We saw the fire log book. We also checked on money managed on behalf of people in the home.

Good

Is the service safe?

Our findings

We spoke to a number of people about how safe they felt and we also observed people's body language. People told us that they did feel safe. One person said, "I like it here as I have my own room and can lock my door." Another person said, "the staff treat us properly… There is nothing bad going on here!" People also told us that they judged that there was enough staff on duty at any time to "make sure everything is okay in the house."

When we looked at training records we saw that staff had been trained in safeguarding vulnerable adults. We spoke to different members of the team and they were able to tell us how they would deal with any concerns. Nursing staff told us that the understood how to make a safeguarding referral. We had evidence to show that safeguarding matters had been dealt with appropriately by the registered manager and the team.

We walked around the building and we saw evidence to show that risks had been assessed and that the building was as safe as possible. For example smoking was only allowed outside and there were special devices outside for lighting cigarettes. This reduced the risk of fire in the building. Staff monitored the use of potentially dangerous items and ensured that these were locked away if people were at risk of abusing these. All staff and visitors in the home were asked to wear alarms so that they could call for assistance at any time.

The service had an emergency plan in place. Maintenance and monitoring of the building was being done on a regular basis. Accidents and incidents were monitored and staff debriefed after any unusual events. The team completed 'lessons learnt 'reviews of any incidents.

We looked at the last four weeks of rosters for the service. We saw that staff were deployed appropriately so that each of the three units was suitably staffed with nurses and support workers. We judged that the staff ratios gave people good levels of care and support.

We looked at the skills mix in the service. We saw that there was a team of nurses with different backgrounds and skills. Most of the nurses were Registered Learning Disability Nurses but there were also some specialist nurses and a nurse with a general training. Support workers came from a range of backgrounds with some staff having experience of working with vulnerable people and other team members with life experience and aptitude. We judged that there was a good mix in the staff team.

The service had recruited staff appropriately with all checks and references completed before any new team member had access to vulnerable adults. We checked a number of files for nurses and support workers. All of the recruitment we checked on had been done appropriately. The registered manager was continuing to recruit more staff as part of the planning for increasing the numbers of people in the home.

The organisation had suitable policies and procedures in place to ensure that any issues of a disciplinary or grievance nature could be dealt with appropriately. We discussed this with the registered manager, one of the directors of the company and the deputy manager. There have been no issues of this nature since the

service opened but we had enough evidence to show that these would be dealt with appropriately if necessary.

The specialist adviser and the inspector checked on medicines management. Medicines were stored securely, disposed of appropriately and records were up-to-date. People were assessed on admission and staff supported them appropriately. Medicines were reviewed by consultants or by one of the local GP's. Staff displayed a good knowledge and understanding of the effects of medicines.

We observed staff working in the units and in the general areas of the home. We saw that they followed good housekeeping practice and that attention was paid to infection control. The home had appropriate equipment and cleaning materials to ensure that infection control was managed correctly. Staff said they had ready access to personal protective equipment and were aware, through training, of how these should be used in the event of any instances of infectious illnesses.

Good

Is the service effective?

Our findings

People who lived in the home told us that they, "Really like this house… It is very nice and I have a really lovely bedroom. It isn't like any other home or hospital I've ever been in." People also told us that they felt confident in the staff team. One person said, "The nursing staff are trained mental health nurses and they know about my illness. The carers get training from them and from the manager so that they can understand too." We observed people at lunchtime and during the day. People told us the food was, "Very nice… Really good." One person said, "I'm really interested in eating well and the staff support me to get the kind of food I want."

We looked at supervision notes and staff meeting minutes. We spoke with nurses and support workers and we learned that in-house training, mentoring and development were underway with everyone in the team. We spoke with a member of the housekeeping team, the cook and the maintenance person and we learned that they had received this training. The registered manager said that he considered that it was important for the safety and well-being of people in the home and the staff that this was done for every person. Every member of the staff team had already received formal supervision and had been monitored in their practice. Appraisal was being planned so that by the end of the first year of operation most of the staff team would have received their first appraisal. All staff at different levels and with different roles were inducted into the service. Induction covered basic skills and also gave staff an understanding of the needs of the people who lived in the house.

