Richmond upon Thames Churches Housing Trust Limited

Viera Gray 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

Overall summary

This was an unannounced inspection that took place on 23 and 24 July 2015.

Viera Gray House is a care home with accommodation for frail elderly individuals and people some of whom may have dementia.

The home had a registered manager. 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 and associated Regulations about how the service is run.

In June 2014, our inspection found that the home met the regulations we inspected against. At this inspection the home met the regulations.

People and their relatives thought a good service was provided, they enjoyed living at the home and there was

Summary of findings

enough staff to meet their needs. The staff team were friendly, caring, attentive and provided the care and support they needed in a way they liked. They found the home's atmosphere was relaxed and enjoyable.

The sample of records we looked at were comprehensive and kept up to date. They contained clearly recorded, fully completed, and regularly reviewed information. This enabled staff to perform their duties well. People and their relatives were encouraged to discuss health needs with staff if they wished and they had access to community based health professionals, as required. They were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. People said there was a variety of well-presented meal choices, the quality of the food was good and it was the type of food they liked.

The home was well maintained, furnished, clean and provided a safe environment for people to live and staff to work in.

There was a thorough staff recruitment process that files showed were followed. The staff were very knowledgeable about the people using the service and their likes, dislikes, wishes and needs. Staff had appropriate skills, training and were focussed on providing individualised care and support in a professional, friendly and supportive way. They said they were well supported by the management team who were approachable, open and honest. People using the service and relatives said they felt comfortable talking with the management team, who were responsive to their views and encouraged feedback from people. We saw that the home consistently monitored and assessed the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People said they were safe. There were effective safeguarding and risk assessment procedures that were followed. The home had appropriate numbers of well-trained and appropriately recruited staff.

People's medicine records were up to date. Medicine was audited, safely stored and disposed of.

Good

Is the service effective?
The service was effective.

People received specialist input from community based health services. Their care plans monitored food and fluid intake and balanced diets were provided. The home's was decorated and laid out to meet people's needs and preferences.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff and people underwent mental capacity assessments and 'Best interest' meetings were arranged as required.

Good

Is the service caring?
The service was caring.

People felt valued, respected and were involved in planning and decision making about their care. The care was centred on people's individual needs.

Staff knew people's background, interests and personal preferences well and understood their cultural needs. They provided support in a kind, professional, caring and attentive way that went beyond their job descriptions. They were patient and gave continuous encouragement when supporting people.

Good

Is the service responsive?
The service was responsive.

People had their support needs assessed and agreed with them and their families. They chose and joined in with a range of recreational activities. Their care plans identified the support they needed and it was provided. People told us that any concerns raised with the home or organisation were discussed and addressed as a matter of urgency.

Good

Is the service well-led?
The service was well-led.

There was a positive culture within the home that was focussed on people as individuals. People were enabled to make decisions by encouraging an inclusive atmosphere. People were familiar with who the manager and staff were.

Staff were well supported by the manager and management team. The training provided was good and advancement opportunities available.

Good

Summary of findings

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and driving improvement.

Viera Gray 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 was an unannounced inspection and took place on 23 and 24 July 2015.

This inspection was carried out by one inspector.

There were 30 people living at the home, during the inspection. We spoke with eight people, three relatives, seven staff and the manager. We also spoke to service commissioners and other health care professionals such as district nurses.

Before the inspection, we considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for ten people living at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their relatives said they thought the service was safe. One person told us, "I use the garden courtyard all the time, it is safe and enclosed." Another person said, "I think there are more than enough staff to meet people's needs." Relatives told us they had never witnessed bullying or harassment whilst visiting the home and had not been told of any by the people they were visiting, other people living at the home or their relatives. A relative said, "Everyone one knows everybody else's relatives and we often have a chat to see what has been going on."

The home had policies and procedures regarding protecting people from abuse and harm. Staff had received training in them. We asked staff what they understood as abuse and the action they would take if they were confronted by it. Their response was appropriate to the provider's procedures. They said protecting people from harm and abuse was part of their induction and refresher training. Staff had also received safeguarding training, were aware of how to raise a safeguarding alert and the circumstances under which this would be necessary. Safeguarding information was provided in the staff handbook and a safeguarding pathway with local authority contact numbers was on display. There was no current safeguarding activity regarding the home although it was providing input into an alert regarding another service. Previous safeguarding issues had been appropriately reported, investigated, recorded and learnt from.

