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** |

# Summary of findings

## Overall summary

The Granary Care Centre is a service which provides personal and nursing care for up to 78 people who are living with dementia. Within The Granary Care Centre is a unit called Crofters Lodge for people with complex needs. Crofters Lodge can provide treatment for up to 18 people detained under the Mental Health Act 1983. At the time of our inspection seven people were living at Crofters Lodge.

At the last comprehensive inspection on 10, 11 and 13 October 2016, the service was rated Requires Improvement.

This responsive focused unannounced inspection on 21 August 2017 was prompted by information of concern. We had received information about people's safety within Crofters Lodge. This included information relating to staff training, staffing levels, record keeping, risk assessments and care planning. This inspection focused only on Crofters Lodge. This report only covers our findings in relation to this area. You can read the report from our last comprehensive and focused inspections, by selecting the 'All reports' link for 'The Granary Care Centre' 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. Each manager was responsible for a number of services.

At this inspection we found the service remained Requires Improvement.

Staffing levels at the service were not always adequate and fell below what the provider had deemed safe. People were also supported by agency staff who could be unfamiliar with people's individual needs.

Personal evacuation plans were in place but were not always accurate and up to date. These records which could be used in the event of an emergency contained different information and duplicate copies.

Risk assessments were completed and were being updated by the provider to ensure they were reflective of people's assessed needs. The environment and equipment viewed during the inspection was safe.

We found two breaches 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 this report.

Further information is in the detailed findings below.

## 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. Staffing levels were not always adequate to meet people's needs. There was inconsistent staffing levels and people could be supported by people who were not familiar with their individual needs.

Personal evacuations plans were not always current and up to date.

Risk assessments were in place and incidents and accidents were reported. The environment and equipment viewed during the inspection was safe.

We could not improve the rating for this key question from requires improvement. There are additional areas for improvement required under this key question. In addition we would require a record of consistent good practice over time. We will review our rating for safe at the next comprehensive inspection.

# 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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a responsive focused unannounced inspection of Crofters Lodge, part of The Granary Care Centre on 21 August 2017.

The inspection was undertaken by one adult social care inspector and two mental health inspectors. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the information we had received was in relation to people's safety.

During our focused inspection we spoke with the registered manager, two quality managers, seven staff members, two people who used the service and one relative. We looked at six people's care and support records. We also looked at records relating to people's safety such as incident and accident records, risk assessments, staffing rotas and safety checks.

Requires Improvement

# Is the service safe?

## Our findings

People were not always safe.

Before the inspection we received information of concern relating to staff training, staffing levels, record keeping, risk assessments and care planning.

During the inspection we received feedback that highlighted staffing as a concern. One staff member said, "Staffing levels are awful." A relative said, "Staffing is an issue, they are always changing. The staff are OK and on the whole they are doing a good job. The staff always know how my relative has been." We were told by one staff member, "People's general needs are met, the residents are safe but things do need to improve."

Crofters Lodge is separated into a male and female wing. Staffing levels had reduced due to the number of people now living at Crofters Lodge, which was seven people. The provider told us that staffing levels were four support workers and a nurse during the day. Two support workers were allocated to each wing and the nurse covered both wings. However, in the week before our inspection and on the actual day of our inspection staffing levels of support workers had fallen below the current level set by the provider, to three on two occasions. One staff member said, "Staff levels are frequently not met." This could be unsafe due to the level of support some people required. For example one person's care record stated, 'Requires assistance from a minimum of three staff members during any personal care interventions.' Which meant that if staffing levels were not at the level deemed safe by the provider there would be no support workers available to support other people.

People were often supported by agency staff. In the previous three days to our inspection 40% of the total staffing within Crofters Lodge comprised of agency staffing. There was a high reliance on agency staff for both nurses and support workers. It was evident from reviewing the previous seven days rotas that all of the nurse's day shifts had been filled with agency staffing. Agency staff were block booked to try and ensure they were familiar with the service. Whilst staff spoke highly of the majority of agency staff employed, staff told us that it did not create a team approach or a good staff morale. For example, the keyworker system was not effective as there was not enough permanent staff to implement it. Each person should have an allocated keyworker who ensures particular parts of their care and support are met. Keyworkers aim to develop positive relationships with a person's friends and family so they can be an additional point of contact.