The specialist adviser spoke with nurses and she felt confident that nurses were able to maintain their continuous professional development in the service. Nurses were given time to study, to maintain their portfolios and to keep abreast of current good practice. We spoke with one nurse who had a general nursing background and they explained to us the training they had received to supplement this. This member of the team also explained that they would keep their practical skills up-to-date and would be able to take the lead on clinical practice of this kind if necessary.

We had evidence from talking with staff and from looking at records of training completed to show that the staff team had received good levels of training. There had been four full days of training for all new staff before any person had been admitted to the home. This induction training covered practical issues like moving and handling people, safeguarding, health and safety and a basic understanding of mental health and learning disability. We judged that a good system of staff development was already in place and was being actively worked on. We saw the promise of good staff development in the service.

The registered manager and his staff team were fully aware of their responsibilities under the Mental Health Act and under the Mental Capacity Act. Deprivation of Liberty authorities had been granted for some people in the service. Other people had their liberty restricted because they were cared for in the service under specific restrictions related to the Mental Health Act. The specialist adviser looked at all of these arrangements and judged that these were in order and that the registered manager was working within the legislation.

Some people who lived in the service had difficulties managing their emotions and behaviours due to their learning disability or their mental health needs. There were times that staff had to intervene without the person's consent. Good, detailed guidance was written into individual plans when this was necessary. All staff had been trained in the management of behaviours that challenge. Staff told us that they only used restraint as a last resort and deployed specific, individual strategies to manage any behaviours that might challenge. We saw evidence to show that people were supported through different techniques and that restraint, when used, was done in the least restrictive way. Any incidents of behaviours that challenge were analysed after the event. Staff in the team were debriefed and any lessons learned from the incident were translated into new care plan guidance.

The staff team told us that some of the people who use the service had difficulty with eating and drinking and maintaining a normal body weight. We noted that nursing staff were competent in nutritional assessment and planning. We spoke with the cook who had only been in post for a number of weeks. She had a good practical understanding of nutritional planning, special diets and the techniques to fortify foods. She was planning to introduce different foods because one person had requested these. She also told us that one or two people worked with her in the kitchen to prepare meals as this was part of their person centred plan.

We checked on the stores in the kitchen and saw that there was a good range of fresh foods available. Lunch on the day of our inspection was well presented and people ate well. The food stores in the unit kitchens allowed people to make breakfast, snacks and their own evening meal. Staff supported people in relation to their needs and abilities. People were encouraged to eat well. The nursing staff told us that they could call on the advice of dieticians if necessary.

The daily notes and care plans gave details of how people's mental health or learning disability needs were supported. People in the service were under the care of psychiatrists, community nurses and specialist social workers. Some people visited the local psychiatric unit so that their mental health could be monitored, other people received regular visits from community psychiatric nurses.

We also saw that people were supported and encouraged to visit other healthcare practitioners. Local GP surgeries had taken on people in the home as patients. The nurses in the home ensured that people had their medicines reviewed and that health prevention work was done with local healthcare practitioners. With permission people allowed nurses to complete checks on things like blood pressure. 'Well woman' and 'Well man' checks were encouraged. Staff were aware of the symptoms of ill-health and the side-effects of certain medication. These were monitored carefully. Healthy eating and smoking cessation were encouraged in the service.

Gregory House was specially designed to accommodate people who are living with mental health or learning disabilities. The environment was suitably adapted so that people who may be living with behaviours that challenge could be safe in the house. Some rooms were specially designed so that staff could access bedrooms if people were distressed and unable or unwilling to come out of the room. The garden areas could be sectioned off so that people would be secure outside. The building was designed around four group living units and these all had kitchens and lounge areas so that people could cook for themselves and spend time together if they wished. These adaptations were discreet and the house had a normal domestic appearance. We judged that the house had the right balance of security and homeliness.

