Care Quality Commission

Shaw Healthcare (Wraxall) Limited

The Granary Care Centre

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

Overall summary

This inspection took place on 11 November 2014 and was unannounced. Our last full inspection took place in June 2013. At that time we found two breaches of regulations. We found that activities did not fully meet the needs of people living with dementia and also that staff did not receive adequate supervision and specialist training in dementia. We returned to the service in October 2013 and found that action had been taken to meet these regulations.

The Granary Care Centre provides care for people living with dementia. Within the home there is a unit called Crofter's Lodge for people with complex needs. Crofter's Lodge can provide treatment for people detained under the Mental Health Act 1983. At the time of our inspection there were 52 people living in the home.

There is a registered manager in place at the home. 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.

Summary of findings

We found that the service was not always safe. At the time of our inspection there were significant staff vacancies amongst both care staff and nurses and high use of agency staff. This meant that people in the home did not benefit from the continuity of care that a stable and permanent care team would provide.

The systems in place for managing people's medicines were safe and the administration of medicines was recorded on suitable charts. People's medicines were stored securely.

We found there were areas of the home that required further attention to ensure people were fully protected from the risks of cross infection.

People were not able to speak with us directly about how safe they felt in the home. However people appeared settled and at ease in the presence of staff. Staff had received training in safeguarding adults and demonstrated awareness of their responsibilities to protect people from the possibility of abuse.

Staff told us they were well supported in their role and received regular supervision and training. This included training in key areas such as moving and handling, fire safety and safeguarding adults. Staff commented on positive changes that had occurred in the home as a result of recent specialist training in dementia.

Staff were aware of the Mental Capacity Act 2005 and in some cases had applied the principles to decision making on behalf of people who weren't able to make the decision for themselves. However we also saw examples of where relatives had provided consent to the use of bedrails. This was not in line with the principles of the Act and did not demonstrate that the person's best interests had been considered or a less restrictive option sought.

People were protected against the risks of malnutrition because their weight was monitored and action taken when concerns were identified. We saw evidence that the advice of healthcare professionals was sought when necessary. For example we saw that guidance provided by dieticians and speech and language therapists was kept on file and people could see their GP when necessary.

People in the home did experience staff that were caring and considerate in their approach, however this was not consistent. We saw some occasions where staff interacted with people in a way that was not respectful and considerate of the person's feelings.

When people weren't able to discuss their views on the care they received, relatives and representatives were included where possible. Staff took account of the person's views by interpreting their behaviours and actions as an indication of their wishes.

We saw examples where people were being cared for in a way that was fulfilling and met their personal wishes. However, not everyone received care that met their individual needs. There were activities available in the home but not all staff supported people to be engaged with these. This meant people experienced significant amounts of time when they were not supported to be involved in activities that reflected their individual interests.

There were systems in place to monitor the home's performance and this included monitoring accidents and incidents within the home to identify any trends and take action accordingly. However, we identified breaches of regulation during our inspection and this meant that quality monitoring processes were not fully effective in identifying concerns.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

There were significant levels of staff vacancies which meant that people weren't able to benefit from a consistent and stable staffing team.

People were protected from the risks associated with medicines, there were systems in place to ensure that they were stored and administered safely.

Staff had received training to help them protect people from the possibility of abuse.

Not all areas of the home were cleaned to a satisfactory standard.

Risk assessments were in place to ensure that people were cared for in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not fully protected in line with the Mental Capacity Act 2005.

Staff received support and training to support them in carrying out their roles.

People were protected against the risks of malnutrition because their weight was monitored and support was sought when necessary from other healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed a number of staff interactions with people in the home. Many of these were kind and considerate, however on some occasions people were not treated with respect.

When people were not able to make decisions about their own care and treatment, the view of family and friends were considered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not fully supported to engage in activities that met their individual needs and preferences. People were not always supported in a way that met their individual needs.

There was a system in place to manage and respond to complaints.

Summary of findings

Is the service well-led?

Requires Improvement

The service was not always well led.

There were some systems in place to monitor the quality of the service, however these were not fully effective. This meant people were not always receiving care that met their needs.

The home was working towards accreditation with an organisation that specialised in the care of people living with dementia.

The Granary Care Centre

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 checked 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 11 November 2014 and was unannounced.

The inspection team was made up of three Inspectors and a Specialist Advisor in the care of people living with dementia and mental health. A Specialist Advisor has specific qualifications and experience relevant to the service being inspected.

Prior to the inspection we reviewed information about notifications, safeguarding adults concerns and complaints. Notifications are information about specific important events the service is legally required to send to us.

