Gracewell Healthcare Limited

Gracewell of Fareham

Inspection report

7 Parker View
Fareham
Hampshire
PO16 0AF

Tel: 01329558700

Date of inspection visit:
04 October 2016
05 October 2016

Date of publication:
17 February 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 4 October 2016 and 5 October 2016. It was unannounced. At our previous comprehensive inspection in November 2015 we found breaches of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We gave the service an overall rating of inadequate, placed the service in special measures and served warning notices requiring the provider to make improvements in three areas where people were most at risk. These were making sure people were protected against the risk of avoidable harm and abuse, making sure people received care and support that met their needs, and making sure records of people's care were up to date and accurate. We returned to follow up the warning notices in May 2016. We found the provider now had effective processes in place to protect people against abuse and avoidable harm. Some improvements had been made in the other two areas. However, the provider was not fully meeting the requirements of the regulations. The provider sent us an action plan showing how they intended to meet the requirements of the regulations.

At this inspection we found the service had continued to make some improvements. It was no longer rated inadequate in any key area, and was therefore removed from special measures. Further requirements were, however, necessary and we found continuing and new breaches of the regulations.

Gracewell of Fareham is registered to provide accommodation, nursing and personal care services for up to 89 older people and people who may be living with dementia or a physical disability. At the time of this inspection there were 78 people living at the home. They were accommodated in a purpose built building consisting of three floors and six bungalows for people with greater independence. The ground floor accommodation was intended for people with less complex needs, people living with dementia were supported on the first floor and the second floor accommodated people with other, more complex nursing needs. Each floor was divided into two named wings. Each wing had a shared sitting and dining area and each floor had a larger, central shared area. The ground floor had a hair dressing salon and cafeteria area.

The service had been without a registered manager since January 2015. 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. Although the provider had appointed experienced managers to manage the improvement plan, none had been registered for this service. One of these had started the process to register with us, but had recently be reassigned by the provider to manage one of their new homes. We refer to this manager as "the previous manager" in this report. A new home manager had been appointed. They had also started the registration process. We refer to the current home manager as "the manager" in this report.

The provider did not always make sure there were sufficient numbers of suitably qualified and experienced staff available to support people safely.

Recruitment processes were in place to make sure the provider only employed workers who were suitable to

work in a care setting. The provider had arrangements in place to protect people from the risks of avoidable harm and abuse. Some risk assessments were not individual to the person at risk, and staff did not always make sure people were safe when using their wheelchair. There were arrangements in place to store medicines safely and administer them safely and in accordance with people's preferences.

Staff received appropriate training to maintain and develop their skills and knowledge to support people according to their needs. However they were not always supported to carry out their duties by means of formal supervision and appraisal.

Staff were aware of and put into practice the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to maintain a healthy diet. People were supported to access healthcare services, such as GPs and specialist nurses.

Care workers and nurses had developed caring relationships with people they supported. People were encouraged to take part in decisions about their care and support, and their views were listened to. Staff respected people's independence, privacy, and dignity.

The provider did not always maintain records of people's care that were accurate and up to date. This meant the service could not demonstrate that people always received appropriate care and treatment that met their needs and reflected their preferences.

People were able to take part in leisure activities which reflected their interests. People were aware of the provider's complaints procedure, and complaints were managed and followed up.

Where significant incidents affect people's care and support, the provider did not always notify us as required by the regulations.

The home had an open, welcoming atmosphere. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided, although some of these were affected by the poor quality of records they relied on.

We identified one breach of the Care Quality Commission (Registration) Regulations 2009, and two continuing breaches and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we told the provider to take at the end of the full version of this report.

We also made a recommendation about improving risk assessments.

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.

People were not always supported by sufficient numbers of staff, although the provider carried out recruitment checks to make sure workers were suitable for work in a care setting.

People were protected against the risks of abuse and avoidable harm. We identified improvements to be made in the way the service managed other risks to people's safety and wellbeing.

People were protected against risks associated with medicines because processes and risk assessments were in place to make sure staff administered and stored medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always supported by an effective system of supervision and appraisal to care for people according to their needs.

Staff received appropriate, timely training.

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

People had developed caring relationships with their care workers.

People were able to participate in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not demonstrate they received care and support that met their needs and took account of their preferences.

People were able to participate in leisure activities in line with their interests and choices.