The staff shared information within the unit teams regarding risks to individuals. This included passing on any incidents that were discussed at shift handovers and during monthly staff meetings. There were also accident and incident records kept and a whistle-blowing procedure that staff were aware of and said they would be comfortable using.

People's care plans contained risk assessments that enabled them to take acceptable risks and enjoy life in a safe environment. There were risk assessments for all aspects of people's daily lives that included health and social activities. The risks were reviewed regularly and updated when people's needs and interests changed. The care plans also contained action plans to help prevent accidents such as falls from being repeated. There were general risk assessments for the home and equipment that were reviewed and updated at specified intervals. These included fire risks, hoists and other equipment used. The home was well maintained and equipment used was regularly checked and serviced. There was also an emergency evacuation plan. Night staff also did internal and external building security checks.

The staff recruitment procedure was thorough and all stages of the process were recorded. This included advertising the post, providing a job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's skills and knowledge of the client group they would be working with. References were taken up prior to starting in post and staff's work histories checked. There was also a six month probationary period, at the start of which new staff shadowed experienced staff. The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them. All staff had completed security checks to keep people safe.

During our visit there were sufficient staff to meet people's needs and the numbers reflected those recorded on the staff rota. Staff thought there were enough of them to meet people's needs. Our observations showed that their needs were safely met. The manager told us that the staff rota was flexible to meet people's needs and extra agency staff were provided if required. Where possible the same agency staff were used as they had knowledge of people using the service and people became familiar with them. The agency staff were included in the home's supervision system and attended staff meetings.

The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records were colour co-ordinated to denote different times of the day when medicine administration was required. The medicine for all people using the service was checked and found to be fully completed and up to date. This included the controlled drugs register that had each entry counter signed by two staff members authorised and qualified to do so. Medicine kept by the home was regularly monitored at each shift handover and audited. There were also body maps showing the areas where creams and ointments were required to be administered. Medicine was safely stored in

Good

Is the service safe?

locked facilities and the temperature of designated fridges where medicine was stored was regularly checked and recorded. Any medicine no longer required was appropriately disposed.

Good

Is the service effective?

Our findings

The staff we spoke with and observed were aware of people's specific needs, knew them well and met those needs in a patient and friendly way. They maintained a comfortable, relaxed atmosphere that people told us they really enjoyed. People said they made their own decisions about their care and support and that their relatives were also very involved. They said the type of care and support provided by staff was what they wanted and needed. It was delivered in a friendly, enabling and appropriate way that people liked. One person said told us, "I came here for respite and enjoyed it so much I moved in." Another person told us, "They adjust mealtimes to your choice." A relative said, "This is an absolutely great home, there is something unique about it. We went on the CQC website, visited 10 to 15 homes and chose here"

During our visit staff enabled people to make their own decisions regarding the care and support they received, when and how it was delivered and activities they may wish to carry out. They were well trained and received induction and annual mandatory training. New staff spent time shadowing experienced staff as part of their induction to increase their knowledge of the home and people who lived there. The communication skills that staff used demonstrated that they knew people as individuals and understand the methods needed to understand people's immediate needs and make themselves understood by people.

There was a training matrix that identified when mandatory training was due. The training provided was based on the Skills for Care, 'Common Induction Standards' (2010). It included infection control, behaviour that may be challenging, medication, food hygiene, health and safety, equality and diversity and person centred care. There was also access to specialist service specific training such as dementia awareness.

Monthly staff meetings identified group training needs and also focussed on communication. Monthly supervision sessions and annual appraisals took place. These were partly used to identify any gaps in individual training. There were staff training and development plans in place.

Staff received mandatory training in The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications under DoLS had been submitted by the provider. They were awaiting authorisation, except one that had been authorised as evidenced on their files. Best interests meetings were arranged as required. Best interest meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in the care plans.

Nutrition and hydration was included as part of core staff training. The home used the 'Malnutritional universal screening tool' (MUST) to regularly assess nutritional needs. Where appropriate weight and hydration charts were kept and staff monitored how much people had to eat and drink. There was also information regarding the type of support required at meal times. Nutritional advice and guidance was provided by staff and there were regular visits by local authority health team dieticians and other health care professionals in the community as required. People had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. Staff said any concerns were raised and discussed with the person's GP. There was a GP practice that attended the home. People were also able to retain their own GP if they preferred. The records we saw were up to date and fully completed. If people required a hospital visit, they were accompanied by a member of staff and written information was provided for the hospital.

