# The Gresham Care Home Limited

# Gresham Care Home

## 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 inspection took place on 26 and 28 September 2016 and was unannounced.

Gresham Care Home is a nursing home providing accommodation and treatment for a maximum of 31 people.

A registered manager was in post. This person is also the provider. However, we have referred to them as the manager throughout the report. 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.

This inspection identified breaches of two regulations. These related to the failure to identify that safeguarding referrals and notifications to CQC were required in relation to two complaints made to the service. We have also made a recommendation that the provider seeks appropriate expert advice in relation to the identification of risks and management of the water system. You can see what action we told the provider to take at the back of the full version of the report.

The service was supporting people with complex physical health conditions. In addition, some people exhibited behaviours that challenged that could put them at risk of harm. The service was managing these challenging situations well with the support of health professionals. Risks to people were identified and staff were knowledgeable about how to keep people safe.

There were systems in place to ensure that people received their medication as prescribed. There was enough staff to meet people's needs. Staff received thorough training and regular updates.

Whilst people's needs were met, some staff interactions with people could be improved upon. People had access to healthcare professionals to support their wellbeing.

People's needs had been assessed and care plans outlined their preferences and how they should be supported. Staff showed a good knowledge of these preferences. The manager ensured that where people were unable to participate in planning their own care that the views of their relatives and representatives were sought.

The service had quality assurance systems in place. However, many of these lacked the final steps that were required to demonstrate their effectiveness.

## 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.

When concerns had been raised they had not been identified as requiring a referral to the local authority's safeguarding team.

There were sufficient numbers of staff to maintain people's wellbeing and ensure they received care and support in line with their needs.

People received their medicines safely from trained staff.

### Is the service effective?

**Good**

The service was effective.

People received care and support from staff that had the skills and knowledge to meet their needs.

Staff sought and received support and specific guidance from healthcare professionals to ensure people's health needs were met.

### Is the service caring?

**Good**

The service was caring.

Most some staff interactions with people were good, however a few were task focused and lacked interaction with people.

When appropriate the service encouraged and actively sought the participation of people's families or representatives in the planning of people's care.

### Is the service responsive?

**Good**

The service was responsive.

People received care which was responsive to their needs and took account of their preferences.

People knew how to make a complaint.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Safeguarding issues that required notifications to be submitted to CQC were not always identified.

Whilst a system of audits and checks was in place some of these lacked the final steps necessary to demonstrate what actions had been taken as a result of any findings.

Staff were supportive of each other and the home's manager.

# Gresham Care Home

**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 26 and 28 September 2016 and was unannounced. On 26 September the inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was completed by the inspector alone on 28 September 2016.

Prior to this inspection we reviewed information we held about the service. Before the inspection, the provider had 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 reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During the inspection we spoke with ten people living in the home and relatives of two people. We made general observations of the care and support people received at the service. We also spoke with the manager (who was also the provider), three nurses, three care staff and the cook.

We reviewed five people's care records and the medication records of three people. We viewed records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

When we viewed the complaints received by the service in the last 12 months we found that two of the three complaints made should have been referred to the local authority as safeguarding referrals. As this had not been done the local authority had not been able to independently investigate if necessary or provide support and guidance to staff to help reduce the risk of harm to people. Instead the manager had looked in to the concerns themselves when this may not have been appropriate.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe in the home. One person said, "No-one here has ever done anything bad to me." Another person told us, "I have always been alright here, they treat me alright." A third person said, "I'm safe, staff are nice to me." Staff told us that they had received safeguarding training, which was confirmed by records we viewed.

We saw that drink thickener was left unsecured in people's rooms. Several people who were mobile and living with dementia resided in the home. There was a risk that if someone ingested this substance their airway could become blocked. Whilst the manager did not feel that anyone in the home was at risk of accidentally ingesting the thickener, it was a prescribed item and should have been secured.

The nursing staff managed people's medicines safely and good practices were in place. Where people required pain patches to be administered to their skin records showed that the area of application was varied to avoid skin irritation. If people required variable doses of prescribed medicines records showed how much was administered and why. Guidance for the administration of 'as required' medicines was in place. Topical cream charts were fully completed with diagrams in place to show staff where creams needed to be applied.

