Pressbeau Limited

Greathed Manor Nursing Home

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

Greathed Manor can accommodate up to 32 people. The service provides convalescence care, post-operative care, rehabilitation, respite care and palliative care. Facilities include single en-suite bedrooms, three lounges, a dining room, library and assisted bathrooms.

Greathed Manor 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 inspection took place on Wednesday 11 April 2018. It was unannounced.

The service was last inspected in January 2016 when it was rated good. No breaches of legal requirements were found. We made two recommendations about activities and the use of best practice in care planning. Improvements had been made. People nursed in their rooms had an extra member of staff to help them engage in activities and be less isolated. Care plans were linked with the nursing needs of people in line with Social Care Institute for Excellence (SCIE) and National Institute for Health and Clinical Excellence (NICE) guidance. This helped staff to understand the needs of the whole person.

There was no registered manager in post at the time of our inspection. The previous registered manager left and the current manager took up their post in February 2018. They had submitted an application for registration with the Care Quality Commission.

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.

A relative told us, "I have only good things to say [about the home]. It's a lovely place to live. The atmosphere is very welcoming" and the staff are, "always friendly, always helpful."

People stated that Greathed Manor was a safe place to live, and that staff did their utmost to ensure that anyone who entered the home was safe and secure. Relatives and people commented that there was a cosy, homely feel to the home, and that staff and management were welcoming and happy.

Medicines were managed safely and there were effective infection control procedures. We saw evidence that lessons had been learned when things had gone wrong by adopting procedures to prevent incidents happening again. Staff had a good understanding of safeguarding procedures.
One told us, "it's about keeping people safe and protecting them from abuse." There were enough staff on duty, and they interacted very well with people, visitors and each other in an appropriate manner.

People's care plans took into account their wishes and preferences. People were provided with a choice of food and drink throughout the day and were supported to maintain their nutrition and hydration needs. The home was well adapted and designed to meet people's individual needs. There were no locked doors or keypads. People had access to healthcare services and were receiving ongoing healthcare support.

We saw staff being caring and compassionate, treating people with dignity and respect. Staff knew people well and had a good understanding of them as individuals. Staff had received the training they needed to deliver care in a way that responded to people's changing needs. Staff had regular supervision and appraisal.

Complaints were taken seriously by the manager and robust efforts made to resolve any outstanding issues.

People and staff praised the new manager for being approachable and always visible. One person told us, "She's very nice, and I always see her around all of the time". People told us that the manager had improved communication with staff, people and relatives. People told us that the manager listened to people when they had suggestions or if they had a problem. There was a lifestyle coordinator delivering activities to people.

There were quality assurance systems identifying where improvements were needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff followed robust medicines management procedures.

Staff maintained appropriate standards of infection control.

There were enough staff to meet people's needs and keep them safe and they were recruited safely.

Staff were aware of risks to people and how to manage them.

Staff understood what abuse was and how to report it should they suspect it.

Systems were in place to keep people safe in the event of an emergency.

Is the service effective?

Good

The service was effective.

People's needs were assessed and the care people received reflected the needs identified in the assessment.

Staff had access to appropriate induction, training and supervision.

People's nutritional needs were assessed; they contributed to menu choices and had a balanced diet.

People had access to appropriate healthcare professionals when needed.

The design of the premises was suitable for the people living there.

People's consent was sought before they received care. There were no door codes or locked doors so people could come and go as they pleased.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People's privacy was respected.

Staff treated people with kindness and compassion and rotas were arranged to afford staff plenty of time with people.

Staff were aware of people's preferences.

People were supported to be as independent as they wished.

Is the service responsive?

Good

The service was responsive.

Care plans were in place to address the needs of people identified through assessment.

People had access to activities based on their interests.

People knew how to complain and felt comfortable doing so.

Technology was used to ensure people received timely care and support.

Is the service well-led?

Good

The service was well-led.

Staff said the manager was approachable and had improved communication.

There were effective quality monitoring systems to monitor the quality of the care people received.

Staff, people and relatives were encouraged to contribute to the development of the service.

Greathed Manor Nursing Home

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 was planned to check 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.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that occurred at the service. Statutory notifications include information about important events which the provider is required to send us by law.

This inspection took place on 11 April 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist nursing advisor and an expert by experience. A specialist nursing advisor is a person who has special knowledge and experience in caring for people with physical nursing needs and who uses this type of care service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of and relatives.