Staff told us that staff retention was poor. Staff said that due to a high rotation of staff members this meant that people did not have time to develop lasting relationships with staff. Some staff we observed knew people well and had developed positive relationships. For example, one staff member offered choices of food they knew would appeal to a particular person. However, another staff member was speaking to a relative about a person's hairstyle and was not aware how the person had usually styled their hair even though photographs of this was contained in the persons care record. Staff turnover statistics held by the provider were not viewed. People did not always have familiar staff members around them, which could impact on their behaviour and support needs. For example, for health appointments or during personal care. Due to the staff team mix there was not always an experienced staff member to mentor and support

newer staff members when they started their role. Changes in leadership and senior staff meant there was not consistent support or oversight available. For example, we looked at an instance of staffing levels falling below the level the provider deemed safe. The provider was unaware of the situation nor did the records accurately document this instance. The provider was aware that staff retention was poor. They were actively recruiting for vacant posts. They had also facilitated a bus service to the centre of Bristol at the beginning and end of shifts to try and attract and retain staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal evacuation plans were in place but were not always current and up to date. Personal evacuation plans described the amount and type of support a person would require in an emergency situation. For example, their mobility, communication needs and the type of mobility equipment they would require. However, we found that this information was not current or up to date. There were two different versions of an emergency procedure document located at the entrance to Crofters unit one updated in April 2016 and the other dated September 2016. Both contained personal evacuation information about people who were no longer living at the service. In addition, the staff details were not current. For example, there were staff members who no longer working at the service listed. We highlighted this to the registered manager who said it would be addressed as a priority.

People's care files had a copy of personal evacuation plans however these records were inconsistent and contained information that was different to those located in the emergency file. For example, in one person's care file we found duplicate personal evacuation plans completed on the same date but recorded by two different agency staff members. The information contained was different in each. For example, one said that the person had, 'capacity into understanding and responding to a fire'. The other record said they did not. Staff told us that personal evacuation plans did not always reflect people's actual need. For example, the time stated in the personal evacuation plan to ensure a person was in a place of safety. This meant personal evacuation plans were not always recording up to date and accurate information relating to an emergency situation.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place that gave staff information relating to any individual risks. This included areas such as risky behaviours, ligatures, falls, and manual handling. The provider had identified in a recent audit, discrepancies in the information held in people's care records. For example, information did not reflect the person's current support needs. In addition the care records were not well organised and had a large amount of documentation that staff, in particular non-permanent staff, would find difficult to find information that they required. The provider was in the process of rectifying this issue and we saw several examples of the changes being made to the care records.

People were supported by staff who had received an induction and training. Mandatory training included areas such as fire safety, moving and handling and safeguarding adults. People living at Crofters Lodge had complex needs and could sometimes display behaviour that may be viewed as challenging. Staff had not always received training in areas that would sufficiently support people to meet their needs safely. Staff told us they received training in dementia but no training in mental health. One staff member said, "Training in mental health needs to mandatory. Else staff don't have the understanding of people's behaviour." The provider said staff training would be reviewed.

The provider had supported some staff to attend training in the management of behaviour that may be viewed as challenging. Called, 'Non-Abusive Psychological and Physical Intervention' (NAPPI). Not all staff were trained in NAPPI as the provider had not considered it necessary due to staff not undertaking physical interventions. However, a recent audit indicated this was not the case for one person and therefore the provider had arranged two NAPPI training days in September 2017. We saw documentation showing that staff members were enrolled in this scheduled training.

The environment was easy for people to move around and people had access to a secure garden. General risk assessments were in place to minimise risks in areas such as water, security and electrical equipment. An environmental risk assessment was in place but was not very detailed. We did highlight some maintenance areas in the communal bathrooms. The registered manager said both these items would be addressed.

The environment was clean and odour free. Cleaning records showed the service was regularly cleaned and maintained. Equipment such as bath hoists and mobility equipment were regularly checked and serviced. Staff told us that equipment they required was in good working order and any repairs required were carried out promptly. Regular checks of fire safety equipment were conducted.

Incidents and accidents were reported. Staff were clear on their responsibilities to report and records incidents and accidents. Incidents and accidents for Crofters Lodge were not separated from The Granary Care Centre as a whole. Therefore it was difficult to analyse incidents and accidents particular to Crofters Lodge. A monthly report of incidents and accidents had not been completed. We viewed records of one person who had an incident where physical intervention had been used. A form the provider required for this type of incident had not been completed. This form is used to ensure this type of incident is effectively managed.

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>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (2)(c)<br><br>People did not always have up to date and accurate records relating to personal evacuation plan in case of an emergency. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 (1)<br><br>The provider had not ensured a sufficient number of staff experienced at the service were deployed to safely meet people's needs. |