There was a complaints procedure in place, and complaints were dealt with professionally.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's care records and other records were not always complete and consistent. The provider did not always notify us of significant incidents which affect people's care and support.

A management system and processes to monitor and assess the quality of service provided were in place.

There was an open, welcoming culture in which people were treated as individuals and could speak up about their care and support.

Gracewell of Fareham

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 4 October 2016 and 5 October 2016 and was unannounced. The inspection team consisted of three inspectors 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. On this inspection the expert by experience had experience of caring for family members who used various care services.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the 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 improvements they plan to make.

We spoke with 11 people who lived at Gracewell of Fareham and five visiting relations. We observed care and support people received in the shared area of the home, including part of a medicines round.

We spoke with the current and previous home managers, the provider's director of operations, the deputy manager and other members of staff, including an administrator, two nurses, two senior care workers, three care workers, the head chef, a catering assistant and an activities coordinator. We also spoke with other staff members who could help with individual questions about people's care and support.

We looked at the care plans and associated records of eight people. We reviewed other records, including mental capacity assessments, authorisations under the Deprivation of Liberty Safeguards, safeguarding records, the provider's policies and procedures, internal checks and audits, quality assurance survey returns and analyses, training and supervision records, call bell records, meeting minutes, staff rotas, and

recruitment records for seven staff members of staff.

Requires Improvement

Is the service safe?

Our findings

When we inspected Gracewell of Fareham in November 2015 we had concerns that people were not safe because procedures to protect people from the risk of avoidable harm and abuse were not followed. We issued a warning notice requiring the provider to meet the requirements of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by March 2016. We also found risks to people's safety and welfare were not identified and assessed, there were not enough suitably skilled and experienced staff to support people safely, and records relating to the administration of prescribed creams and ointments were incomplete. The provider sent us their action plan to show how they proposed to meet the requirements of the regulations in these areas.

We inspected again in May 2016 to follow up our warning notice with respect to Regulation 13. We found sufficient improvement had been made in this area and the provider was no longer in breach of this regulation.

At this inspection we found the provider had sustained the improvements we found in May 2016. The provider had made some improvement in other areas, although these were not always sufficient fully to meet the requirements of the relevant regulations.

At our inspection in November 2015 the provider relied heavily on agency staff who were not always skilled or experienced, or supervised adequately to support people according to their needs. The provider had started a recruitment programme to fill 500 hours per week. At this inspection we found the provider relied much less on agency staff. Where agency staff were employed, they were familiar with the home and the people living there. The provider made sure employed staff were distributed throughout the home so people were not supported only by agency staff. The provider was actively recruiting for another 138 hours which included vacancy and contingency.

The manager told us they normally had two nurses and six care workers on the top and middle floors during the day with a team leader and four care workers on the ground floor. At night there were two care workers on the ground floor, and two care workers with one nurse on each of the top and middle floors. The director of operations told us this was higher than the provider's standard staffing levels for a home the size of Gracewell of Fareham. This took into account the design and layout of the home, which was built with curving corridors with a shared lounge and dining area at each end of each floor. This meant it was difficult for staff to monitor people's needs from a central position on the floor.

All the people we spoke with told us the planned staffing levels were not always sufficient to support people safely, and there were occasions when the planned levels were not met. One person said, "I think they need more staff as lots of people need two carers to help with personal care and the hoist." Another person told us, "I think they are short of staff and people get left. Sometimes you have to wait a long time for help." A third person told us, "There are not enough carers as a lot of people need two people to help them. Last week there were a lot of carers away and there were hardly any carers here."

A person's relation told us when they visited recently there had been only two staff on their family member's floor, and one of the staff members was distressed because they were going to be on their own after 2pm. A visitor we spoke with during our inspection telephoned us a week later to say there had been two other occasions since our inspection when there had not been enough staff on the top floor. They said on the first occasion there had only been two staff present at the weekend. On the second occasion when there had been insufficient staff, they had raised their concerns with the manager who had reassigned a member of staff from another floor.

Staff members told us there were occasions when there were not enough staff on duty. One staff member said there had been staff shortages recently, but the week of our inspection was a "good week". Another staff member said there were "just enough" if the floor was fully staffed, but nurses had to help out, particularly at meal times. The manager told us they were aware there had been occasions when insufficient staff were deployed, in particular there had been one occasion the weekend before our inspection. This was mainly due to agency staff engaged to cover annual leave of employed staff not turning up on time. They had made arrangements for weekend management cover, which had not previously been in place, so that any future problems could be resolved promptly.