Meals took place on the individual units to make them more intimate. People told us they enjoyed the meals provided. A person using the service said, 'great food'. Another person told us, "I get the food I like." During our visit people chose the meals they wanted, there was a good variety of choice available, the meals were of good quality and special diets on health, religious, cultural or other grounds were provided. The lunch we saw was well presented, nutritious and hot. Meals were monitored to ensure they were provided at the correct temperature. The chef visited each unit to ask if people had enjoyed their meals. Pictorial menus were available for people who required them.

Good

Is the service effective?

The home had a restraint policy based on event de-escalation that staff were trained in. They were aware of what constituted lawful and unlawful restraint. There were no instances of restraint recorded.

People's consent to treatment was regularly monitored by the home and recorded in their care plans. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout the visit.

Good

Is the service caring?

Our findings

People told us that the staff and management treated them with respect, dignity and compassion. The staff always made that extra effort to make sure people's needs were met and this was reflected in the care practices we saw. There was a policy regarding people's privacy, dignity and right to respect that we saw staff following throughout our visit. They were very courteous, discreet and respectful even when unaware that we were present. People enjoyed living at the home and were supported to choose what they wanted to do. Staff listened to what people said, their opinions were valued and we were told staff were friendly and helpful. One person we spoke to told us, "I receive good individual care." Another person said, "I've been here three years and the home's great strength is the care, which has been outstanding." A further person told us, "I was in a home before that was excellent, but this is even better with more personal attention." A relative said, "My overriding emotion is that this is a place for (person using the service) to live out their days in a comfortable safe environment."

During the visit we saw numerous positive interactions with staff spending time engaging with people and whenever they wanted a chat. They reassured people who required it, told them what was going on and also any visitors that they could expect. They were familiar with people's preferred names, introduced them to us and asked if they wished to speak with us. Staff respected confidentiality and had discreet conversations with people privately without other people listening to their conversations. Personal care was delivered behind closed doors and staff discreetly enquired if people needed the toilet. They were skilled, patient, knew people, their needs and preferences very well. They used open, positive body language, took time and made an effort to ensure that people were happy, joined in and enjoyed themselves. Staff engaged with people in a friendly, kind and compassionate way and treated them equally, talked to them as equals and listened to what they had to say. Staff took time to find out about people's lives and what they were interested in. This was supported by the life history information contained in care plans that people, their relatives and staff contributed to and regularly updated. One person was born in Paris, but said they were staunchly English and definitely not French. This led to good natured banter with staff that the person clearly enjoyed. The care plans contained people's preferences regarding end of life care.

The home's approach to delivering care and support was individualised to the person and staff had been trained to promote a person centred approach that was reflected in the care practices we saw. Everyone was treated as a person in their own right rather than a task to be completed. A staff member said that the numbers of people on the units was quite small and this made it easier to be aware of everyone using the service in that area and become more familiar with them. A relative told us, "(person using the service) knows and is familiar with the people they live with and have struck up friendships." Staff involved people in discussions about their care, and care plans were developed with them and had been signed by people or their representatives. Staff practice we observed demonstrated that staff had a good understanding of caring for people with dementia.

There was an advocacy service available through the local authority and people had been made aware of it. Currently people did not require this service.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on going training and contained in the staff handbook.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People said that they were asked for their views, opinions and choices by staff and the home formally, informally and this happened during our visit. Staff enabled people to decide things for themselves, listened to them and took action when required. They made themselves available to talk about any problems and wishes people might have and needs were met and support provided appropriately. One person said, "I attend exercise classes and also love the home's cat." Another person told us, "Local school children and another group of young people, who I think are medical students visit and I like their company." A relative said, "Staff always have time for a chat with people."

