Grosvenor Care Homes Limited

Grosvenor House 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 4 October 2016 and was unannounced. Grosvenor House provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 40 people who require personal and nursing care. At the time of our inspection there were 39 people living at the home.

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.

On the day of our inspection people were cared for safely. People and their relatives told us that they felt safe and cared for. Staff knew how to keep people safe. The provider had systems and processes in place to keep people safe.

Medicines were not consistently administered safely. We saw that staff obtained people's consent before providing care to them.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

We found that people's health care needs were assessed and care planned and delivered to meet those needs. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals. People had their nutritional needs assessed but were not always supported with their meals to keep them healthy. People had access to drinks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

Staff responded in a timely and appropriate manner to people however people and their relatives felt there were insufficient staff on occasions. Staff did not always provide emotional support to people. Staff were kind to people when they were providing support and people had their privacy and dignity considered. Staff had a good understanding of people's needs and were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs. The provider had a training plan in place and staff had received regular supervision.

People were encouraged to enjoy a range of social activities. People were supported to maintain relationships that were important to them.

Staff felt able to raise concerns and issues with management. Relatives were aware of the process for raising

concerns and were confident that they would be listened to. Regular audits were in place for areas such as medicines and infection control however they had not consistently improved the quality of care. Accidents and incidents were recorded and analysed. The provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.

The provider had participated in a number of local and national initiatives in order to improve the quality of care to people.

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.

Medicines were not administered safely.

There were sufficient staff to provide safe care.

Staff were aware of how to keep people safe. People felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005.

People had their nutritional needs met. People were not always supported with their meals.

Staff received regular supervision and training.

People had access to a range of healthcare services and professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff did not always respond to people's emotional needs.

Staff were kind to people.

People were supported to make choices about how care was delivered.

People were treated with dignity and their privacy was respected.

Is the service responsive?

Good

The service was responsive.

Staff used a range of methods to communicate with people however people were not always able to communicate their needs.

People had access to activities.

The complaints procedure was on display and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems and processes in place to check the quality of care and improve the service were not always effective.

The registered manager created an open culture and supported staff however the support was not person centred.

Staff felt able to raise concerns.

Grosvenor House 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 4 October 2016 and was unannounced. The inspection was completed by an 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.

Before the inspection, the registered 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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection we observed care in the home and spoke with the registered manager, two nurses and a member of care staff. We spoke with six people who used the service and two relatives. We also looked at three people's care plans and records of staff training, audits and medicines.

Requires Improvement

Is the service safe?

Our findings

We found there were shortfalls in the way the provider managed the administration of medicines and people were at risk of not receiving their prescribed medicines. We saw that two people had their medicines left with them. One person's medicines remained at the side of their plate for over an hour and there was a risk that other people could access the medicines or that the person did not take them. Although the nurse said they went back to check they may not be aware if the person had taken them or not. For example, during the morning of our inspection we found what we appeared to be a tablet on the floor. Staff were not sure whose tablet it was and were not aware that it had not been taken. Additionally risk assessments had not been completed to assess and minimise the risk to people if tablets were left with them.

Staff explained to people what their tablets were and people were asked if they wanted their as required medicines (PRN) such as painkillers. We saw that the medication administration records (MARs) had been fully completed according to the provider's policy and guidance. However the front sheets in the MARS folder had not been consistently completed with people's names, date of birth and allergies. This meant that they could not easily be used to check people's identities when administering medicines. PRN protocols were not in place to indicate when to administer these medicines and whether or not people could request and consent to having their medicines. The registered manager showed us a template which they were in the process of completing for these. Medicines were stored in locked cupboards according to national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control.

Individual risk assessments were completed for issues such as a risk of falls and skin care. Risk assessments were also in place where equipment was used such as bed rails. However a risk assessment had not been completed for a person who preferred to lock their bedroom door at night but the provider had an arrangement and system in place which meant that staff could access people's rooms in an emergency. Accidents and incidents were recorded and investigated to help prevent them happening again.