During our inspection, we made observations about the care people received and carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Many people were not able to speak with us directly about their experience due to the level of their dementia.

During our inspection we spoke with 15 members of staff, including a psychiatrist, nurses, care staff and auxiliary staff. We spoke with three relatives and one person who used the service. We reviewed 10 people's support plans and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

The registered manager told us that they were currently having difficulty recruiting staff to the home and were relying on agency staff to ensure staffing was maintained at the expected levels. This meant people were not able to benefit from a consistent and established staffing team with whom they could build positive relationships and who understood their needs. At the time of our inspection, we were told there were 16 vacancies for care staff and there were four staff waiting to begin their induction. In addition to this there were three vacancies for nurses across the home. This could impact on the continuity of care for people, particularly those living with dementia where routine and familiarity is important.

We found improvements were required to ensure the home had clear systems in place to ensure that people were fully protected against the risks of cross infection. The home was situated over three levels with kitchenettes on all levels. All were used to serve cold foods for example, cereals and had the facility to re-heat foods and serve toast. Hot foods were brought up from the kitchen. Foods which had been opened and which were stored in fridges and cupboards did not have the date of opening. For example, we found opened milk products within the cupboards with no date of opening.

We observed the housekeeper cleaning the three levels throughout the day using the correct personal protective equipment (PPE). Staff told us they had a daily allocated list of areas to clean. We saw staff using colour co-ordinated mops defined for specific areas. Most areas in the home were cleaned to an acceptable standard; however there were areas that required further attention. In Crofter's Lodge, there were areas of the corridors and bathrooms that were not cleaned satisfactorily.

Staff had received training in how to protect people from potential abuse and felt that the training was sufficient to support them in protecting people in the home. Staff told us about the signs of abuse and how they would report any concerns to the manager or senior staff. There was a safeguarding adults policy in place. People in the home weren't able to speak with us about how safe they felt, however people appeared settled in the presence of staff and accepted physical reassurances from staff, such as arms being placed around their shoulders.

We looked at the medicine records of 18 people. Medicines were stored and accounted for safely. Each area of the home had cupboards for the storage of people's medicines and a medicines trolley so that they could be administered safely. There were fridges for the storage of certain medicines with temperatures accurately recorded each day. Records were kept on medicines that were received in to the home and those that were unused and disposed of. There was list of homely (over the counter) remedies approved by the GP which was updated annually and signed by senior staff. We checked the stock of controlled drugs and found that they were as expected.

There was guidance within the records for the administration of 'as required' (PRN) medicines and medicines which were in packets. This meant people were protected because staff had clear information to follow. We looked at the medicine administration records of 18 people and they were completed accurately.

We observed staff re-visiting people who had declined to take their medicines throughout the day. There were no clear guidelines in place for staff as to how often they should re-visit and when they should report the medicines as having been 'refused'.

Staff told us people's needs were assessed prior to accessing the service. We saw completed risk assessments which included the use of specialist equipment for example, motorised wheelchairs.

We recommend that general hygiene and cleaning in the home is reviewed to ensure it meets the standards set out in current guidance, such as that produced by the Health Protection Agency throughout the home.

Requires Improvement

Is the service effective?

Our findings

We discussed the Deprivation of Liberty Safeguards (DoLS) with the registered manager. DoLS provides a framework to deprive someone of their liberty if it is in the person's best interests and necessary to keep the person safe. Authorisation had been provided for some people in the home and other applications had been made. The registered manager had prioritised the applications in light of recent changes in guidance relating to who would need an authorisation in place. This meant the rights of people in the home were being considered and respected.

Where people were not able to make decisions for themselves about the care and treatment they received, we saw some evidence that staff in the home were aware of the Mental Capacity Act 2005. However this was not yet fully embedded in to practice. For some decisions, we saw that a mental capacity assessment had been made and a best interests decision documented to ensure that a person's rights were respected and their wishes considered. However in some cases, we saw that consent had been sought from a family member. Where bed rails were in place, a mental capacity assessment was not always carried out when the person might not be able to give their consent. A relative was asked to sign their consent form instead. This is not in line with the Mental Capacity Act code of practice and did not demonstrate that any other less restrictive options had been considered.

This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they felt well supported to carry out their roles. Staff said they received regular supervision and appraisals and this provided opportunity to review their training and development. The provider ensured that new staff employed at the home completed an induction training programme that encompassed periodic supervisions. Staff we spoke with had completed the induction and felt the training programme prepared them for their role.

The training record for the home showed the training that staff had completed and when this needed to be refreshed. This included a range of topics such as infection control, health and safety and safeguarding. Staff told us that they had also completed 'dementia matters' training and felt positive about the changes that had occurred as a result of this. One member of staff told us for example that the home had recently become much friendlier and "less clinical".