There was a good understanding of risks to people's welfare. Risks assessments were in place that covered areas such as falls, mobility, nutrition and hydration and skin care. Some people living in the home had complex health needs and multiple risks had been identified. These included risks to people's welfare presented by behaviour that challenges. Plans were in place to mitigate the risks. Staff were able to describe, in detail, what risks were applicable to specific individuals and how they acted to help ensure their welfare.

One person had a very high risk of falls and declined to use equipment that they had been assessed as needing. The person was regularly seen by the falls team in order to review the person's risks and determine the best way to support them. A visiting health professional who was familiar with the person's needs told us that the service was doing all they could to minimise risks to the person and were satisfied with the care that the person received.

We found that some people were unable or not always able to use their call bells, despite records saying

that they could. One person told us, "I keep meaning to ask for a little bell. I shout but they don't hear me down here." Another person had their call bell next to them, but they were unable to use it when we spoke with them. The manager told us that sometimes the person was able to use it, so they made sure it was available to them. Staff told us that they were allocated to certain areas of the home and knew which people were unable to use their call bells. These people were checked on at regular intervals.

Risks in relation to the premises and the environment were well organised. The water system had been tested for legionella in April 2016 and the results had been negative. However, the risk assessment and maintenance control measures in place were not robust. We recommend that the provider seek guidance and advice from a reputable source about the assessment of risk and control mechanisms required in relation to the water system and legionella bacteria.

There were six or seven care staff on duty on the morning shift, six staff on duty in the afternoon shift and two staff available overnight. There was also a registered nurse on duty 24 hours a day. The manager was also a registered nurse. There were 30 people living in the home. Staffing rotas showed that staffing levels were routinely maintained.

We reviewed the recruitment records for three recently employed staff members. The systems in place were robust and included criminal records checks, identity checks and references were obtained.

Good

# Is the service effective?

## Our findings

People were mainly positive about the food. One person told us, "It was a jolly nice breakfast I had today." Another person said, "The food is very good." People told us they had choices for meals. However one person stated, "I had porridge, but I'm getting fed up with it. Soon I will look like a bowl of porridge."

We saw that drinks were not always available for people in communal areas. The manager told us that there were two people living in the home who were mobile and wanted to eat and drink items easily available that were not theirs. Both were living with different but significant health conditions that would put them at serious risk of harm if they were able to consume food and drink unsupported by staff. Consequently, the manager had tried to ensure that limited foodstuffs were clearly visible when staff were not on hand in communal areas without taking away other people's access to food and drink.

Many people needed the assistance of staff with eating and drinking. However, we noted that cold desserts were served at the same time hot main meals. This may have put people off their meals or made people feel rushed. A staff member told us and we observed that drinks and snacks were offered frequently and a trolley came round more than once each morning and afternoon.

Some people had specific dietary preferences and the home provided a good range of suitable options for people. For example, savoury soya mince was an option one day. The manager often made meals for one person who was vegan. We saw that another person was a vegetarian but had had not been given a vegetarian meal on one day of our inspection. Conflicting information had been given to the service about the person's preferences by the person's family and the local authority. The manager told us that they would clarify this, but in meantime would ensure that the person was provided with a vegetarian diet.

We saw that guidance and support was routinely sought from health professionals. As the service was supporting people with significant and complex health conditions a wide range of health professionals were frequently involved to help ensure people's wellbeing. We reviewed records that showed significant input from these health professionals, including reports, assessments of people's needs and multi-disciplinary reviews of people's care. These were used to inform how best to support people with their health and well-being.

The majority of mandatory care staff training was up to date. The manager had undertaken training so that they could train staff in certain areas, for example first aid and moving and handling. In addition care staff told us that they could undertake training in areas of specific interest to them, for example end of life care. Several care staff had opted to do this training.

Training for nurses was also comprehensive and regularly refreshed. Nursing staff were shortly due to undertake detailed training in male catheterisation. Whilst nurses were all qualified the manager ensured that they had updated training in specific areas, such as the use of feeding tubes, before they were able to support people with specific needs. In the meantime, some nursing tasks were supervised.