People who used the service told us they felt safe living at the home and had confidence in the staff. A person said, "I'd be very afraid without them." Relatives told us that they felt their family member was safe.

Although there were enough staff to manage people's care needs, people felt that they did not have time to spend with them an individuals. We corroborated this through our observations and address the impact of this on people further on in the report. One person said, "Staff are very busy, don't have time," and "Too busy to talk, they say come back later, no one to one time." A relative said, "At the weekends if you press the buzzer you could wait 20 to 25 minutes, [family member] needs to staff to help, the buzzer can be going constantly." However staff felt there were sufficient staff to provide care to people. Additional nurses had been recruited with a range of skills and experiences such as mental health in order to meet people's needs more fully. A staff member told us, "Staffing levels are good." During our inspection we observed staff responded promptly and we did not hear call bells ringing for a prolonged time. However we did observe that staff were busy with practical tasks and this is dealt with in another section of this report.

The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable people were employed by the provider.

Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example to the local authority. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

Requires Improvement

Is the service effective?

Our findings

The registered provider did not act consistently in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

We observed that people were asked for their consent before care was provided. Records included completed consent to treatment forms to ensure that care was provided with people's agreement. Where people were unable to consent this was detailed in the care records and records detailed what support people required and why. However we observed a person used equipment to keep them safe for example, bed rails and a lap belt but it was not clear in the person's care plan whether they were able and had consented to the use of these or if a best interests assessment was required. There was a risk they were being restrained inappropriately.

If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there was no one who was subject to DoLS, although 18 applications had been made and the provider was awaiting the outcomes of these. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. Staff had received training about DoLS and understood what this meant when providing care to people. One staff member said, "People are considered to have capacity unless we have confirmed otherwise, we always try to involve people in decisions about their care."

We observed lunchtime and saw two staff assisting people with their meal to ensure that they received sufficient nutrition. Staff sat alongside people however there was little conversation from staff with people. We observed some people were waiting for long periods for their meals, for example, a person waited for over 30 minutes for their pudding. We also observed that a number of people struggled to eat their meat as it was not cut up and they did not have the utensils available to cut the meat up. We observed people attempted to eat it without cutting it up and due to their difficulties with verbal communication were unable to ask for assistance. People were offered a choice of meals. Staff told us if people did not want the offered meals or the meal they had chosen they were able to provide alternatives. One person said, "The food is acceptable, we do get a choice but not in the true sense. There is one main course and a choice of three sweets." Another person told us the food was excellent.

People had been assessed with regard to their nutritional needs and where additional nutritional support was required appropriate plans of care had been put in place. For example, people received nutritional supplements to ensure that people received appropriate nutrition. We saw that care plans detailed what nutrition people required. For example, a person was recorded as often refusing their meal and the care plan stated that snacks should be offered later in the day as often the person preferred these. Where people had allergies or particular dislikes these were highlighted in the care plans. We observed people were offered drinks during the day according to their assessed needs. Staff were familiar with the nutritional

requirements of people and records of food and fluid intake were maintained appropriately.

We observed people received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. Staff told us they were happy with the training that they had received and that it ensured that they could provide appropriate care to people. Staff received mandatory training on areas such as fire and health and safety. They also received training on specific subjects which were relevant to the care people required such as training on how to provide specialist nutritional routines. In addition some staff in the home had received additional training on areas such as specialist feeding regimes so that they could provide training and be on hand to give advice to staff in order to meet people's needs. We observed the clinical training ensured that staff knew how to provide practical care to people.

There was a system in place for monitoring training attendance and completion. It was clear who required training to ensure that they had the appropriate skills to provide care to people and that staff had the required skills to meet people's needs. Staff also had access to nationally recognised qualifications. New staff received an induction and when we spoke with staff they told us that they had received an induction and found this useful. The induction was in line with national standards.