We spent time observing people in areas throughout the home and were able to see interaction between people and staff. We watched how people were being cared for by staff in communal areas. This included the lunchtime meals in the dining room and in people's rooms.

We spoke to five people using the service, two relatives and four staff. We viewed four care plans, three staff files, training programmes, medicine records, duty rotas, maintenance records, menus and quality assurance records. We observed medicines being administered to people, lunchtime, the home environment and activities. We also asked the provider to send us information following the inspection, which they did. We spoke to the manager and the regional manager and the lifestyle coordinator.

Good

Is the service safe?

Our findings

People and their relatives told us the service was safe. One relative told us, "There is always staff around" and another told us, "They make sure relatives and visitors sign in and out" and, "You can go home with a happy feeling that he's being looked after".

The provider's systems, processes and practices safeguarded people from abuse. We asked a staff member what they understood about safeguarding and they said, "It's about keeping residents safe and protecting them against any abuse". Staff were able to identify different types of abuse such as, physical, psychological, financial, emotional, institutional and neglect. The member of staff said, "I have not seen any abuse. If I saw it, I would report it to my manager and if my manager doesn't do anything, I would report it to social services".

People's risks were assessed and their safety monitored and managed so they were supported to stay safe and their freedom respected. Risk assessments were in place for areas such as nutrition, moving and handling and falls. For example, one person's case notes showed that they had been admitted to the home with a pressure ulcer. They were referred to the tissue viability nurse (TVN).The care they prescribed included use of an air mattress, changing dressings every three days and two hourly turning. The ulcer had healed at the time of inspection. There was a personal emergency evacuation plan (PEEP) for each person. This recorded the support they would need in the event of an emergency. We saw the emergency lighting and firefighting equipment had been serviced by a fire safety engineer in March 2018. The home's maintenance officer recorded weekly checks on the fire alarm system and equipment. Appropriate equipment was provided for people.

There was an emergency (business contingency) plan in place which had been reviewed by the manager in 2018. Staff said they had all the training they needed to meet people's needs but one member of staff told us that they did not feel confident in emergency evacuation procedures. We informed the manager of this and in response the manager told us that they had arranged refresher fire training.

There was sufficient staff deployed to meet people's needs. The manager told us they calculated the numbers of staff needed on each shift using a dependency tool, which they reviewed each month. The manager said there were usually six care staff and one registered nurse on duty each morning and five care staff and one registered nurse on duty each afternoon. We checked the rota and found that the staffing levels calculated as necessary were maintained. Where needed, agency staff had been deployed to ensure safe staffing levels were sustained. The manager told us the previous clinical lead had left and that the provider was recruiting a replacement. The staff team included a care co-ordinator whose role was to manage care staff and to work alongside them to ensure they maintained good practice in the care they provided.

People told us that that they did not have to wait long to be helped by staff. One person told us, "I have a call bell in my room, and they come quite quickly when I use it". Another person told us, "Yes, I use the call bell. The one in my room…the staff come quite quickly…5-10 minutes but it depends how busy they are. But I

never have to wait very long".

Staff files contained evidence of robust recruitment processes to check staff were suitable for their roles including application forms and interviews. All contained a job description and contract of employment, proof of identity and address and evidence of Disclosure and Barring Service (DBS) certificate. DBS certificates help employers ensure staff are suitable to work in care and support services.

The provider ensured the safe and proper use of medicines. One person told us, "I get them on time and I know what they're for, it's the same it's been for years".

The nurse on duty told us that they had completed medicine management training online. They also had a practical face-to-face competency test when they joined the company a year ago. There was a list of staff with signatures and initials in front of the medicines records, to ensure staff who administered medicines could be easily identified. We saw that efforts were made to help people understand their medicines.

Staff were familiar with the provider's medicines policy and Patient Information Leaflets (PILS) were available for people. Staff had available a British National Formulary (BNF), policies and procedures and (NICE) guidelines which all help them to understand the medicines, possible side effects and good practices. A nurse told us that as part of their training they had to read the policy and procedures and then sign a form to say that they had read and understood it.

There was a clear system for ordering, dispensing, storing and disposal of medicines. Entries of receipt of medicines and the quantity received was recorded on the medication administration records (MAR) and signed by two nurses. Stock balances were recorded consistently on the MAR charts.

