Elysium Healthcare (Gregory House) Limited

Gregory House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 18 July 2018 with a short follow up visit on 30 July 2018. The service was last inspected in March 2016 where there were no breaches in regulation seen and the home was rated as Good.

Gregory House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The original company who owned this service was bought out by Elysium, who are now the registered provider.

The care home accommodates up to 24 people across four separate units, each of which have separate adapted facilities. One of the units was being used for respite care purposes when we visited. There were 17 people in residence when we visited. People living in the service may have a learning disability and/or are living with mental illness. Where people are in the home for long periods of time they are assessed as being in need of specialist nursing care to support them. The service supports people to move on to more independent living, where possible.

The home has been open since 2015 and was purpose built to accommodate people in a 'group living' setting. Each of the four units has six bed rooms with ensuite shower and toilet, a shared bathroom with adapted bathing facilities, a lounge area, dining area and a fully equipped kitchen. Some bedrooms have 'anti-barricade' adaptations and there are other specialised adaptions to support people who may have issues managing behaviours and emotions. Each unit has its own secure garden. The unit is in a residential area of Workington and is in walking distance of local shops. People are supported to access public transport to get out an about into Workington and beyond.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The home has a suitably qualified and experienced registered manager who has both a nursing and social care background. 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.

The staff team understood how to protect vulnerable adults from harm and abuse. Staff had received suitable training and spoke to us about how they would identify any issues and report them appropriately.

Risk assessments and risk management plans supported people well. Good arrangements were in place to ensure that new members of staff had been suitably vetted and that they were the right kind of people to work with vulnerable adults. Accidents or incidents management was of a good standard.

The registered manager and her senior team kept staffing rosters under review as people's needs changed. Staffing reflected the numbers of people in respite and any issues individuals needed more support with. We judged that there were suitable professionals employed and sufficient care and support staffing levels in place by day and night. There were suitable numbers of ancillary staff employed in the home.

Staff were appropriately inducted, trained and developed to give the best support possible. We met team members who understood people's needs and who had suitable training and experience in their roles. Nursing staff told us they were given time and opportunity to keep their practice up to date.

Medicines were appropriately managed in the service with people having reviews of their medicines on a regular basis. Any issues were dealt with promptly and appropriately. This service did not rely on the use of strong sedatives and would ask for review from psychiatrists and specialist practitioners rather than use these strong medicines.

People in the home saw their GP and health specialists whenever necessary. Specialist nurses and psychiatrists kept people's care needs under review. The staff team had good working relationships with the local mental health team and with the learning disability team in the area.

Good assessments of need were in place, and the staff team reviewed the delivery of care for effectiveness. They worked with health and social care professionals to ensure that assessment and review of support needed was suitable and up to date.

People told us they were very happy with the food provided and we saw well prepared meals that people told us they enjoyed. We also noted that people could shop and cook for themselves if they wished. Nutritional planning was being developed further.

Gregory House is a purpose built home that was opened in 2015. It has suitable adaptations to ensure people were safe and had enough personal and shared space. The house was warm, clean and comfortable on the day we visited. Suitable equipment was available.

The staff team were aware of their responsibilities under the Mental Capacity Act 2005. Staff were also aware of their responsibilities when care was subject to mental health legislation. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People who lived in the home told us that the staff were caring. We also observed kind and patient support being provided. Staff supported people to understand the appropriate boundaries for living together with others. They made sure that confidentiality, privacy and dignity were maintained. Care planning reflected independence and skills building for many people who hoped to live more independently.

Risk assessments, person centred plans and care plans provided detailed guidance for staff in the home. People in the service were aware of their care plans and many had influenced the content. Where possible people set their own short and long term goals. The management team had ensured the plans reflected the person centred care and nursing that was being delivered.

Staff could access specialists if people needed communication tools. Many of the nursing staff had training and qualifications that would help them use specific communication strategies. Documents were available in an easy read format.

Staff took people out locally and encouraged people to follow their own interests and hobbies. On the day of our visit people went shopping and swimming. We saw evidence of people being encouraged to develop interests and activities as individuals with a view to living more independently.

The service had a comprehensive quality monitoring system in place and people were asked their views in a number of different ways. Quality assurance was used to support future planning.

We had evidence to show that the registered manager and the operations manager were able to deal with concerns or complaints appropriately .