We saw that the manager also provided training updates to staff from training they had been on. For example, they had led updates and discussions with nursing staff about managing Parkinson's disease and the use of syringe drivers to administer medicines. They had also recently provided updates to all staff on practical first aid and hydration.

All staff received regular appraisals and supervisions. Staff were positive about the training they received and the opportunities for personal development.

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 authorisation 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 found that it was.

We noted that, where people did not have capacity, applications had been submitted to the local authority. Where people did have capacity we saw that staff supported them to make day to day decisions, and sought consent before providing care.

Good

# Is the service caring?

## Our findings

Seven of the people we spoke with who lived in the home were positive about the staff. Comments included; "Staff are lovely. They give me all I need and they do their best." "It's nice living here. The staff are good." "They are very good staff, they get me dressed." However, two people told us some of the staff were not as good as others. One of them said, "They do look after you. But some are a bit abrupt and I get easily upset. I try not to get into an argument with them, but it happens." Two people told us that visiting family members were not offered drinks by staff when drinks were being offered to people living in the home. They told us this made them feel a bit uncomfortable.

We spoke with two relatives of people living in the home. They were positive about the care their family members received. They told us that their family members were clean, warm and comfortable.

Most staff interactions were people were friendly and staff engaged people in conversations. However, we observed a few staff interactions with people that were task focused with little conversation or encouragement being given. For example, whilst some staff were skilled at supporting people to eat in a considerate and interactive manner, other staff spooned food into people's mouths with little attempt at conversing with them.

People were able to spend time in communal areas or in the privacy of their rooms. Several people's rooms had few personal effects and their rooms could have been made a bit more inviting for them. We saw that some of these rooms contained a poster that had been made about the person, their life and interests. However, these posters were old and faded.

Staff respected people's right to privacy and knocked on bedroom doors before entering. Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and affectionate way.

People were generally well dressed and clean, showing that staff took time to assist them with their personal care. One gentleman was dressed smartly, wearing a shirt and tie. We saw from his care records that he had a professional background and his appearance was important to him. A staff member told us that some people declined to change clothing or accept assistance with personal care on occasion. They described the actions staff took to support people in these circumstances.

Staff we spoke with told us they enjoyed supporting the people they worked with and were able to give us a lot of information about people's needs, preferences and personal circumstances. This helped to show that staff had developed positive relationships with the people they supported.

Many people living in the home were unable to be actively involved in the planning of their care in any detail. Where this was the case staff had utilised their own knowledge of people's likes and dislikes and input from people's families to help design care and support for people in a way which suited them.

The service had organised meetings for people's relatives but these had been poorly attended. However, we saw that the service pro-actively contacted people's relatives or representatives to provide updates about the service and seek their feedback. The manager said that this approach had worked better. In addition, where specific issues needed input from people's relatives, direct contact was made.

Good

# Is the service responsive?

## Our findings

Each person had their needs assessed before they moved into the home. This was to determine whether the service was able to meet the person's needs and expectations. From the initial assessments care plans were devised to ensure staff had information about how people's needs were to be met.

The home used a computerised care records system. Care records were personalised to each person. There was also a second record in respect of each person which held detailed information and reports from external health professionals such as specialist nurses and clinicians. This information was used to update care plans and risk assessments.

Care staff did not have access to the computerised care records system. The manager and nurses completed and reviewed people's care records. Care staff we spoke with did not consider that being unable to access people's care records hampered them in their ability to support people effectively. They told us that the nursing staff gave them all the information they needed to support people safely and effectively and they liked being able to concentrate more on providing care and support than completing records.

We observed a shift handover session between the morning and afternoon shifts which was run by the manager. All staff carried notebooks which they used to record information that they would need during their shift. The handover was detailed and changes to people's care requirements were discussed and actions agreed. For example, one person needed a change to the assistance they required to mobilise. Staff diligently recorded necessary details. They also used these notebooks to record care they provided for people during their shift and these were handed in at the end of the shift so that nursing staff could assure themselves that people had been cared for appropriately, e.g. that people had been repositioned as necessary. The care records system could then be updated.