Good

Is the service caring?

Our findings

One person wanted to talk to us at length about how caring the staff were. This person named a number of individuals on the staff team and also said, "They are all really nice… Good people and they try to understand me and my problems. I think they care about what they do and about us."

We also observed interactions and we saw that people in the service were treated with dignity and respect. Staff worked very carefully with people who might experience behaviours that challenge. Some people in the service needed very specific approaches and we observed these being carried through. We noted that staff were patient and explained things to people in a quiet, measured and considerate way.

We also looked at the written observations that staff made on each shift. These gave clear evidence and were written in a respectful way. Behavioural issues were recorded clearly without any detrimental or judgemental comments. Outcome judgements in relation to care delivery were made in a professional manner using relevant evidence and clinical judgements.

We observed a number of affectionate, yet professional, interactions. People were spoken to appropriately and due regard was given to individual opinions and needs. We observed care staff talking to people about decision making and we heard staff supporting and assisting people to make appropriate decisions.

Some people who lived in Gregory House had limits placed on their liberty because of their complex needs. We noted in care plans and daily records that this was done in the least restrictive way.

In each care plan that we looked at there was guidance about how to help people to be as independent as possible. This was evident even when the individual had a number of challenges because of their mental health or learning disability diagnoses. Some of the care plans had very complex steps in place to lead people in a realistic way towards more independence. This service had not been operating long enough to show major movement in independence building but we saw the promise of this in a number of plans. For example we saw one person with a long term aim of attending further education and their care plan had a number of small steps that were being worked through progressively to start a registration process with a local college. Staff told us that they felt this progress towards independent study was pitched correctly. The person had told their caseworker that they felt they had made progress. We judged that building independence was a fundamental aim of this service and that staff were approaching this in a measured way.

The service had not started to look at end of life care because most people who came to the service were not at this stage in their lives. The registered manager told us that they were planning to look at this aspect in a way that would be appropriate for each person coming in to the service. He said that this would be done as part of future planning and would be considered in contingency planning for individuals if appropriate.

Good

Is the service responsive?

Our findings

People we spoke with told us that they had been involved in drawing up their person centred plans. One person said, "I know all about it. I have a plan done by [my mental health worker] and this one about being here and getting better and moving on."

We looked at care files for people with differing needs. We saw that each of the files had suitable details of the assessed needs of people in the service and contained details of all needs of the individual. We learned from staff and from people in the home that admissions were done in a planned way. Initially a full assessment of need was completed and then a transitional care plan developed. New admissions were invited to come to the service for short visits or overnight stays. Admission processes related to the needs of the person and in some cases admissions were completed without visits. The staff considered how any new admission would impact on the people who were already in the group.

The service cared for people with complex nursing needs. People in the home needed support because they had been diagnosed with a mental health problem, had difficulties managing their behaviour and emotions due to this or because they had a diagnosis of autism or were living with a learning disability. The staff team gave us evidence to show that the assessment process did not stop post admission. We saw full and detailed assessments in place for people in the service. The team used a number of specialised nursing assessments as well as more general assessments. The service employed a psychologist and an occupational therapist who also completed assessments of people in the service. The service also worked with other professionals and a multi-disciplinary approach was taken to both assessment and care planning.

We reviewed care plans and saw that these were person centred, detailed and current. We had evidence to show that there had been input from the person wherever possible. Some people were very involved with their own goal setting. We also noted that the staff had developed positive behaviour support plans for people in the service. We could see from looking at the on-going recording that people were progressing because of this and that good strategies were in place. We saw that the staff team approached care planning from a positive stance and looked at strengths as well as needs.

People were being encouraged to maintain or develop social contact, activities, lifelong learning and social and leisure pursuits. We met one person who was interested in healthy eating and was being supported to enrol in a catering course. People were given support to join in with community activities and to maintain or re-establish links with families and friends. Staff helped people with a recovery model approach where appropriate and activities were based on developing skills and coping strategies. The aim was to support people to move on to independent living wherever possible.