Records were well organised, easy to access and stored securely. The original company who owned the home had been bought out by a new provider and the staff were in the process of assimilating some of their templates. This was being completed incrementally.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Gregory House

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 18 July 2018 and was unannounced. The inspection team consisted of an adult social care inspector and a health and justice inspector and a specialist advisor who was a registered nurse specialising in the care of people living with mental health issues and the care of people with a learning disability. The team also had an expert-by-experience to support them. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The team were experienced in the care of vulnerable adults who have difficulties related to mental health or learning disabilities.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This was received in a timely manner and in good detail. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We also spoke with social workers, health care practitioners and commissioners of care during our regular meetings with them. We planned the inspection using this information.

We met all of the 17 people in the home and spoke in some depth with six of them. The team spent time in shared areas simply observing the life of the home. We also met a visiting family member.

The team checked all of the care files for people who made the service their home. We read 12 care plans in depth and looked at daily notes related to these care plans. We also looked at five care files for people who came to the service for respite care but we did not meet these people. We also looked at records of medicines and checked on the medicines kept in the home.

We saw risk assessments, hospital passports, risk management plans for generalised risk and for

behavioural issues. We looked at moving and handling plans and charts that helped staff record care delivery.

We met the deputy manager, two nurses, the cook, a domestic and seven support workers on the first day of our inspection. We talked with them in small groups or individually. We looked at four support staff files which included recruitment, induction, training and development records. We checked on the details of the supervision and appraisal notes on these files. We discussed nursing portfolios with nurses on duty. We returned to the service and met the registered manager and the operations manager.

We saw rosters, records relating to maintenance and to health and safety. We looked at money managed on behalf of people in the home. We checked on food and fire safety records and we looked at some of the registered provider's policies and procedures. We saw records related to quality monitoring.

We walked around all areas of the home and checked on infection control measures, health and safety, catering and housekeeping arrangements.

We received information related to staffing issues and quality audits during and after the inspection.

Good

Is the service safe?

Our findings

Staff were suitably trained in understanding harm and abuse. Safeguarding matters were discussed in supervision and in team meetings. We had evidence to show that the management team would make safeguarding referrals, if necessary. One person told us, "Staff would help me if something bad happened...". Another person said, "I feel safe here...and am being supported to keep feeling safe when I move on". Some people who used the service were not always able to explain how safe they felt but we saw that they were relaxed in the home and with the staff.

Good arrangements were in place so that staff could 'blow the whistle' if they had any concerns. Staff told us they had, "No problem talking to management ...they are approachable. There is no bullying here...we are respected as staff". There had been one instance of an anonymous person 'blowing the whistle'. The allegations had been looked at by the local authority and health commissioning and by the operations manger with the allegations unfounded.

We saw rosters for the four weeks prior to our inspection and spoke with nurses and support staff who told us there were plenty of staff to meet people's needs. Rosters showed us that there was always a trained nurse in charge by day and night. The team had general nurses and specialist nurses in mental health and learning disability. The service also employed a psychologist and a psychology assistant. Suitable levels of catering and housekeeping staff were on duty every day. We noted that the registered manager and her deputy would deliver care and support where necessary. There was also an administrator who played a key role in the management of the service.

Staff were trained in understanding human rights and matters of equality and diversity. Staff could also talk about the balance between individual rights and the duty of care. We spoke with support staff who understood the need to allow some people to take risks in order to move towards independent living. They also understood that some people, due to the disorders they lived with, needed to have their rights managed for their own safety. Detailed risk assessments and risk management plans were in place. We also saw best interest meetings had taken place and that some people had formal reviews of risk completed by psychiatrists, psychologists or social workers.

We walked around the building and found it safe and secure. Good infection control measures were in place. We saw records related to the premises and to the equipment in the home. We also looked at equipment and saw it in use. The environment was as safe as possible. The service had a good contingency plan in place for any potential emergency.

Accidents or incidents had been reported to the Care Quality Commission. The senior staff understood the policies and procedures around this and understood how they would deal with these. The registered manager logged and analysed any on-going incidents or accidents and would risk assess behavioural issues or things like falls or recurrent illnesses. The staff told us they used a 'lessons learned' approach after incidents and ensured the team had a de-brief.

We looked at recruitment files and spoke to staff who confirmed that background checks were made prior to new staff having any contact with vulnerable people. We looked at personnel records and these were in order. There had been some matters of a disciplinary nature in the home and we saw documents which confirmed that the registered manager had dealt with these appropriately and fairly.

