Bupa Care Homes (CFHCare) Limited

Grey Ferrers Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 and 9 December 2015 and was unannounced.

Grey Ferrers Nursing Home has four separate units. Brandon Unit provides low level dementia/mental health care and care for those with a physical disability. Stewards Hay which provides medium level dementia/mental health care and care for those with medium physical disabilities, Woodville provides high level dementia/ mental health care, and Bradgate Unit which provides end of life care. All four units provide both residential and nursing care. The location is registered to provide care for up to 120 people with dementia and physical disability. At the time of our inspection there were 83 people using the service.

Grey Ferrers Nursing Home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe at the service, and were happy living there. Staff had a good understanding of how to safeguard people and protect them from abuse. Staff were confident about what action they would take if they had any concerns, this would include reporting concerns to the unit manager or the registered manager. Staff were aware of the whistleblowing policy and felt confident to use it.

People were protected by safe staff recruitment procedures. Staff had received training which reflected the needs of the people living at the service and enabled them to provide support in a safe manner. This included supporting people with specific health related conditions and the appropriate use of equipment to move people safely.
We saw that people received their medication in a timely and safe manner, administered by staff who were trained in the administration of medication. People's needs had been risk assessed to promote their safety. We saw there were sufficient staff to support people's individual needs.

People told us that the food had recently improved as there was a new chef. People were offered choices with food and drinks and appropriate support was given when needed. There were drinks and snacks available between meals. We were informed that the nutritional risk screening tool and food record charts were not being completed correctly. This meant that people living at the service who are at risk of poor nutrition may not be being supported appropriately in order to meet their nutritional needs.

People were protected under the Deprivation of Liberty Safeguards (DoLS). We found that appropriate referrals had been made where people were thought to not have capacity to make certain decisions and had restrictions placed upon them.
We found conflicting information in people's mental capacity assessments. We saw that in some instances documentation stated that a person living at the service lacked capacity but further documentation stated the same person had capacity. There were no decision specific mental capacity assessments in people's

plans of care. This meant there was a possible risk that people's human and legal rights were not being respected.

People's health and welfare was promoted and they were referred to relevant healthcare professionals in a timely manner to meet their health needs.

People's plans of care were personalised and accurately reflected people's care and support needs, the plans of care included information about people's life histories, interests and likes and dislikes which provided staff with sufficient information to enable them to provide care effectively.

People told us they were happy with the care they received and were complimentary about the staff. The service had an atmosphere which was warm, friendly and supportive. We saw staff positively engaging with people living at the service and treating people with dignity and respect.

Audits and checks were effectively used to ensure people's safety and the building and equipment were well maintained.

The provider's management team and registered manager provided effective leadership to the service and sought regular feedback from people living at the service, and their relatives. They encouraged staff to attend meetings to share their views in order for them to review and develop the service.

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.

People were protected from abuse because staff had a good awareness of abuse and how to report concerns.

People were protected by safe staff recruitment procedures. There were sufficient staff available to meet people's assessed needs and ensure their safety.

Risks to people had been appropriately assessed. Measures were in place to ensure staff supported people safely.

Medicines were administered in accordance with best practice. There were protocols in place where covert medicines were given.
People received their medication as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate training to enable them to provide the care and support people required. There were appropriate induction procedures in place for new members of staff.

We found conflicting information in people's mental capacity assessments. There were no decision specific mental capacity assessments in people's plans of care

People's dietary requirements were met and their choices and preferences were taken into consideration. The nutritional risk screening tool and food record charts were not always being completed correctly.

Staff had a good understanding of people's health care needs and referred them to health care professionals in a timely manner.

Is the service caring?

Good

The service was caring.

The staff knew people well and there were positive relationships between the staff and people living at the service.

People were treated with dignity and respect.

People were encouraged to make choices and decisions for themselves.

Is the service responsive?

Good

The service was responsive.

Care was responsive to people's individual needs and preferences.

Activities were available within the service to suit the individual needs of the people living at the service.

Staff responded to people's needs in a considerate and timely manner.

Is the service well-led?

Good

The service was well led.

The registered manager provided staff with appropriate leadership and support, staff were complimentary about the support they received from the manager and the management team.

There were effective quality assurance systems in place to monitor the quality of care and to drive improvements within the service.

The provider's management team and registered manager were clear about the aims of the service and worked collaboratively with people living at the service in order to improve and develop the service.

Grey Ferrers Nursing and Residential 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.