We found that the service was adept at identifying people's health needs and taking the appropriate action. For example, staff were concerned that the prescribed pain relief for one person was not effective. They had promptly contacted the surgery to request a review. A visiting health professional told us that the service was very good at healing any pressure areas. Surveys completed by visiting health professionals were all positive. Comments included; "Staff have information readily available when I visit" and, "Staff take all measures to meet patient's needs."

People were able to make choices about their day to day lives. One person told us that they liked a bath every day. Staff were able to explain about people's likes and dislikes and how they liked their care to be provided. For example, a staff member told us how one person liked their hair in a plait. We saw that the person's hair was arranged in this style.

The activities staff member told us that they supported people with activities or their interests in small sessions. Some people liked group activities but as many people preferred to stay in their rooms the activities staff member spent time with them reading or going through photo albums. They assisted some people to go shopping or spend time in the garden.

Information about how to complain was available to people in the home. However, this required updating to ensure that people were advised about suitable escalation routes should their complaint not be resolved to their satisfaction within the service.

We saw that when a complaint had been received from a relative about their family member's oral health the manager had invited a dentist in to assess the person. The person's relative had also been invited to the assessment. The person had a tendency to decline support with cleaning their teeth. Following the new assessment and advice from the dentist the relative and the manager had agreed how best to practically support the person with their oral health, whilst ensuring this was with the person's consent.

One person told us, "If I have anything to say I'll say it and they know it. I wouldn't complain about the staff, there is nothing to complain about."

Requires Improvement

# Is the service well-led?

## Our findings

The provider is required by law to notify the Care Quality Commission of significant events which included any allegations or instances of abuse. During this inspection we identified two issues from complaints records that should have been reported to us as safeguarding issues. This indicated that the provider did not have systems in place for identifying when notifiable incidents had occurred, or for ensuring the necessary notifications were carried out.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We recommend that the manager refreshes their understanding in relation to what incidents might constitute a safeguarding referral and what incidents require notification to CQC.

The manager had a good oversight of people's care and support needs and training was well organised. There was a system of audits and management checks in place. These were wide ranging and covered equipment maintenance and cleaning schedules to health and safety and infection control. However, in some cases where issues or concerns had been identified it was not clear what action was being taking to address these, what the timescale for completion was or whether the action had been completed.

The maintenance staff member needed support form a reputable and knowledgeable person in relation to the management of the water system. This was specialised area and it was not feasible for the maintenance person to be able to identify and plan to manage any risks in the area without expert support.

A system of surveys was used to formally obtain the views of people living in the service, their relatives or representatives and health professionals. Some surveys allowed people completing them to leave additional information or comments. Others didn't which meant that these were less effective. For example, a survey had been carried out to obtain people's views about the food in September 2016. However, people's specific comments or suggestions were not recorded. There was only the option to rate aspects of the provision as excellent, good, average or poor. This was a missed opportunity to gain valuable insight into people's preferences and personalise the service people received. Whilst the ratings had been mainly positive, no analysis had been undertaken of the areas identified as having room for improvement.

Records were kept securely. All care records for people were held in the computerised care system or in individual files which were stored in a locked cabinet. Records in relation to medicines were stored securely. Records we requested were accessed quickly. However, we found that there were gaps in the recording of activities that people undertook.

The manager was well liked by people living in the home and the staff. People living in the home told us; "The manager has done good for me, she's kind." "Matron is marvellous." "The manager is lovely."

Staff told us that the service was well led and that the manager was caring and supportive of people living in the home and of staff. One staff member told us, "I have absolute confidence in the nurses and the manager.

The manager is very hot on providing individualised care." Another staff member told us, "Staff are all each other's back up. We're all happy to muck in if someone is off sick. The manager is the kindest person I know. You couldn't find anyone better."

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<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered persons had failed to ensure that notifications regarding specific incidents were submitted to the Commission. Regulation 18 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured that referrals were made to the local authority when necessary. Regulation 13 (1) (3) |