We saw staff acting in a calm, professional manner, but there were times when people with restricted mobility were left without staff contact for up to 20 minutes. We also raised concerns with the manager that people were left in wheelchairs for long periods. People with poor skin health are at risk of pressure injuries if they do not change their position regularly. If there had been more available staff they would have been able to assist people to move to a different chair or into their bed.

Failure to deploy sufficient numbers of competent, skilled and experienced staff at all times was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt safe living at the home. They told us they felt protected from the risk of abuse and from risks that might arise from the environment in the home. We saw people had their call bells within reach to summon help if required. One person said, "I feel safe. Having the call bell it is reassuring someone will come if I need them." Another person told us, "At night the staff will often come in and check I am ok and that makes me feel safe."

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. The responsibility to report any safeguarding concerns was emphasised in the employee handbook. Records showed 94% of staff were up to date with their refresher training in safeguarding adults. Training had been followed up with a group supervision on safeguarding adults and abuse. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the manager.

Senior staff were aware of processes to follow if there was a suspicion or allegation of abuse, although they were not confident they knew when safeguarding concerns should be notified to us. We discussed this during the inspection and explained the relevant regulation. Records showed safeguarding concerns had been followed up and reported to the local safeguarding authority. However of 19 safeguarding records, none had been recorded as "closed" and seven showed they had been notified to us. Of the remaining 12 we found two which met the criteria for notification.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with falls, behaviours that challenge, self-medication, and skin health. People's care plans contained

instructions for staff to avoid and manage risks. One person's falls risk assessment had been followed up with an assessment for bed rails to manage the risk of them falling from their bed. Records showed there had been a further risk assessment which had concluded this was the least restrictive way to keep the person safe. Checks that bed rails were in place were included in the records of regular checks staff made to support the person. Another person had been identified as being at risk of choking, and this had been followed up with their GP and a speech and language therapist. A third person was at risk of poor skin health. Their care plan included a regime of creams and regular support to change their position in bed. Records of checks made to support the person showed their care plan was carried out.

Some people had standard risk assessments for risks associated with bathing, showering, choking, the use of equipment when moving about the home, and activities in the garden. These assessments identified hazards, the person at risk, and measures to control the risk. Each risk was given a rating. However, these risk assessments were not individual to each person and did not take into account their personal circumstances and how the risk might affect them in a different way to other people.

Nurses and care workers were aware of risks associated with people's behaviours. They knew how to avoid possible triggers for behaviour that challenges, and strategies to support the person. These were individual to the person, for instance the use of classical music, soft lights and a quiet environment to help a person become calm again. The service used standard tools to assess people's risks of poor skin health and poor nutrition monthly. Systems were in place to identify changes in people's risk assessments.

However we saw examples of poor practice which exposed people who used wheelchairs to risk of injury. In one example the person was supported to move about the home in a wheelchair with no footplates in place. In two other examples, footplates were in place, but staff had not made sure the person was using them safely. This meant those people were at risk of injuring their feet and lower legs against the footplates.

We recommend the provider review risk assessments to make sure they are individual to the person and review risk assessments and staff practice and take appropriate action where people use wheelchairs to move about the home.

Procedures were in place to keep people safe in an emergency and reduce risks to their health. Staff were trained in fire safety and first aid. People had personal evacuation plans which assessed their needs in the event of an emergency evacuation. However, these personal emergency evacuation plans did not always include clear instructions for staff how to support the person in the event of an evacuation being necessary.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

Medicines were stored and handled safely. Suitable arrangements were in place for controlled drugs and medicines which needed to be kept below room temperature. The temperature of the refrigerator was checked regularly, the refrigerator and other storage facilities for medicines were cleaned regularly, and appropriate records were kept.

All the people we spoke with said their medicines were well managed by the staff and said they received their medicines on time. One person said, "We have them just after 8am, again at lunchtime and then tea. They always come at those times."

We observed part of a medicines round. Nurses observed suitable hygiene practices. They were aware how people liked to take their medicines and explained what they were for, and how many pills people needed to take. Where people were prescribed pain relief "as required" nurses checked if people were in pain, and if people declined their medicines, the nurses respected their wishes. Where people were not able to communicate verbally, there were pain assessment charts with information on how people might indicate they were in pain, for instance by holding their head. If people had over the counter, or "homely", medicines, staff checked with their GP to make sure they were safe to take with their prescribed medicines. Where people administered their own medicines, risk assessments were in place to make sure the person and others were protected against the associated risks.

