R S Property Investments Limited

Gresley House Residential Home

Inspection report

Gresley House
Market Street, Church Gresley
Swadlincote
Derbyshire
DE11 9PN

Tel: 01283212094

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 24 March 2016. Breaches of legal requirements were found safe care and treatment and in good governance. On 30 March 2016 we issued two warning notices to the provider. We told the provider to take action to meet the regulations before 30 June 2016.

We undertook this focused inspection on 7 July 2016 to check that they now met legal requirements and to review the rating of inadequate in Safe. This report only covers our findings in relation to those requirements and that review. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gresley House on our website at www.cqc.org.uk

There was a registered manager in post. 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.

Gresley House provides residential care and support for people, some of whom are living with dementia. It is registered to provide care for 27 people and at the time of our inspection 22 people were resident.

At this inspection the provider had made improvements in how they managed risks to people's health and wellbeing. Staff had received additional training and they now supported people to move safely, using the correct equipment. The provider had purchased new equipment which assisted the staff to meet people's needs safely. They had implemented new systems to analyse and review accident and incidents, including falls, and were putting actions in place to reduce the risk of them occurring more promptly. Staff supported people when they became anxious or when their behaviour could cause harm to themselves or others. Records were up to date and amended to reflect changes in people's health and wellbeing and referrals were made to health care professionals for additional support and guidance.

The provider had made improvements in the management of medicines. People consented to take their prescribed medicine and there was enough in stock to be able to administer them. When people did take medicines as required there was guidance in place for staff to know when they should support people to take them.

The environment was improved to reduce risk as hazards were removed and renovations had taken place which reduced the risk of spreading infection. Staff had protective equipment more readily available and there were better arrangements in place for the disposal of clinical waste.

At our last inspection the provider had not ensured that there were adequate staff to meet people's needs. At this focused inspection staffing levels had been increased and we saw that people did not have to wait for staff to attend to them. Falls which occurred at night had decreased with additional staff deployed to

observe and support people.

Systems had been put in place to check the quality of the service to ensure that there was improvement in quality. These included auditing medicines management, infection control, pressure care, nutrition and environmental maintenance. The impact of these measures was already evident and the provider had plans in place to fully embed them to ensure that they were effective.

At this inspection the provider had not always considered people's longer term care needs and there were not always plans in place to support staff to know what the next steps for people were. Some improvements had been made to ensure that people consented to their care and when they were unable to do this that assessments showed that decisions were made in their best interest. However, it had not been fully implemented.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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
People's longer term care needs were not always planned for and staff were unsure how to provide ongoing support. Accidents were reviewed promptly to ensure that measures could be put in place to reduce the risk of them happening again. Medicines management ensured there was sufficient stock of medicines in place. There were sufficient staff to meet people's needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led
Systems were in place to measure quality and to drive improvements. New procedures ensured that accidents and incidents were reported and investigated promptly. Referrals were made to healthcare professionals when needed. Staff competency was assessed and further training was organised. Audits had assisted the prioritisation of work to improve the environment. The provider was developing the management structure to provide more managerial support. Some best interest decisions had been made when people couldn't consent but this was not fully embedded.

Gresley House Residential 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.

We undertook an unannounced focused inspection of Gresley House on 7 July 2016. This inspection was completed to check that improvements had been made to meet the legal requirements described in two warning notices and to review the rating of inadequate in safe. We inspected the service against the safe and well led questions.

The inspection was carried out by two inspectors. We spoke with four people who used the service about their experience of the support they received. Some people were less able to express their views and so we observed the care and support that they received in communal areas. We spoke with five care staff, the registered manager, the operations manager and with a visiting health professional. We looked at care records for five people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 17 and 24 March 2016 we found that risk was not always managed to protect people from harm. People were not always supported to move safely, they did not always have the correct equipment to assist them safely and they did not always have plans in place to assist them to manage behaviours which could cause harm. The management of medicines was not safe because people were not receiving their medicines as prescribed as they were not available and there was no guidance in place to ensure that people's needs were met when they needed 'as required' (PRN) medicines were met. These were breaches of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the way medicines and risks associated with people's health and wellbeing were managed. We told the provider that improvements must be in place by 30 June 2016. At this inspection we found that improvements had been made.

At our last inspection we found that people were not always supported to move safely, including using incorrect equipment. At this inspection we observed that people were supported to move safely and in accordance with the risk assessments and care plans which were completed. For example, we saw that two staff were supporting one person to move using the correct equipment to do this safely; they explained what they were doing throughout and encouraged the person to assist themselves. We also observed that aids were used to support people to re-position themselves in line with their care plans to protect their skin. Staff we spoke with told us that they had received additional training and that they had their competence checked through observations. One member of staff said, "We have had a lot of training and it has been good because it has been done here so it makes sense". The registered manager told us, "We have purchased a new hoist and slings and reviewed everyone's risk assessment to ensure that we are using the correct aids for each individual". At our last inspection we also found that people did not have beds which could be altered to meet their health needs or to assist them with transferring from bed. At this inspection we saw that these had been provided for people who required them and that there was a plan in place to continue to review this. One health professional we spoke with said, "People who need them now have beds which help to manage their healthcare needs." Records that we reviewed demonstrated that risk assessments and management plans were in place to guide the care that people received in their bedrooms.