We checked on medicines managed on behalf of people in the home. These were kept securely with good recording in place. Nurses ensured that they kept medicines under review and reviews with specialist psychiatrists ensured people got appropriate medicines. Suitable monitoring of administration was in place with nurse training and competence checks being undertaken. Any problems with medicines were seen and dealt with quickly. Our specialist adviser judged that good medication optimising was in place with very little reliance on sedatives or strong medications.

Staff had suitable training in infection control and access to protective clothing and equipment. We walked around all areas of the home and found it to be very clean and hygienic. Staff could explain cleaning routines and chemicals to use. We saw good stocks of aprons, gloves and chemicals to ensure any infections did not spread.

We had a number of conversations with staff at all levels who could talk about how they routinely analysed the delivery of care and the systems used in the home. We noted that 'lessons learned' was one of the agenda items on nurse meetings and general staff meetings.

Good

Is the service effective?

Our findings

We looked at assessments for people on admission and as part of the on-going care delivery. We noted that the registered manager or one of the nurses did a full nursing assessment, usually with an external professional before a person came to the home. All aspects of a person's needs and preferences were considered, without discriminating against them. Any legislation around the placement was recorded and given appropriate consideration when planning care delivery. General risk assessments for the building and activities in the building were also in place.

Assistive technology could be accessed to allow staff to monitor people, whilst protecting their privacy. We saw special alarms were used to allow staff to summon help. We also noted that the home had environmental adaptations to keep people safe. Attention was paid to the safety of people who, due to their disorders, could self harm. Some bedrooms were designed to allow access if a person had locked themselves in during a time of crisis.

We observed staff asking people and giving them options about their lives. We also met people who had grown in confidence because they knew their opinions were listened to. We also saw that, where appropriate, people were asked for both formal and informal consent. We spoke with one person who had signed saying they had consented and who told us, "I am doing well and I know what I want ...Staff ask me what I want and they help me."

The registered manager was aware of her duty of care under the Mental Capacity Act 2005. When people lacked capacity to make major decisions the team had undertaken 'best interest' reviews with social workers and, where appropriate, family members. This had been done where people were living with a learning disability or had other mental health needs. The team had considered that some people were being deprived of their liberty to ensure they were kept safe. The Mental Capacity Act 2005 (MCA) 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 as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that authorisations were in place, where necessary, and that staff supported those people in the least restrictive way possible to comply with the authorisations. New applications had been completed and the team were waiting for updates and approvals.

The staff team and the registered manager were aware of their responsibilities under the mental health legislation. This was confirmed by our specialist advisor who looked at the documents related to the arrangements made under this legislation.

We looked at the needs of people and we looked at the training the provider deemed to be mandatory. This included training on safeguarding, equality and diversity, learning disability and mental health needs, health and safety and person centred thinking. Staff were trained in moving and handling and the registered manager was planning to train some staff to be co-ordinators for moving and handling to strengthen the skills in the team. Staff had effective induction, supervision, appraisal and training. Nurses were given time and support to maintain and update their skills.

We looked at menus and care plans about eating and drinking. We also went into the kitchen and spoke with a knowledgeable and experienced cook. We saw that the food was well prepared. Special diets were catered for and advice of dieticians and other professionals was followed, when necessary. No one was underweight in the service but the cook was aware of how to fortify foods if necessary and how to support people who needed to loose a little weight. We saw that these things were covered in the general care plans but more complex nutritional planning was being developed. People were weighed as appropriate and given advise on healthy eating. Each unit had a small budget so that people could buy and prepare food for themselves in the units. This gave people more choice and helped with independence building.

The people in the home looked well and well cared for. They told us, and we saw in files, that the staff helped people to good health by supporting them to choose healthy living habits and to access health care support. One person had been to the dentist during our inspection and they told us they had a lot of support to improve their oral hygiene and mouth care. People saw consultant psychiatrists, community mental health nurses and other specialist nurses when appropriate. We saw that people attended 'Well man' and 'Well woman' clinics and also went out to the GP or to opticians or chiropodists. Everyone had a 'hospital passport' so that health care staff could understand their needs if they had to go into hospital.

Gregory House is a modern, specially designed group living home where people live in small groups and have single ensuite rooms with shower. Shared areas included well equipped unit kitchens and adapted bathrooms and shower rooms. Shared lounge, dining and outside areas were of a good size and helped people to socialise in groups of no more than six people. The home had specialist equipment in place or in store to ensure people could be helped with mobility or with keeping themselves safe. A relative we spoke with told us, "This house is fabulous...I wouldn't let [my relative] go to anywhere in the past but this is lovely, a home from home."