People's medicine administration records, including those for prescribed creams and ointments, were accurate and up to date. Where people were prescribed creams and ointments "as required", records showed these were offered at the correct times. If the person declined them, staff updated the records to show they had been prompted but not required. At the end of shifts, nurses checked each other's records to make sure they were correct. The provider made sure records relating to people's medicines, including creams and ointments, were accurate and up to date.

Requires Improvement

Is the service effective?

Our findings

When we inspected Gracewell of Fareham in November 2015 we found staff did not always act in accordance with the Mental Capacity Act 2005. This meant people who lacked capacity were at risk of receiving care which was not in their best interests and of being deprived of their liberty without lawful authorisation. The provider sent us their action plan to show how they proposed to meet the requirements of the regulations in these areas.

At this inspection we found the provider had made improvements in this area and was no longer in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, but we found a new breach of regulation concerning supporting staff by means of supervision and appraisal.

People and relatives told us they thought staff were suitably trained to be able to meet their needs. One person said the staff "seemed very professional". One visiting relation told us, "I do think they are quite experienced as [Name] has to have a special brace applied to her legs from the physiotherapist and they always do it."

Staff were satisfied they received appropriate and timely training which helped them to support people according to their needs. They confirmed they had completed the refresher training which the provider considered mandatory. Induction for new staff was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The provider encouraged staff to work towards recognised qualifications.

The manager had an effective system for monitoring staff training. Records showed clearly where staff had completed training, where it was due and where it was overdue. These records were updated daily. They showed staff had completed 89% of the training identified for them, and mandatory refresher training was 100% complete.

However staff were less satisfied that they received appropriate support from management and senior staff in the form of formal supervision and appraisal. They told us they felt supported informally by their colleagues, and care workers said there was always a nurse available for advice and support. However the frequent turnover of managers and senior staff meant there was no consistency in formal support.

Formal supervisions were not carried out consistently. One staff member had five supervision meetings in the previous year, another staff member had three, and a third told us they had never had a supervision. There were no records of supervision in this staff member's file since they started work at the home in January 2014. None of the files we looked at contained a record of annual appraisal. Staff told us they were aware of other staff members who had not had a formal supervision since starting work at the home. They also told us, "Appraisals are lacking." Records showed 30% of staff were not up to date with supervisions.

Failure to make sure employees received support in the form of supervision and appraisal was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were in place to show most people had consented to their care and support at Gracewell of Fareham. Where people had agreed lasting or enduring power of attorney, copies of the appropriate records were on file. However we found two examples where people's families had signed on behalf of the person where there was no legal justification for them to do so, and the person had not been assessed as lacking capacity to make the decision themselves. One person's care plan stated that staff should give them time and not pressurise them when they needed to sign documents. Where people had made an advance decision to decline resuscitation in the event of heart failure, records showed this had been discussed with the person and their family.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed assessments of people's capacity followed the principles of the Act and its associated code of practice. Where people were assessed as lacking capacity, this was followed by a best interests process in which others, such as the person's family, were involved. Care plans took into account people's capacity assessments and best interests decisions. Assessments were specific to one decision, took into account that people's capacity might change with circumstances, and that people who lacked capacity for major decisions were still able to make minor decisions about their daily support and care.

Where people were at risk of being deprived of their liberty the provider had applied to the supervisory authority as required by the Act. Of the authorisation records we saw, two had applied conditions. One condition had been met and the other referred to a date in the future. People were protected against the risk of being deprived of their liberty unlawfully because staff understood and applied the principles of the Mental Capacity Act 2005.

People were supported to eat and drink enough and to maintain a healthy diet, although we received mixed reports about the quality of food and menus. One person described the food as "excellent" while another said, "It's not brilliant." One person described the food as "just like home cooking" while another said it was "dreadful quality".

The manager and staff were aware of people's mixed views. There had been a meeting for people living in the home with the chef where a number of concerns were raised. Staff were working through these where they were able to make changes. The provider set the menu for the home which was changed every three months. The chef said this was not to everybody's liking, but they were able to "bend it a bit" to respond to people's individual preferences. The chef said they would endeavour to source people's favourite juice and drinks and had introduced French pastries at breakfast.