Risks to people's health and wellbeing were not always reviewed at our last inspection to ensure that prompt action was taken to reduce the risk. At this inspection we saw a new system had been implemented to ensure that incidents and accidents, including when people had fallen, were reported to the manager within a day. There was a review of the circumstances and referrals were made to relevant healthcare professionals for support. Additional training had been given to staff to enable them to reduce risks associated with some health conditions. One member of staff told us, "We have had training from the local healthcare team in catheter care and skin care. It has been really detailed and then we were observed doing some of the techniques in practise to check that we were getting it right. It has reduced the number of times we need to call the healthcare professionals in to assist because we are much more confident". A healthcare professional we spoke with said, "It has improved and we will continue to offer support as there are new staff starting all the time and some staff are more experienced than others".

At our last inspection we saw that people were not always supported to manage behaviours which could cause harm to themselves or others. At this inspection we observed that staff knew how to support people through engagement in activity and that people were observed regularly. Staff we spoke with were able to describe what circumstances may cause someone to become agitated and how they would support them. Records that we reviewed demonstrated that referrals had been made to healthcare professionals for additional support when required.

Medicines were not managed safely at our last inspection because people did not always consent to take it, there were not always sufficient amounts of medicines in stock to administer it when it was required and there were no PRN protocols in place to guide staff when medicines should be given. PRN protocols give guidance to staff to know when to administer medicines which are prescribed to use 'as required'. At this inspection we observed that people were told what medicines were for before they were administered. We saw that it was administered to meet individual need and that records were completed. We checked whether there was enough stock in place for people to be able to take medicines prescribed and found that there were and that the amount was correctly recorded. We saw that there were systems in place to communicate when extra medicines were needed so that they could be ordered promptly.

Environmental risk was not always managed at our last inspection because there were hazards which could cause harm to people. At this inspection we saw that there were improvements because the hazards had been removed. We saw that a communal room had been re-arranged so that mobility aids could be stored in a place where the risk of them being a trip hazard was significantly reduced. Other hazards such as a gate which did not close sufficiently and exposed pipes had been fixed or replaced. Storage in a staff room had been removed to ensure that there was no longer a fire risk.

At our last inspection we saw that there were not always enough staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities). At this inspection we saw, and people told us, that there were sufficient staff. One person we spoke with said, "There are always enough staff walking around. There isn't a call bell but you wouldn't need one anyway". Staff told us that there were more staff which meant that they could meet people's needs. One member of staff we spoke with said, "There are more staff now which is much better". A health professional we spoke with said, "It is clear when we visit that staffing levels have increased". We observed that people did not have to wait to have their needs met and that staff had time to spend talking with people. At our last inspection there had been several falls at night and staffing levels had not been increased to address this. At this inspection the manager told us, "We have increased staffing levels at night and can see that as a consequence there has been a reduction in the number of falls that have happened at that time because staff can be more responsive to people's needs".

At our last inspection we looked at people's emergency plans and saw that these did not provide guidance about the level of support people would need to be evacuated from the home in an emergency situation. At this inspection the manager told us that staff had received training in using aids, such as evacuation sheets. However, they acknowledged that the plans still needed to be updated and would need to incorporate the change to staffing levels at night. This meant that the emergency plans required improvement.

People were not always safeguarded from avoidable harm and abuse at our last inspection. At this inspection we saw that some improvements had taken place but that people were not always protected. We reviewed one incident which was not raised as a safeguarding concern. When we spoke with the manager they recognised that it should have been reported and more thoroughly investigated. We saw that other incidents had been referred and investigated in line with the providers safeguarding procedure; but the plans that were put in place to avoid repetition were not robust because they only addressed the

immediate risk and did not consider ongoing support to people; for example, the actions to resolve one incident was for one person to keep their door locked but this did not fully resolve the ongoing protection of people who lived there.

At our last inspection people were not always protected from harm because the systems in place to control the risk of infection were not sufficient. At this inspection we saw that improvements had been made. A healthcare professional we spoke with said, "The protective equipment provided is much better because they are now provided in each room". We saw that bathrooms had been cleaned and that floors were sealed. The manager told us, "The whole building has had a deep clean now, we have increased housekeeping hours and we are working through an action plan to refurbish throughout the building".

At our last inspection recruitment procedures were followed to ensure that staff were safe to work with people. At this inspection records that we reviewed demonstrated that all relevant checks continued to be made when employing new staff.