Controlled drugs checks were carried out twice a day and a register was completed accurately. A body map was in use for transdermal patches to ensure these were placed in the correct places each time. Temperatures were checked regularly to ensure that medicines were kept and stored in line with the manufacturer's guidance. MAR charts were legible with no gaps. A GP reviewed medicines every six months, but 'as required' (PRN) medicines were reviewed monthly. Staff had access to PRN protocols to guide them on when to administer these medicines to people. We observed that the administration of medicine was safe and staff followed best practice. The manager carried out weekly medicine audits.

We observed that staff maintained appropriate standards of infection control. All areas of the home were clean and hygienic. Relatives told us that their family members' bedrooms were kept clean and that standards of cleanliness in the home were good. The manager told us two cleaners were employed to ensure the home had a cleaner on duty every day. Cleaning rotas were in place to ensure that all areas of the building were cleaned regularly. Staff had access to personal protective equipment (PPE), such as gloves and aprons, when providing personal care. All bathrooms had soap and paper towels available and good practice in hand-washing guidance was displayed for staff. A person told us what staff did when they came into their room, "The first thing they do is pick out the gloves and pick out the aprons from the drawer."

We saw evidence that lessons were learned when things went wrong. For example, following an occasion when a nurse missed administering medicine to people, measures were taken to prevent this from happening again. There was a signing in sheet so that staff could tell at a glance whether the medication round had been done or not.

Good

Is the service effective?

Our findings

People were supported to eat and drink enough and to maintain a balanced diet. One relative told us, "There is a wide range of food." They told us their family member enjoyed the food and had plenty of choice. They said, "They come round with the menu. She has plenty of choice. She has asked occasionally for things like smoked salmon and they have made those available." Another person said of the food, "It's very good. They have a questionnaire sometimes about what you like and don't like".

The chef knew people's dietary needs well and their likes and dislikes. They confirmed that the menu had recently been changed to reflect people's views about the food. They told us they had spoken to people after the introduction of the new menu to hear their feedback.

Care staff communicated effectively with kitchen staff about people's dietary needs, such as texture-modified diets or people who needed supplements. The chef was also provided with information about any food intolerances people had and their particular likes and dislikes. People had been encouraged to contribute to planning the menu. A residents meeting had been held to establish which dishes people enjoyed and their ideas had been incorporated into the menu.

We saw that there were sufficient staff to assist people at meal times where necessary. There were staff trained to feed people by PEG (percutaneous endoscopic gastrostomy). People fed in bed were sat up before being assisted and some people had fluids thickened if prescribed by the speech and language therapist (SALT). This support means that the risk of choking is reduced.

People's needs were assessed thoroughly. There was an effective use of technology. People were assessed holistically and their care plans were held on an electronic system. We saw that staff had hand-held electronic tablets they could use to update the care plans. For example, one person who was nursed in bed needed two-hourly turning. The care plan was updated as soon as the person was turned by staff using the electronic device.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care and treatment was always sought in line with legislation and guidance. Mental capacity assessments had been carried out and people were encouraged to make decisions about their care and treatment. Best interests decisions were made when people lacked capacity. For example, one person had a

MCA and a best interests decision made for the use of bed rails. A relative and the person were involved in the discussion and it had been signed by a doctor with a review date set.

Staff files contained evidence of an induction that included fire procedures, reporting incidents, health and safety, infection control and safeguarding/whistle-blowing policy. One staff member told us they had all the training they needed to meet people's needs but did not feel confident in their knowledge of the MCA. We discussed this with the manager who took action to address it. After the inspection, the manager notified us that a programme of face to face MCA and DoLS training had been arranged for all staff.

The service made sure that staff had the skills, knowledge and experience to deliver effective care and support. A relative told us of staff, "He had lots of falls before he came here but they manage it well here and he's only had a couple. I think that they are trained very well". A staff member told us that they received a lot of training. They told us that they had been encouraged to develop in their role. Training had been made available so that they could take on more responsibilities such as administering medication. A nurse told us that their training included medicines management and competency training, safeguarding and certification of death.

People were supported to live healthy lives, have access to healthcare services and receive ongoing healthcare support. For example, one person was identified at risk of malnutrition from the MUST (malnutrition universal screening tool) in their care plan. The nurse said, "If somebody has a score of two, I would refer them to the dietician and the GP. The dietician would normally recommend that the food is fortified, the person is given extra snacks, is prescribed nutrients and is weighed regularly." The care plans were followed by staff and reviewed regularly.

The care plans recorded when people needed to see healthcare professionals and staff made arrangements for people to attend appointments. For example, two people were receiving visits from community nurses. One person told us, "I'm going to see a dentist soon. They come in. The chiropodist comes regularly as do the optician and doctor".