The menu offered a choice of main courses with other alternatives including sandwiches or omelettes for those who did not like either of the main courses. We saw staff offering different alternatives to encourage people to eat. One person's relation said, "When we take [Name] out and she has missed their mealtimes, she is always offered something when we get back in the evening."

Where people were supported to eat, this was done sensitively and discretely. However staff did not offer to re-heat the meals of people who ate independently but slowly. One person told us they would have appreciated that, as it would make their food more palatable.

Where people had dietary requirements because of medical conditions or personal preferences, catering staff were aware of this, and were able to accommodate them. They were also aware if people were considered to be at risk of poor nutrition or wanted to lose weight. The information was available on colour-coded cards in the kitchen area.

People were satisfied they were supported to maintain good health. One person told us they had recently seen their doctor for a persistent cough. A visitor told us, "When my Mum first came here she didn't eat and she lost a lot of weight. The staff were excellent. They did everything to encourage her. We were very worried and they were always really quick to call the doctor in when we asked."

Records showed people were supported to maintain good health through access to other healthcare services. These included visits by and appointments with people's GP, district nurse, community mental health team, speech and language therapist and chiropodist. Where people had mobility difficulties staff consulted with occupational therapists. People had attended the local hospital for a respiratory out-patient appointment, and for x-rays scans and other tests when there were concerns about their health.

Good

Is the service caring?

Our findings

When we inspected Gracewell of Fareham in November 2015 we found staff did not always treat people with dignity and respect, which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us their action plan to show how they proposed to meet the requirements of the regulation in this area. At this inspection we found the provider had made sufficient improvements and was no longer in breach of this regulation.

People told us they thought the home provided a caring atmosphere. One person said, "There is a very helpful carer who always comes in and helps me move my legs at night." Another person told us, "When I first moved in here, straight from hospital, the nurses were very kind to me and helped me to settle in. It really helped me and made a difference." A third person we spoke with had a condition which sometimes caused incontinence. They told us, "The staff are sympathetic and realise I can't help it." A family member told us, "When [Name] was really ill ..., we wanted her to stay here because the carers were really good and looked after her so well."

We observed many positive, caring interactions between staff and people as they supported them. Staff were polite, used people's preferred names, explained what they were about to do, and made sure people understood and were happy for them to proceed. Staff chatted with people in a friendly manner while supporting them. People were confident to explain their needs to staff, and consequently received appropriate care and support. A visitor whose relation had recently come to live in the home, described their assessment as "like a breath of fresh air". They appreciated the way staff interacted with their relation and said, "They spoke to him like an adult".

Staff had introduced a named nurse and keyworker system. This had not been completed for everybody but where it was in place, people and their families knew who they could speak to if they had any queries or concerns. Staff had also started to collect photographs of people participating in leisure and hobby activities into individual albums. Where people were living with dementia this would help visitors know what the person had been doing and provide topics of conversation, making visits more rewarding for everybody.

People were encouraged to participate in and make decisions about their day to day care. Care plans included guidance such as, "Ensure you talk to [Name] explaining step by step procedure and gain consent." Care plans also gave staff guidance on how best to communicate with people. One person's plan stated, "Closed questions used to good effect". One person's end of life care plan showed that advance decisions had been discussed with the person and their family.

We saw staff offering people choices, explaining instructions and respecting people's choices. Staff asked people if they would like the TV on. When they declined, they asked if they would like the radio instead. We heard one care worker say, "Would you like to go to sleep or would you like lunch?" Staff checked if people were happy with their choices: "Is that nice?" and encouraged people to finish their meals, praising them with "well done" at the end. Staff also responded to non-verbal communication. For instance when they were clearing away at the end of a meal, a person put their hand out, and staff left their plate in case they

had not finished.

Staff respected people's privacy and individuality. They knocked on people's doors before entering their rooms, and explained why they were there. A nurse said, "Hi [Name]. I have just got your medication." We then heard them explaining the medicines to the person, and reassuring him where he had concerns. When another person came back to his room, a care worker explained, "I am making your bed. Is that OK?"