Staff were happy with the support they received from other staff and the registered manager of the service. They told us that they had received regular support and supervision and that supervision provided an opportunity to review their skills and experience. We saw that appraisals were in the process of being carried out. Appraisals are important as they provide an opportunity to review staff's performance and ensure that they have the appropriate skills for their role. Nursing staff had received support so that they had the skills and experience to meet the standards required to renew their professional registration.

We found that people who used the service had access to local and specialist healthcare services and received on-going healthcare support from staff. The registered manager told us that they had good relationships with the local GP services and the district nurses who visited regularly. When providing specialist end of life care to people we observed that they had purchased similar equipment to that used by the district nursing service in order to ensure continuity of care to people. This also meant that staff could access advice and support regarding the equipment from the district nursing service. Where people had specific health needs such as diabetes information was available to staff to ensure that they provided the appropriate care.

Staff received daily handovers where they discussed what had happened to people on the previous shift and their health and wellbeing. Where people had specific needs such as physical health issues advice was included in the record about how to recognise this and what treatment or support was required. This helped staff to respond to people's needs.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the practical care they received. However people said they would like staff to have more time to be with them and provide emotional support. One person said, "I've no complaints, you can complain, they work hard though and though I'd say, it's alright, they haven't time to spend, that time they'd like to spend with you. " Another person said, "We laugh and joke but they never have time to sit and talk with me for anything more than a minute" and another told us, "Could do a bit more caring, not that they don't want to do it, so busy changing people they don't have the time."

We observed staff supporting a person to mobilise using a hoist on two occasions. The person was supported safely and staff were competent in the use of the equipment. However the person became quite distressed whilst being moved and staff did not provide any reassurance whilst supporting them apart from telling them when they were going up or down. On another occasion we observed a person trying to talk with a member of staff. Although their conversation was confused it was clear they were trying to communicate with the member of staff, however the staff member did not respond and carried on with the task of serving drinks. As the person was unable to mobilise without support they failed to attract the attention of the staff member and eventually gave up and sat quietly in the chair. There was a risk the person's needs were not being met because staff did not respond to them. During the morning we observed staff walked through the lounge area without speaking to people. We observed that most interaction was between staff about what required doing next rather than with people who lived at the home.

Relatives confirmed they thought the staff were kind, courteous and treated the residents with respect. We observed that staff were aware of respecting people's needs and wishes. For example, we observed when morning refreshments were served people were offered a choice of drinks. One person asked for orange and staff checked whether they wanted fresh orange or orange cordial.

We saw that when providing care staff were kind and considerate, for example, one resident spilled a drink, the staff serving drinks pressed the buzzer for someone else to help and they came quite quickly and took the person off to change. The staff member spoke respectfully and reassured the resident. Drinks were being served in a range of different mugs according to people's choice. People were involved in deciding how their care was provided, for example a person preferred to wear dresses rather than seperates and this was detailed in their care plan.

People who used the service told us that staff treated them well and respected their privacy. People told us and we observed that staff knocked on their bedroom doors. We saw that staff addressed people by their preferred name and that this was recorded in the person's care record.

Good

Is the service responsive?

Our findings

Care records detailed how staff should communicate with a person, for example, a record stated, 'speak slowly and clearly and ensure [person] has heard.' Staff told us that they used a number of different resources such as pictures, gestures and written word in order to aid communication with people who were unable to use verbal communication easily. We observed a member of staff supporting a person to choose what they wanted for tea and observed they used written information to help them to communicate their choices. However we also observed two people struggling to gain support because of their communication difficulties.

On the day of our inspection we observed that most people who were sat in the lounge areas were asleep and did not receive meaningful interactions from staff. People told us they had taken part in a 'Good old days' sing song the day before our visit. A mini bus was available for use by people and this was used for transporting people to day care, hospital appointments and outings. One person told us they went shopping and would be going at Xmas to see the lights in town. Another person said they went to the local pub supported by staff. A person told us, "We normally have communion here, it's well attended, Tuesday is bingo, Friday is quiz, it brings us into the same room."