The home's design was suitable for people living and working there, apart from the example below regarding someone who was unable to sit at a table with others until we raised the issue with the manager. There were lifts and ramps for wheelchair users. One person who used a wheelchair told us, "I manage to get all around the home…. more or less." In the dining room, we saw that one person was unable to sit at a table with other people because their wheelchair would not fit under the table. The person said, "I'm always put here by the wall, and I want to sit at a table, I'm always sitting alone". We spoke to the manager about this. After the inspection, the manager notified us that table raisers had been ordered and that they were awaiting the delivery. This meant the person would be able to join others at the dining table according to their wishes.

Good

Is the service caring?

Our findings

Staff treated people with kindness, dignity and respect. A relative said of staff, "They (staff) are incredibly caring, very kind and very personable." A person living at the home told us, "The staff are really lovely, very kind and respectful."

The staff were friendly towards people. They knew people well and had a good understanding of their individual needs and choices. People were supported with their spiritual needs, and a priest visited the service. Visitors were welcomed at any time at the home.

People were encouraged to remain independent. A relative said of their family member, "He likes to be independent and they encourage that." Thought had been given to the layout of rooms, so that everything people needed was accessible to them. Tables and chairs were not a hindrance or a risk when people moved around the home. We saw some people had been given beakers with a spout to make it easier for them to drink without assistance.

People were supported by staff that knew them well. There were "About Me" life histories stored on the electronic records system and staff were knowledgeable about these. There were many family photographs and familiar memorabilia from people's lives before they moved to the home plus paintings, crafts and memories made since they had arrived. In one person's room, there was a hanger with different colours of wool for their tapestry work which was in easy reach for them to access from their wheelchair.

One person who enjoyed the scenery and birds had two metal stands with five different types of bird feeders and there were ledges for the birds to stand on so the person could see them feed. They belonged to the person and had been put into the ground outside their window. The person benefited from this as they liked to identify the different types of birds that visited. This showed that staff knew the person and made efforts to improve their wellbeing.

People's dignity and respect were maintained. Staff said that they always offered people a choice of what they wanted to wear. We observed staff knocking on people's door before entering and maintaining people's privacy when carrying out personal care. During the medicines round, the nurse knocked on the door of people's rooms and introduced herself and asked them whether it was OK to give them their medicines.

At lunchtime, people were clean and well dressed in appropriate clothing. People were wearing jewellery, nail varnish and make-up with their hair clean and styled. Staff gained permission from people to put aprons on them saying, "It will protect your nice clothes." All people asked agreed and staff helped them with their apron. A member of staff was encouraging one person to feed themselves independently. The member of staff very gently coaxed the person and kept a close eye on them. The member of staff praised the person when they successfully managed independently.

Staff involved people in their care. We saw staff spending time to sit and chat with people. They did not

appear to be rushed. We saw evidence that they were involved in decisions such as what to wear and what to eat and what activities they would like to do. We also saw that people were given choices through regular reviews and residents' meetings.

Good

Is the service responsive?

Our findings

People were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. One relative told us, "There are sufficient activities for him to take part in if he wants. There are activities on every day. He particularly enjoys the music." Another relative told us, "There's a real range of activities. They started a cooking club and she joined in with that. There's a gardening club. They planted seeds, which was nice."

We observed two people and two members of staff were playing badminton with racquets and a balloon in the lounge. They all seemed very happy playing as there was much chatter, joking and laughing as they tried to keep the balloon afloat. A person using the service told us, "I like art, singing…but it depends on who does it. We have a lady that comes in and she is very good." Another person said, "I do painting, embroidery, knitting and we do planting up when the weather is better. They put what we need out on tables and we plant up there and it goes into the garden, there are a few people that do it."

The two lifestyle co-ordinators provided activities from including art and crafts, games, outings, entertainers, books, jigsaws, quizzes, physical exercises, films, knitting, tapestry, gardening and visiting animals. They had links with the local community and school students visited weekly to work with people. The extra member of staff meant that people had access to activities at weekends in addition to weekdays. They spent time trying to engage with people nursed in their rooms in addition to implementing group activities. People were encouraged by staff to continue with their interests and hobbies and even to try new ones.

People received personalised care responsive to their needs. People we spoke to did not remember being involved in the care plan process but did say that staff have asked them questions about their care. We saw that people's wishes had been taken into account and adjustments made. For example, a couple were given adjacent rooms to enable them to be near to each other. This showed staff were responding to what was important to people. Where people needed support with personal care, there was detailed guidance for staff. We also noted information such as people's routines and preferences were documented.