A visitor told us they were happy staff were respectful when supporting their relation with personal care. They told us it was done professionally, in a way that preserved the person's privacy and dignity. When another person called for help in a situation which could compromise their dignity, staff responded quickly to support them. Staff distracted the person, settled them in their room and brought them a cup of tea. One person's family had written to the manager saying, "Thank you for all the care you showed [Name] and her family. The respect and dignity with which you all treated her was very much appreciated."

Staff told us nobody living at the home had particular needs or preferences arising from their religious or cultural background. The care assessment process was designed to identify if people had relevant needs or preferences in this area and took into account people's spiritual and social values.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Gracewell of Fareham in November 2015 we had concerns that people did not receive care that was appropriate, met their needs and reflected their preferences. We issued a warning notice requiring the provider to meet the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by March 2016.

We inspected again in May 2016 to follow up our warning notice with respect to Regulation 9. We found some improvements had been made in this area but the provider was not fully meeting the requirements of the regulation. At this inspection we found the provider had made further improvements. However there were still some examples where people's care records were not accurate and up to date which meant we could not be certain they received appropriate care that met their needs.

The service did not always keep accurate and up to date records of people's care. Some people's care plans did not reflect their changed needs and conditions or contained contradictory information. One person was noted as having a grade two pressure injury, which had been photographed and measured. However their care plan for skin health did not reflect this or state how it should be treated. Another person who had been noted as losing weight had confusing information in their care plan, which stated they should be allowed to eat independently. However, our observations and discussion with staff showed they were not able to do this. Their daily notes showed they had not eaten a number of meals, but there was no follow up to these observations. Their daily notes also described incidents of behaviour which challenges, but there was no risk assessment or associated care plan to address these behaviours beyond a statement that the behaviours might relate to their diagnosis of a type of cancer. However there was no care plan associated with this diagnosis. Staff we spoke with were aware of these people's conditions, but we could not be certain they were receiving consistent and appropriate care because their care plans did not reflect their needs at the time of our inspection.

Some people's care plans contained "Who am I" information which recorded people's preferences, important people in their lives, their life history, hobbies, and things which upset or worried them. However, other parts of their care plans were not always written to reflect their needs as an individual. One person's consent and capacity care plan stated, "Consent can be given in different ways such as not resisting, nodding, smiling." It was not clear if this was a general statement or specific to this person. This person's personal care plan stated staff should support them to shower and shave, but there were no details about how they preferred this to be done, for instance did they prefer a wet shave or electric shave. A third person's mental health care plan had general information about depression, but nothing about the individual person's signs and symptoms.
One person's communication care plan stated they "should be checked hourly", but the handover sheet in use on the floor stated checks every two hours. The same person's dietary preferences were recorded as "regular / normal" in their care plan, but the handover sheet had "soft". Their daily notes for 6 September 2016 stated an occupational therapist would be visiting the following Thursday, but there were no other records about the visit or to confirm whether it had taken place.

Another person's nutrition care plan stated, "On good days can feed self without assistance, on bad days will need to be fed, especially if in bed." However the "Who am I" section of their care plan state, "Requires assistance to eat and drink, encourage to eat and drink, drink through a straw." People were at risk of inappropriate care and support because their care records were not consistent.

Another person had lost weight each month since March 2016. Their nutrition care plan had not been updated since March which meant there was no clear picture of what was being done to address their weight loss, and there was no new risk assessment. Their daily notes for 27 August 2016 stated staff should monitor the person's weight weekly, but there was no evidence in their records this was done. Staff told us they had been recommended dietary changes, included milky deserts and fortified drinks, but there was no evidence in their records they received these. There was a falls risk assessment in place which assessed they were at a very high risk of falls, but their night care plan dated 15 March 2016 stated they were not at risk of falls.

Failure to keep accurate and up to date records of people's care and treatment was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other people's care and support were based on assessments and care plans designed to meet people's needs and reflect their preferences. In these cases, people's care plans described their needs, goals and the actions staff needed to take to support them to meet their goals. There were specific care plans for different aspects of people's care, including communication, personal care, continence, mobility, skin health, nutrition and hydration, and mental health. Care plans included information about the person as an individual, and their cultural, spiritual and social values. Care plans were reviewed every month and there was a care plan audit every six months.

There were some examples where people's care plans had been updated when their needs or conditions changed. One person had suffered a number of falls, and their care plan took these into account. Another person had been losing weight, their GP was consulted and their care plan amended. A third person had suffered an accidental wound to their leg. Records showed how this had been treated over six weeks until the nurse noted, "Discontinued as has healed nicely and just requires creaming."