During this inspection we saw the care that was planned for people did not always meet their longer term needs. One person was receiving medicines for a short term condition. One member of staff we spoke with said, "I do not know when they should stop taking that medicine. They do seem better though". Records we reviewed showed that the medicine should have been for three to six months duration. The person had received them for six months and there was no plan in place to reduce this or seek professional guidance. Another person had plans in place to manage their wellbeing after an injury which included plans to assist them to rest and to move safely. Another member of staff told us, "They seem nearly ready to weight bear and move more independently". When we spoke with the manager they said that there was not a plan in place for rehabilitation and that a referral to a healthcare professional had not yet been made to support this. We saw that another person had medicines in place which assisted through end of life care. However, this had not been communicated with other health care professionals and there was not a plan in place to support them through this period.

This evidence represents a breach in regulation 9 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014 Person-centred care because the planned care did not meet people's needs or reflect their preferences.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection we found that there were not always systems in place to protect people from harm. The provider did not respond to the analysis of falls to increase staffing levels, staff competence was not routinely assessed, care plans were not reviewed and updated and quality checks and audits were not completed to improve quality. These were breaches of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the systems that they used to manage the home in order to protect people from harm. We told the provider that improvements must be in place by 30 June 2016. At this inspection we found that improvements had been made but further information was required to support people who lacked capacity.
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At our last inspection we saw that where people were unable to consent the provider had not completed mental capacity assessments and best interest decisions had not always been completed to protect people's rights. At this inspection we saw that the provider had made some improvements to address this. They had completed some decision specific capacity assessments for example in making decisions about a course of treatment. When it was deemed that the person did not have capacity some decisions had been made in their best interest with important people. The manager recognised that there were still decisions and capacity assessments that needed to be reviewed. They said, "We have had some support from our local social work team which has helped us to reflect on how we approach this and we will continue to work through it".

At our last inspection the provider did not always respond to highlighted risks to ensure that people received safe care and treatment. At this inspection we saw that the provider had taken action to improve this. There were additional staff employed at night and in the evening in response to the number of falls that happened at that time. We saw that new processes had been put in place to report and review falls and the registered manager said, "Taking prompt action and looking at people's wider healthcare needs has helped us to see what might be happening for people so that we can take action". The registered manager had implemented an audit of falls and we saw that the number of falls had decreased in the last two months. The manager recognised that this analysis would need to continue to assess the longer term impact of the measures that they had put in place and continue to review them. Records that we reviewed at the last inspection were not always up to date or amended to reflect people's changing needs. At this inspection we saw that they were amended. For example, one person's health needs changed and we saw that all of their care plan was amended because the provider recognised that it put the person at greater risk of falls, skin damage and nutritional risk. We saw that daily records were maintained and that referrals to healthcare professionals were made when required; for example, in response to someone's reduced appetite and weight loss. We also saw that the provider was reviewing the suitability of the care that they could provide for some people and that they were working with healthcare professionals to consider whether the home was the correct environment for them. We did see that some records were maintained on a daily basis without a clear purpose. The manager said, "We wanted to make sure we weren't missing anything but I realise there may be too much and we will review the purpose of all of our record keeping and ensure that the staff have clear guidance".

The provider did not always ensure that staff had the required skills to do their job effectively at our last inspection because they did not check that training had been effective. At this inspection staff we spoke with said that they had received additional training and that their competence was reviewed. One member of staff we spoke with said, "I have been observed administering medicines to make sure that I am doing it properly". When we looked at the medicines audits we saw that staff had been questioned to assess their understanding and observed to ensure that they demonstrated the correct skills. Staff also told us that they had been observed in other aspects of their roles including moving people. When we spoke with the manager they told us about one incident when someone's catheter care was not completed correctly and to resolve this they had provided additional training for the member of staff and observed them afterwards to ensure they understood the direction.

At our last inspection audits and quality checks were not completed or were not acted upon which meant that people were not always protected from harm. At this inspection we saw that systems to drive improvement were being implemented and had already had some impact on the quality of the service. For example, we saw that infection control audits had been completed which had enabled the provider to prioritise refurbishment and maintenance work to reduce the risk. The manager told us, "We have asked one member of staff to become the infection control lead and they will attend training with the local health authority. This specialism will ensure that we keep up to date with this". There was also a pressure care audit which included checks of equipment and an audit of people's weights to ensure that all of the measures were being taken to keep people safe. The manager said, "We have reorganised the senior team so that each person has a champion role that they can take the lead for and develop". The provider had also employed a compliance manager to support all of the services and implemented managers meetings. The manager said, "I really value the chance to spend time with other managers and learn from them and help each other come up with solutions. At the moment we are looking at how we ensure that people consent to their care and sharing ideas and plans with each other".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care A breach in person-centred care because the planned care did not meet people's needs or reflect their preferences.