The team worked with social workers and health professionals to ensure that a multi-disciplinary approach was taken to these complex pieces of work. We met a visiting professional who told us that they were, "Very pleased with the progress of (my client)...I think the positive, structured approach has really helped...I am kept up to date and the transition was as good as it could be."

There had been no formal complaints received since the home started admitting people at the end of the summer in 2015. The company had a suitable complaints policy and procedure. People told us they felt they could complain to the staff or the registered manager. People had copies of the complaints procedure.

We judged that this relatively new service was very responsive to need and we saw the promise of continued good practice in the systems that had been developed and were in place.

Good

Is the service well-led?

Our findings

People in the service were aware of how the scheme of delegation operated in the home. They could talk about the roles and skills of different staff members. One person said, "[A nurse] is my named worker and I can go to her...Any problems I would go to [the clinical lead] or to the manager. It all seems to be arranged well." People told us in the service that they were aware of how the home was managed. One person told us, "That's the manager and I can see him whenever I need to and he will help me with anything I'm not sure of. The nurses and the staff know their job and know he's the boss." People also told us, "We are asked all the time about what we want and we have [review] meetings where we can say what we think."

The service had a suitably qualified and experienced manager who was registered with the Care Quality Commission. We learned from the staff team, the visiting company director and from the manager himself, that the registered manager was a trained learning disability behaviour nurse specialist. We had evidence to show that he had experience and expertise in management and in the delivery of care. He told us that he had a particular interest in developing person centred planning for people who may display behaviours that challenge. We had evidence to show that his expertise in all these areas had been shared with members of the staff team.

The service had a system of delegation in place so that the registered manager could ensure that the home operated effectively. He was supported by senior nurses and an administrator. Each of the four units had a clinical lead who would manage the delivery of care and the staff team in the unit. Support workers were part of a key worker system. This meant that each individual person in the home had dedicated workers who would help and support them in their recovery.

The organisation had developed detailed and appropriate policies and procedures that covered all aspects of the service. We checked on some of these as the inspection progressed. We noted that procedures reflected local needs in Cumbria. For example the organisation had a suitable policy about safeguarding vulnerable adults but there was information available about local arrangements in Cumbria. Senior staff told us that the policies and procedures were easy to understand and follow. Staff told us that they were expected to read them and to follow them in practice. We learned that staff discussed these in supervision and in team meetings.

We looked at a range of documents related to the quality assurance system in the service. There were suitable audits of care planning and assessment, medicines management, incidents and accidents. The quality assurance system also included audits of staff related matters. Good systems were in place to ensure that nursing staff had clinical practice supervision and that care staff received supervision and competence checks on their care delivery. We also noted that the systems for recruitment, grievance and disciplinary procedures were routinely monitored.

Records in the service were detailed and up-to-date. The psychologist and the learning disability clinical lead told us that it was considered to be vital to record appropriately and in detail so that the best care delivery was in place. We noted that daily records, on-going assessments, clinical matters and the views of

the person were used in reviews and in the routine monthly reports of people's progress. We judged that this in depth assessment, planning and review of care delivery had established systems that would ensure the best possible outcomes for people in the service.

When we spoke with people in the service and with the care and nursing team we learned that the people who used the service and the staff were fully aware of the vision and values of the service. We were impressed by the way that everyone in the home had an equitable and non-judgemental approach. People were accepted, their strengths valued and their background and health issues understood. Staff told us that they had been trained in matters of equality and diversity and that this was monitored in their practice. A robust system of involving people with the care delivery and service provision was being developed. This included surveys, meetings and group discussions.

We had spoken with commissioners of health and social care prior to our visit. The general consensus of opinion was that this service worked well with other professionals. During our visit the specialist adviser and the inspector noted that joint working was part of the everyday experience in the service. The staff team were fully aware of their responsibilities in joint working with mental health practitioners and social workers. We saw evidence that reviews and assessments were often done jointly and that assessment work was completed so that other professionals would be fully informed of the progress of their service user.