People's support files showed staff received guidance from other health professionals when necessary. For example, on one person's file advice had been sought from the speech and language therapist to support the person in being able to eat their meals safely. We also noted that the advice of a dietician had been sought and recommendations made about nutritional supplements.

People were protected from the risks of malnutrition because their weight was monitored regularly. The risks of people being inadequately nourished were assessed using a standard tool and action taken when this identified that the person may be at risk. For example, we saw that weight loss was discussed with the person's GP and care plans updated accordingly when advice was provided by other professionals.

At the lunch time meal people were given a choice of meals that were presented to them on a tray. This helped the person make a choice about what they wanted to eat. Although we found that this practice was not in place across the all areas of the home. People didn't always have cutlery and crockery available that met their needs and helped them to be independent. For example, we saw one person who was attempting to eat their meal with the handle of their cutlery. We also saw that people did not have plate guards in place to help them manage the food on their plate.

In another area of the home, we saw one person who was seated at the table with a meal placed in front of them. They made no attempt to eat it until 15 minutes later when a member of staff was available to sit next to them to support them. By this time the meal was cold and staff needed to warm it in the microwave. Another person was asked to sit at the table ready for their meal, however this didn't arrive for a further 15 minutes by which time we saw they were becoming upset about the situation. This meant that not everyone had a pleasant experience during their mealtime.

Food and fluid records were kept for people for whom there were concerns about their nutritional intake. Accurate recordings were made about the amount of food and fluids people had. This helped staff monitor how well

Requires Improvement

Is the service effective?

people were being supported nutritionally. We did find that on occasion fluid totals for the day had not been calculated which meant that it would be difficult for staff to monitor people's fluid intake effectively.

Where necessary, specialist diets could be catered for such as a gluten free or a diabetic diet. People's preferences, likes and dislikes were recorded in their support plans. This helped to ensure people were provided with a diet they enjoyed and met their needs. One relative who came to visit on a regular basis told us "the quality of food is excellent".

We recommend that people's experiences at mealtimes are reviewed to ensure that their needs are fully met and reflect current best practice.

Requires Improvement

Is the service caring?

Our findings

Staff did not always respond to people in a way that met their individual needs. For example, we observed one person being encouraged to get ready for their lunch time meal. This person was holding flowers and clearly wanted to keep hold of them. A staff member removed the flowers from the person in order to be able to place cutlery on the table. The person appeared upset which suggested they would have been happier if they'd been allowed to hold the flowers whilst staff made preparations for lunch. This demonstrated that staff were focused on the task of getting ready for the lunch time meal rather than the feelings of the person concerned.

We saw one staff member approach another person to suggest that they get changed out of their night clothes. When the person refused, the member of staff walked away with an audible sigh demonstrating that they were frustrated with the person. One member of staff also referred to a person as having been "toileted". This language does not reflect an individualised approach to care. These observations suggested that people were not always treated with dignity and respect.

This was a breach of regulation 17 of the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Overall staff interactions were mixed. We saw some examples of people being treated with affection by staff and being spoken with in a kind and pleasant tone. One person for example, asked a member of staff for a bowl of ice cream and the member of staff went to get this for them straight away. During our visit we also observed a member of staff hold a person's hand to offer reassurance during a two minute silence for armistice day.

Relatives and people in the home gave positive feedback about the care provided. Comments included staff are; "very kind, nothing is too much trouble", and; "staff will tell me what my options are and I decide what I want to wear". We also heard staff paying people compliments, for example about their hair looking nice. This meant that people did experience positive relationships with staff, however this was not yet consistent and attitudes and practices varied amongst staff.

Not everyone in the home was able to express their opinions or wishes about the ways in which they wanted to be cared for, however we saw examples of where families were involved and processes were followed to ensure that the person's best interests were considered. For example, we saw a documented decision about a particular aspect of one person's care where the views of family had been sought in reaching the decision. The person's own behaviours had also been considered in informing the decision making process. In the Crofter's Lodge area of the home, we observed people being treated with kindness and respect. One person had made a particular choice about their appearance and staff had respected this.

Relatives and friends were able to visit the home and support with meals for example. One person told us that they visited the home on a regular basis to have their lunch time meal with their relative. This meant that people were supported to maintain relationships with people that were important to them.

Requires Improvement

Is the service responsive?