The support people received was recorded in daily notes and "intentional rounding" charts which included regular checks, food and fluid intake and support for people to reposition themselves. Where people's risk of behaviour that challenges had been identified and assessed, appropriate records were kept. There were also records of the involvement of other healthcare services such as the older people's mental health team.

People were able to take part in a variety of hobbies and leisure activities which were tailored to their individual wishes and preferences. One person said, "There is lots going on. They get entertainers in and I like the singing. I also enjoy the bingo, but I didn't think I would." Another person said, "I am a football supporter and I went to Fratton Park last Saturday with one of the carers. Someone else supports Tottenham and they organised a live video and we watched them play." A visitor told us, "There are loads of activities and [Name] particularly enjoys the gardening club. Some of the children from the local school visit and [Name] really relates to that."

The provider subscribed to a daily newsletter which contained short articles designed to encourage conversation and reminiscence, a quiz and puzzles. Staff used this in individual activities, both in the shared areas of the home and with people who were nursed in their rooms.

There was a weekly plan of activities which included individual activities, such as making memory books,

arts and crafts and individual music therapy, and group sessions, such as a quiz, karaoke and parties. People were supported to go shopping and visit nearby tourist attractions. People's rooms were decorated individually, and one person had their own clock installed on the wall of their room. Outside each person's room was a reminiscence box with photographs or personal objects which identified the room as individual to that person. There were jigsaw puzzles in the shared areas of the home which we saw people working on at different times. The service had a "resident of the day" scheme. This person had tailored activities on that day. Staff told us of one person who had their favourite smoked salmon for lunch, and on another occasion staff arranged for family members who lived some distance from the home to visit when their relation was resident of the day.

The provider had a complaints policy and process in place. People and their families were aware of them and knew how to voice any concerns. One person said, "Yes, we have residents meetings once a month but I would tell the senior carers on my floor if I was not happy." They described a meeting with the chef where people had been able to raise concerns about the food and menus.

The manager had a complaints file which contained six complaints raised since our last inspection. These were a combination of complaints about billing, financial concerns and concerns about people's care. They had been addressed, investigated and the outcome communicated to the complainant.

Requires Improvement

Is the service well-led?

Our findings

When we inspected Gracewell of Fareham in November 2015 we had concerns that the provider had failed to make sure there had been consistent leadership at the home. There had been no registered manager in place since January 2015. We also found that the quality of records to do with people's care and treatment and the management of the service did not meet the requirements of the regulations. We issued a warning notice requiring the provider to meet the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by March 2016.

We inspected again in May 2016 to follow up our warning notice with respect to Regulation 17. We found improvements had been made with respect to management records. There had been some improvement in people's care records, but the service was still not fully meeting the requirements of the regulation. There were still examples of inaccurate, inconsistent and confusing records, although there were fewer than there had been in November 2015.

At this inspection we found, although there had been continued improvement, there were still concerns with records relating to the management of the service. The service was still without a registered manager, and there was continued lack of continuity in the management team.

In November 2015 a new home manager had recently started work. They were the sixth manager at the home in three years. At the time of this inspection, the seventh manager had recently handed over to the eighth. Both the seventh and eighth managers had started the application process to register as the manager of Gracewell of Fareham, but neither had completed the process at the time of our inspection. The provider had taken steps to make sure an experienced manager was always in post at the home, but there had been no registered manager for 587 days.

The eighth home manager and a new deputy manager were still finding their feet, and a new clinical lead was due to start work the day after our inspection. None of the three senior staff at the home had been in post for more than two months. People living at the home and their families were concerned by the lack of continuity of leadership. One person's relation said, "I couldn't point out the manager. I think I missed the meeting where they were all introduced." Another person's relation said, "The quality of care is generally good, but there have been at least four or five managers since mum moved in. One of the managers sanctioned too many care staff to take leave and that is why they were so short last week." A third person told us, "I am not sure who is responsible for what, but it is getting better and we are having more meetings now." A fourth person said they would not know who to complain to, as there were too many managers.

Although improvements in staff records and records concerned with the management of the service had been sustained since our focused inspection in May 2016, there were still examples of inconsistent and incorrect records.