Good

Is the service caring?

Our findings

Some people in the service could talk in-depth about how caring the staff team were. One person said, "I like it here." Another person told us, "I've learned a lot about how to control my temper". Yet another person said, "This has been the best place I've been" and "we have good laughs". People were complimentary about the staff telling us, "I like the staff" and "The staff are nice, pleasant and friendly". The lead inspector spoke with a visiting relative who told us, "The staff are really wonderful...so good to me and to my[relative]. I think that all the nurses are very good at their jobs and [the registered manager] really understands all the things I am going through. Nothing is too much trouble for the staff."

We spent time just observing how staff interacted with those people who found verbal communication more problematic or where people did not wish to engage with members of the inspection team. We observed people responding warmly to staff. People made good eye contact with the support staff and were relaxed with any interventions we witnessed. People responded well to staff guiding and supporting them in tasks. Staff could talk about people's preferences and routines. We also noted that staff explained how they could avert behaviours that were not part of social norms. Interactions were done with care and at a pace which people responded to.

Staff displayed appropriate values when talking about people with learning disabilities, people living with autism, people with mental health needs and people with differing cultural, social and sexual preferences. The staff team spoke about people with warmth and affection. They were clear and objective when discussing the individuals they supported and no one made any judgemental statements. Care files were written clearly and without judgmental or prejudiced statements. We observed genuine acceptance and caring. Staff told us that the registered manager ensured the team had appropriate supportive relationships with people. We also noted that the registered manager ensured that staff relationships with people had appropriate boundaries.

Staff understood the need for confidentiality and privacy. Staff gave examples of how they encouraged people to maintain their dignity during personal care support. People were given their own space and privacy. Some people had complex needs in relation to their lifestyle choices and we saw that staff supported people appropriately and helped them maintain their choices without impacting on any other person's life choices.

People could be helped to access independent advocates where necessary. Some people had relatives who would act as advocates on their behalf. The staff team worked with families in an open and appropriate way. We had some examples where the registered manager had helped families who found it difficult to allow their family member to come for respite, become more independent or follow a lifestyle choice.

We heard staff giving people information and choices about decision making. Staff helped people in a manner that reflected each person's needs. The pace, timing and content we observed met each person's needs and choices appropriately. Staff were also able to give people written or 'easy read' information. Some people had care plans or charts in their rooms which would remind them of the progress they wanted

to make and to the barriers to change and how to combat any problems.

Some people had moved, or were moving, from the service to more independent living. Some people wanted to remain in the service and they too had plans that encouraged as much independence as possible. We noted that independence building was geared towards individual needs and that although people were encouraged, no one was set up to fail at improving their life skills. A member of the team told us, "We assess ability and need and we also have a psychologist who will ensure were are supporting people appropriately. Our residents have not always had the choices and support they need and we have to take things at each person's own pace. We can't hurry them...they need to want to progress and sometimes that takes a while".

Good

Is the service responsive?

Our findings

We looked at a range of care plans for people with different needs. We saw that full assessment of nursing, care and support needs had been completed for everyone in the home. These covered physical, psychological, emotional and social needs. The care plans were detailed and comprehensive. Each person also had a person centred plan that covered goals and aspirations. Where people had the need these plans could be in an easy read format. Some people had written their own care and support plans.

The care plans gave staff strategies for how to support people in an appropriate manner. We saw guidance for staff to follow if a person became mentally unwell or who had difficulties controlling emotions or behaviours. We also noted that some people had charts and plans in their own rooms that helped them deal with emotional or behavioural difficulties. We saw staff following the guidance in plans and people were calm and relaxed in the home. We noted that incidents had reduced over the previous 12 months. We saw plans that gave guidance about preferences and needs including psychological, physical, social and emotional needs. We also saw that people's sexual, cultural and religious needs were noted and support given. We had an example of support that was discreet, apt and fundamental to the person's sense of self and met their needs in relation to their sexuality.

Each person had an individual activity plan. Some activities tied into long term goals. People might buy their own food to help them budget and prepare meals. People walked and used public transport and becoming confident in travelling was, in most cases, supporting people to be more independent and more confident. People were given the right levels of support to go out to shop, attend activities or go for meals and drinks. Some people went together to activities like fell walking, swimming or a local club which helped with socialising and understanding social norms. Each person had an activity plan in place.