Throughout our visit people were consulted by staff about what they wanted to do and when. They were reminded of and encouraged to join in activities and staff made sure no one was left out. People were also encouraged to interact with each other as well as staff. There were regular changing daily activities. The home did not have an activities co-ordinator as it was felt better to encourage staff to take responsibility for this area of quality of life care. We saw that the system worked well. There was also a large, positive input from the 'Friends of Viera Gray House' who provided and funded some of the activities. One person said, "They want you to be happy." Another person told us, "Staff always have time for a chat and there are regular concerts." There was a weekly activities list. The activities included exercise class, reading, music therapy, arts and crafts, visiting hairdresser, coffee and conversation sessions, visits to the Wetlands Centre, Kew Gardens, Brighton and Windsor Castle. There was also a 'Men's club with beer, chat and football. The 'Friends of Viera Grey House' also operated a mobile shop at the home where people could make purchases.

Before moving in people were provided with written information and a service guide about the home and what care they could expect. People, their relatives and other representatives were fully consulted and involved in the decision-making process. They were invited to visit as many times as they wished and have meals before deciding if they wanted to move in. One person was visiting for a fourth time prior to making a decision during the inspection. Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual.

People were referred by local authorities and privately. Assessment information was provided by local authorities and sought for the private placements where available. Information was also requested from previous placements and hospitals. The home then carried out its own pre-admission needs assessments with the person and their relatives during visits to the home. As well as identifying needs and required support, the home's assessment included meal observation and interaction with staff and people already using the service. New placements were reviewed after six weeks and then annually. The care plans were comprehensive and contained sections for all aspects of health and wellbeing. They included consent to care and treatment, medical history, mobility, dementia, personal care, recreation and activities and last wishes. They were focussed on the individual and contained people's 'Social and life histories'. These were live documents that were added to by people using the service and staff when new information became available and if they wished. The information gave the home, staff and people using the service the opportunity to identify activities they may want to do. The home operated a keyworker system and the care plans were reviewed by the keyworker, supervisor and person using the service, if they wished, monthly.

People's needs were regularly reviewed, re-assessed with them and their relatives and care plans changed to meet their needs. The plans were individualised, person focused and developed by identified lead staff and people using the service. People were encouraged to take ownership of the plans and contribute to them as much or as little as they wished. They agreed goals with staff that were reviewed and daily notes confirmed that identified activities had taken place. People's personal information including race, religion, disability and beliefs was also clearly identified in their care plans. This information enabled staff to respect them, their wishes and meet their needs.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and

Good

Is the service responsive?

investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. There was also information provided to contact an Ombudsman, if required.

People and their relatives were invited and encouraged to attend regular meetings to get their opinions. The meetings were minuted and people were supported to put their views forward including complaints or concerns. The people using the service and relatives meetings and food forums took place regularly.

Good

Is the service well-led?

Our findings

The provider had a clear vision and values that set out that people's care and support was the primary concern. The management and staff practices we saw reflected this as they went about their duties. People, their relatives and staff told us there was an open door policy that made them feel comfortable in approaching the manager and management team. One person told us, "Any problems are addressed by the management team." Another person said, "I attend the house meetings, they are very useful, we had a very good meeting two days ago." Staff told us the support they received from the home manager was excellent. They thought that the suggestions they made to improve the service were listened to and given serious consideration by the home. They said they really enjoyed working at the home. A staff member said, "You can turn to someone when you need to". Another staff member told us, "It's a pleasure to work here." A further staff member said, "We get lots of support. I like the whole staff team atmosphere, you can move from one unit to another and everyone knows each other and works well together." Throughout our visit people were actively encouraged to make suggestions about the service and any improvements that could be made. There were also clear lines of communication within the organisation and specific areas of responsibility.

There was a robust quality assurance system that contained performance indicators, identified how the home was performing, any areas that required improvement and areas where the home was performing well. Concerns about a minor medication concern were picked up and attended to. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

The home used a range of methods to identify service quality. Information from the home and relatives meetings, that included menu suggestions were monitored and compared with that previously available to identify that any required changes were made. One relative said, "Relatives have an informal auditing function during visits and at meetings." Surveys for people using the service, staff and relatives concentrated on areas such as cleanliness, laundry, staffing, activities and dignity and privacy. There were regular reports covering areas such as occupancy, staff retention and significant events. Monthly audits included infection control, falls, pressure sores, number of (DoLS) referrals, care plans, risk assessments, the building and equipment. The medicine records were checked at the end of each shift. There were also shift handovers that included information about each person.