The care records we looked at did not always detail people's past life experiences. Information such as this is important because it helps staff to understand what activities people have previously enjoyed and try to offer similar experiences. The registered manager told us that they were considering the best approach to complete the care records about people's previous experiences as it was not always successful when asking relatives to complete these and some people did not have relatives who could assist with the completion of these. People had access to church services and we saw that any specific cultural wishes were recorded in care records.

Assessments had been completed on admission to ensure that the home could provide the appropriate care to people. Care records included personal care support plans and detailed people's choices. For example, a record detailed the carer that a person preferred to provide assistance with their personal care.

People were supported to maintain their skills as they wished, for example, one person administered their medicine themselves and they were supported to do so. This was recorded in the care record and care provided as the person chose. Care plans had been reviewed and updated with people who used the service.

Relatives told us that they felt welcome at the home and that they were encouraged to visit so that relationships were maintained. Staff told us that they sometimes provided support to people so that they could visit their relatives. Where relatives liked to be involved in providing care to their family member this was detailed in the care record. For example, one family member who often came in the morning liked to be involved in providing their family members personal care.

A complaints policy and procedure was in place and on display in the foyer area. At the time of our

inspection there were no ongoing complaints. The complaints procedure was only available in a written format. This could result in a lack of accessibility to people with poor reading skills. Complaints were monitored for themes and learning.

Requires Improvement

Is the service well-led?

Our findings

A system was in place for checking the quality of the service and making improvements to the quality of care. Where checks had been carried out we saw that action plans were in place. However the audit process had not identified issues which we found during our inspection, for example, incomplete identification sheets in the MARS and gaps in risk assessments.

People felt the home was well run and told us all of the management team were approachable. The registered manager had a good understanding of people's needs and personal circumstances. However they were not aware of some of the issues we raised during our inspection such as people's concern about emotional support and feeling that staff did not have time to spend with them. Although there was an open culture within the home the philosophy of care was was not focussed around people's emotional needs because staff were busy with physical care tasks.

The home had met the Gold Standard Framework for palliative care and had maintained this over a three year period. This is a national standard in the provision of care for people at the end of their life. The home was also involved in a pilot project with community health services. The project involved working with the district nurses. Nursing staff employed by the home provided treatment and care to people who would usually have received this from the district nurses. The registered manager told us that this meant that people were not waiting for a visit from the district nursing service and could have their care at a more convenient time. For example staff were carrying out checks on people's skin condition and insulin injections. As part of the project nursing staff liaised with the district nursing service to ensure that appropriate care was provided to people.

A member of staff told us, "The manager is supportive and innovative." Staff understood their role within the organisation and were given time to carry out their role. They said they felt supported in their role and that staff worked as a team in order to meet people's needs. Staff and relatives told us that the registered manager and other senior staff were approachable and supportive. Staff said that they felt able to raise issues and felt valued by the registered manager and provider. They told us that staff meetings were held and if there were specific issues which needed discussing additional meetings would be arranged. A member of staff said, they thought the staff meetings were useful because you got to say what you thought.

The service had a whistleblowing policy and contact numbers to report issues of concern, were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed and felt able to raise concerns and issues with the registered manager. The provider had informed us about accidents and incidents as required by law.

Resident and relatives' meetings had been held on a regular basis. We saw from the minutes of a meeting held issues such as meals and activities had been discussed. Where issues had been raised actions had been taken to resolve these. For example, concerns had been raised about car parking availability for relatives when they visited and we saw an incentive scheme for staff had been put in place to reduce the number of staff cars parked at the home. If staff shared a car the registered provider contributed towards the cost of

petrol.

Surveys had been carried out with people, their relatives and professionals in July 2016. However at the time of our inspection the outcomes were not known. Surveys were in a written format and may have been difficult for some people with dementia or sensory issues who lived at the home to access and complete.