There were inconsistencies between the home's monthly falls analysis and the numbers reported in the monthly "quality indicators" report. In April 2016 there were five falls recorded in the monthly analysis, but

26 were reported in the quality indicator. In July 2016 there were 34 falls in the monthly analysis, but 15 reported in that month's quality indicator. The total numbers recorded for the first seven months of the year were 109 and 123 respectively. It was not clear that falls were being recorded consistently, and this put the quality of any analysis in doubt. An internal falls risk assessment undertaken in July 2016 gave the service a score of 69% overall, partly because the service scored zero on the questions "trend tracker in place?" and "action plan resulting?"

Records did not support an effective process for reviewing and learning from falls and accidents. Failure to maintain accurate and up to date records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the management and recording of safeguarding concerns with senior staff. Records showed the provider had taken appropriate steps to preserve people's safety and welfare, and had notified and involved the local authority safeguarding team. However we found three examples where the provider had not notified us where the safeguarding report indicated possible abuse or an allegation of abuse. These included one example where the police had been involved.

Failure to notify us of any abuse or allegation of abuse, or any incident reported to the police, was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People's relations told us they found there was an open, friendly atmosphere in the home. Two relations had written to the manager with positive compliments about the home. One described the service as "Mum's extended family". The other wrote, "What really struck me about the staff is that they created a family environment. Even staff not directly involved with [Name]'s care knew her name and always asked how she was."

Although people using the service told us they felt staff morale was not always good, the manager and senior staff felt improvements had been made, and staff were starting to see the benefits of the "Gracewell way of doing things". Feedback from staff supervisions was that the home "felt nicer", and was open to two way communication. Requests from staff were listened to.

The manager had not had time to embed their management system or establish their management style, but they had inherited an effective system of meetings with staff, people using the service and their families. There were minutes on file of meetings with heads of department, quarterly health and safety team minutes, all staff "town hall" meetings, and meetings with night shift, and catering staff.

There was a daily "huddle" meeting of heads of departments and senior staff, which was used to highlight concerns such as the backlog in supervisions. The meeting was used to report on record keeping, planned activities, accidents and incidents and complaints. There was also a "mission moment", where a participant could focus on and share a positive experience. Heads of departments used the notes from this meeting to cascade information to their teams.

The provider had worked on an improvement plan, known as the "community development plan" which had been in place since our inspection in November 2015. This was a continuous plan, with some items added in the months since our inspection when the provider's own processes had identified improvements to be made. The latest version of the plan showed 15 action items completed with nine ongoing.

The manager and senior staff told us they had concentrated on staff engagement and team spirit. They said there were some "excellent carers" who needed direction. The provider had put in place a "heart and soul"

award, which allowed staff to nominate their peers who had exhibited behaviours in line with the provider's ethos. This had been given particular focus at Gracewell of Fareham, and two members of staff had attended the provider's national award ceremony.

The provider supported the manager through weekly conference calls covering progress on the improvement plan, the ongoing recruitment programme and "headlines" covering the general status at the home. There was a network of home managers which provided peer support to the manager with quarterly meetings to share experiences. The manager told us they had found their induction "excellent". The director of operations told us they considered all the required management processes were in place, but some still needed to be embedded in day to day practice.

There were systems in place to monitor the quality of service provided. The manager completed monthly "quality indicators". These covered areas to do with the management of the service, such as recruitment and incidents that had been notified to us, and areas to do with people's care such as pressure areas, infections, accidents and nutrition. The provider combined information from this home with the quality indicators from 15 other homes to provide a consolidated analysis which helped to highlight trends and identify areas where this home might be out of line with similar services.

The provider commissioned a "mock inspection" by independent consultants to assess progress on improvements since our last inspection. The manager described their report as "very complimentary". It had found that people were happy and well looked after and staff morale was good. Actions for improvement from this report were fed into the service's improvement plan. The provider had carried out internal operations audits in June and September. Both had flagged the service as "red". The director of operations said the red status reflected the priority the provider attached to making improvements at the service.

The provider had carried out quality surveys among staff, people who lived at the home and their families. The staff "your voice counts" survey had achieved 86% participation. The surveys were recent and no action plan based on findings and comments had been developed at the time of our inspection.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of incidents involving any abuse or allegation of abuse in relation to a service user and any incident which is reported to, or investigated by, the police. Regulation 18 (1) and (2)(e) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons. Persons employed did not receive appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (1) and (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not operate effective systems and processes to maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1) and (2)(c)

The enforcement action we took:

Warning notice