Our findings

Not everyone's individual needs were met. One person who was at risk of pressure ulcers had been seated in one of the lounges for several hours. We checked with staff to see if this person had been supported to reposition during this time. Staff told us that the person would be supported with their continence needs and at the same time would be supported to reposition. At the time we checked with staff it was 3.00pm and we were told that the person had been in the chair since getting up in the morning and hadn't yet received support with their continence or repositioning. This meant that this person's individual needs were not being met.

There was a team of people in the home responsible for providing a programme of activities. This included two activities coordinators and an occupational therapist. The programme of activities was displayed in the home and included things such as music workshops, arts and crafts and 1-1 sessions.

One of the activity coordinators told us they had worked to make areas of the home in to environments to provide sensory stimulation. One was a seaside theme with a beach hut, donkeys, sand castles, and mermaid which had been painted on the walls. There was a stand that had buckets and spades. Staff could take these things to people or people could come and sit and talk to staff about their associated memories.

We were told it was difficult to engage the whole staff team in supporting the activity programme. We observed that there were activities available, such as bags of items for people to explore but we did not see staff encouraging people to use them. We spoke with the registered manager who agreed that activities suitable for the needs of people with dementia were not yet fully embedded or seen as the responsibility of the whole staff team to encourage. This meant that people did not always have access to activities that met their individual interests and preferences.

The support of one person in relation to their risk of developing pressure ulcers and also the lack of support for people to be involved in activities meant there was a breach of regulation 9 of the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was information available in people's care files to help staff care for them in a way that treated them as individuals with their own likes and preferences. For example, people had information in their files entitled 'about me', which provided details about the person's life before moving in to the home and important events. We observed one person in the home who was keen to help staff by folding clothes in the laundry and helping with the washing up. Staff supported the person to carry out these duties whilst also monitoring their safety. This enabled this person to spend their time in a way that was fulfilling and met their individual needs.

People had support plans in place for a range of their care needs that included aspects such as their mobility, nutrition and communication. These plans were reviewed regularly to ensure that they were current and reflective of people's needs. We saw examples of where care plans had been updated following a change in a person's situation.

Complaints were handled in line with the provider's policy. Initial complaints were dealt with by the registered manager. If they were unable to deal with the person's concerns satisfactorily, they would be directed to the relevant service. If the person still had concerns, they would be advised how to make a formal complaint.

Relatives told us about the relatives meetings that they attended and told us they felt able to raise any issues or concerns.

Requires Improvement

Is the service well-led?

Our findings

the inspection we asked the registered manager to send us information about the home's quality assurance systems and how this had led to improvements in the home. At the time of writing this report, the information had not been received and therefore we did not have the full information about how the registered manager was monitoring the performance of the home. However we did find breaches of regulation during our inspection which demonstrated that the quality monitoring systems were not fully effective in identifying breaches of regulations.

This is a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said the service was well-led and the registered manager had a visible presence in the home and was approachable. We saw the registered manager openly engaging in conversation with people and staff. Staff told us they felt they could ask for assistance or guidance at any time.

Staff told us they felt able to raise concerns. The provider had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. The policy made it clear that it was not an option to do nothing if staff had concerns. Staff were aware of different organisations they could contact to raise concerns, for example, care staff told us they could approach the local authority or the Care Quality Commission.

The provider had arrangements for reporting incidents which included behaviour that challenged other people and accidents. The registered manager told us they reviewed every reported incident or accident. The supporting records showed that incidents and accidents had been reviewed to establish any trends and to see if any action could be taken to reduce the risk of reoccurrence. We looked at the provider's analysis of incidents over a two month period which showed no trends in the reported incidents. Staff said they had received feedback from incidents and knew how to report incidents. This meant that the provider was open and transparent and able to learn from previous experiences.

The home is a service for people with dementia and so we spoke with the registered manager about how they were working to achieve best practice in the field. We were told that the home were working towards accreditation with the Dementia Care Matters – Butterfly Project. This is a programme that provides specialist support and training for homes that care for people living with dementia. The registered manager told us about some of the learning from this project and how this was being implemented. For example we were told that in their interactions with people, staff were being encouraged to avoid questions that required a specific answer and instead make comments. During our inspection we observed for example, staff commenting that people's hair looked nice that day. This showed that learning from this programme was being implemented.

The registered manager also told us about changes in the environment of the home that had taken place to make it more pleasant and suited to the needs of people living with dementia. We saw that where there had previously been nurses stations, these had been made in to sensory areas that providing a pleasant visually stimulating environment.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People's rights were not always protected when making decisions about their care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **2(a) People were not always treated with dignity and respect**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **1 (b) (i) People did not always receive care that met their individual needs**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **10 (b) The systems in place for monitoring the quality and safety in the home were not fully effective in identifying breaches of regulation**