People told us that they knew how to complain. One told us that they could use the residents' meeting to raise any issues, "Yes, I should think so…there are residents' meetings…we just had one". Another person told us, "I suppose I'd talk to the manager".

There was a complaints log. A relative had a concern about items going missing in the laundry. They had raised this as a complaint with the manager. They were not satisfied with the manager's response and told us that the manager was considering their response. This corresponded with what the manager told us, that she was continuing to work with this relative to find a solution.

At a residents' meeting in March, complaints were made about cold food. In response, a new food trolley was purchased to keep food hot until it was served. People told us that the food was served much hotter as a result.

People received appropriate and sensitive end of life care. One person had a life limiting illness and the local hospice provided support. The dietician was also involved as the person had lost weight. We saw that staff had been liaising with a community nurse regarding PEG feeding. We saw written documentation from relatives who were very complimentary about the staff when they had to break the news to their relative that someone close to them had passed away.

Good

Is the service well-led?

Our findings

Staff we spoke to said the manager was supportive. One member of staff said of the manager, "She is supportive and knowledgeable."

Relatives we spoke with said the manager was very visible around the home and approachable. They were aware that the manager had initiated some changes, such as the new menu, as a result of people being encouraged to make their own suggestions. One relative described the manager as, "Very friendly and approachable."

The manager had applied to be the registered manager and was supported by the provider's regional manager. There was no clinical lead in post at the time of our inspection but the provider was recruiting to this role and the post had been advertised. The staff team included a care co-ordinator whose role was to manage care staff and to work alongside them to ensure they maintained good practice in the care they provided.

People were involved in the running of the home. The manager had recently improved the communication with people and their relatives and amongst staff. Residents meetings and relatives meetings had been implemented and were held each month.

The meetings file provided evidence that people had been asked for their ideas about the food at the home and these had formed the basis of the new menu. People had been asked which activities they would like to try and a number of these had been planned. The provider included the dining experience in the quality audits carried out. The residents' meeting topic of the month this month is menus and diet.

A relative told us that they had been made aware the manager had arranged a relatives meeting for the following week. One relative told us of the home, "They are very good with communication and letting us know what's going on." The manager told us that they planned to send out a survey to relatives and residents in the near future.

Systems in place enabled effective communication between staff. Meetings for key staff groups, such as care staff, nursing staff and heads of department, had been introduced. The manager told us these were used to identify any challenges to the service and to plan how to address them. We saw from the minutes that staff had been encouraged to contribute their ideas about how the service could be improved. Staff had a clear understanding of their roles and structure of the organisation when we spoke with them.

Staff told us that the manager encouraged them to be open and transparent. One member of staff said, "[the manager] has been really good. She has made a lot of changes for the better." The member of staff told us staff meetings were held regularly and that the manager encouraged staff to have their say. For example, staff had reported to the manager that they did not have sufficient clinical waste facilities in all areas of the home and the manager had made sure this was addressed.

Staff told us that there was always a handover at the beginning of a shift. Handovers are where staff from the previous shift update the next shift coming on duty about the people they care for and any other relevant information, for example, faulty equipment. The chef told us that the heads of departments meetings introduced by the manager had improved communication amongst the different parts of the service, which had benefited people and staff.

People benefitted from the provider's links with the community and relevant stakeholders. The manager told us they aimed to establish and build links with local community groups. For example, the manager had contacted the local school and as a result, children would be coming in to read to people. We also saw evidence of the provider working alongside community healthcare organisations as well as the local authority when meeting people's needs.

There were regular, comprehensive audits carried and recorded in key areas of the service. These included infection control, medicines management and health and safety. Equipment used in the delivery of people's care, such as lifting equipment and pressure-relieving mattresses, were checked regularly. Other aspects of people's experience at the home, such as their mealtime experience, were also audited on a regular basis. The provider also regularly audited infections, pressure ulcers, bruising, complaints and unplanned hospital admissions.

The service was subject to regular quality assurance monitoring from the provider. We were told that the company was investigating and reviewing a new quality assurance system which would enable them to see if there were any trends, particularly for accidents. This would enable them to see what action needed to be taken to prevent accidents in the future.

Care records were stored securely within the home on their electronic system. There was evidence that the home shared information and assessments with other relevant agencies such as, GPs and community nurses for the benefit of people who use the service.