Most of the people in the home had some form of learning disability or were living with mental ill health. This meant that some, but not all, people had problems with communication. Some people did not use speech or sign language. Staff used various ways to communicate depending on the person's need. No one in the home at the time of our visit used specialist forms of communication like British sign language or braille. The deputy manager said that they could access support or training for communication needs prior to admission. Staff said they would be keen to learn any signs or other forms of communication so they could work well with people. Nurses with a background in caring for people with a learning disability had training in using specialist communication.

Consent forms were in place as were Do Not Attempt Cardio Pulmonary Resuscitation forms. We saw good details of how people had been consulted and advised, where approriate. People had signed their care plans and person centred plans, where possible. These documents had all been updated as necessary. Staff ascertained that any legal requirements were in place and would act upon them. We also heard staff asking for permission. Residents' meetings were well attended and people's views recorded in review meetings and in daily notes. The time of meals had been changed because staff had listened to people's views.

The service had a comprehensive complaints and concerns policy and we had evidence to show that the

registered manager, the operations manager or other senior managers employed by the provider could all be involved in investigations if necessary. We had an example of an investigation which had been done thoroughly and promptly. There were no current complaints about the service.

Staff were trained in anti-discriminatory practice and we saw that they were aware of people's needs and preferences. Staff made no difference to the way they treated people or the choices they offered them. We saw that people were treated very much as individuals. We also noted that staff helped people to have discrete boundaries so that their life choices did not have a detrimental effect on others.

This team had not dealt with end of life care but were open to the possibility of caring for a person at this stage. The registered manager said that she was planning to access basic training for this. Some of the nursing team were experienced in end of life care from previous roles and said they could access support from community teams and GP surgeries.

Good

Is the service well-led?

Our findings

The home had a suitably qualified and experienced registered manager. She had previously managed similar services elsewhere and had taken over the management of the home in September 2017. Staff told us that she was, "Very knowledgeable, very skilled and easy to talk to". They also told us, "She knows how to manage teams, she is fair and professional...but you know that she is the boss ! We are well aware of her standards and we work to these...she's a good role model for nurses and support staff."

The registered manager had extensive nursing experience and had training and experience in strategic and operational management. We had confirmation from the operations manager that the provider was very satisfied with the way she was managing the service. We noted that people using the service sought out the registered manager and this showed us how closely involved she was with the work of the service.

The registered manager had built on the established systems in place in the home and had developed further strategies to ensure the service was running smoothly. She was working with the new company who had bought out the original provider and was assimilating some of their systems into the existing systems. Staff were not unduly concerned about the change because as one person said, "[The registered manager] will make sure we are fine...she has the residents' welfare at heart but she cares about us as a staff team."

Staff and people in the home judged that the registered manager created an open culture where they were valued and respected. The registered manager was aware of up to date good practice and was introducing approaches like positive behavioural support (PBS), which has an upbeat approach to giving the right kind of support to people who have many challenges to contend with. We also saw that she encouraged the staff to see the people they supported as individuals with strengths as well as needs. This had encouraged staff to be enthusiastic about the work and to be realistic about the goal setting.

The service had a quality monitoring system in place. Improvements were made as a result of on-going quality monitoring in the service. There were regular internal and external audits of quality in place. Surveys were sent to people and families and other professionals involved in the care of the person. We saw audits of care planning, audits of medicines management and good records of things like accident analysis, maintenance of equipment and personnel records' reviews. Staff and residents' meetings minutes showed that lots of lively discussions went on about the way forward for the service. We also noted that when issues arose swift action was taken to deal with the problem. The inspection team judged that positive values were present in all areas of the service and that the registered manager led the team in delivering a caring service that valued people.

Records were easy to access and simple to understand but recording was in enough depth to reflect on the well run systems in the home. Both electronic and paper records were stored safely to protect confidentiality. Some changes were being made by the new company to ensure the home was in line with their other services but this was being done incrementally.

We discussed the quality monitoring and future planning with the registered manager and the operations

manager. They had some very specific plans in place. These included the development of experienced support staff so that they would have in-depth training and supervision that would give them advanced skills and knowledge related to working with people living with very complex needs. We also heard about the plans they had for the range of support they wanted to provide. The plans were in place and were being considered by the new directors of the company. An analysis of quality outcomes and the subsequent planning would be sent to CQC once it had been agreed and ratified by the senior managers of the company.