This inspection took place on 08 and 09 December 2015 and was unannounced.

The inspection team comprised of four inspectors and one expert by experience that had experience with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a dementia care service.

We looked at and reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted commissioners for social care, responsible for funding some of the people living at the service. We also reviewed the information we held about the service which included notifications of significant events that affect the health and safety of people living at the service. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with eight people living at the service and nine relatives. We spoke with eight members of care staff, three unit managers, the registered manager, area manager and the regional support manager. We also spoke with three health and social care professionals. We reviewed the records of eight people, which included plans of care, risk assessments and medicine plans. We also looked at recruitment files of four members of staff, a range of policies and procedures, maintenance records of equipment and the building, quality assurance audits, feedback forms and minutes of meetings.

Good

Is the service safe?

Our findings

People living at the service told us they felt safe there, one person said, "I am safe here, all the staff are wonderful". A relative we spoke with told us, "My wife is safe here, in all aspects of the word". Another relative we spoke with said, "I know my wife is safe here otherwise she wouldn't have been here for six years. I visit every day and have never seen or heard anything that would concern me".

Staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. Staff informed us that they had received safeguarding (protecting people from abuse) training and they knew where the whistleblowing policy was kept, all staff we spoke with said they would feel confident to whistle blow if they felt it was necessary.

Staff understood the type of abuse that could occur and their responsibility which was to report concerns to the nurse in charge or the unit manager in the first instance. Staff were able to describe the different types of abuse that could occur, and the action they would take, which was to report the incident and record what was witnessed, said or found. Staff were confident that the unit manager or registered manager would act promptly and appropriately. They were also aware that they could report concerns to external agencies, such as the local authority, or Care Quality Commission. This meant that people living at the service could be confident that issues would be addressed and their safety and welfare promoted.

Plans of care contained risk assessments (an assessment to evaluate or analyse the risks to the individual), including those related to nutrition, falls, pressure care and moving and handling. We saw that measures were in place to manage and monitor those identified risks. For example, we saw one person was unable to use the call bell system. We saw there was a risk assessment in place with instructions that the person be checked hourly when in bed. We saw evidence that these checks were being completed in order to maintain the person's safety.

We saw there was sufficient staff to meet people's needs, and we saw evidence that staffing levels were increased if a person's needs increased. For example, we saw that one person required additional support when receiving personal care in a morning, therefore an extra member of staff was provided for this period of time each day. The registered manager regularly assessed the staffing levels to ensure they reflected the needs of the people living at the service.

Staff told us that they felt there were sufficient staff to meet the needs of the people they cared for. Staff rotas were reflective of the staff on duty and we saw that the unit managers and nurses worked alongside staff in the delivery of care and support to people with their meals and activities. For example, we saw that during lunch the unit manager and the nurse complete what they had been doing in order to provide support to people eating their meals.

Staff informed us that they were aware of how to deal with emergencies; they had received training in first aid and fire safety. We saw evidence that people had personal evacuation plans within their records to be acted upon in the event of a fire. This was to help ensure people received the appropriate level of support in

the event of a fire to help keep them safe.

We saw that there were accident and incident records which were up to date. We saw evidence that appropriate action had been taken when accidents and incidents had occurred. For example, we saw that one person living at the service had sustained a skin tear caused by a disc attached to a sling. We saw that appropriate first aid was given, family were informed and all discs on slings had now been removed to reduce the risks of this happening again.

We found that staff recruitment procedures operated by the provider were safe and in line with their policy and appropriate checks were carried out. This showed that suitable arrangements were in place to reduce the risk of unsuitable staff being employed at the service.

There were effective systems in place for the maintenance of the building and we saw records of services for equipment such as slings and hoists as well as testing of water, fire equipment, boilers, heating and gas. This meant people were accommodated in a well maintained building with equipment that was checked for its safety.

People received their medicines safely, when they needed them. One person living at the service told us, "The staff help me with my medication thank goodness, I would never manage without them". We saw that people were supported by staff to take their medicines in a safe way. There were protocols in place for people who took PRN (taken as and when required) medication, and there were also protocols in place for people who took covert medication (covert medication is the intentional administration of medication to people without their knowledge and may be administered without their knowledge in food or drink). We found decision specific assessments completed for covert medication as well as a GP authorisations and confirmation from the Pharmacist of what food and drinks the medicines can be given in.

We observed the nurse on the units to administer the medicines to people individually and the medication administration record (MAR) completed to confirm the medicines were taken. All staff who administered medication had received appropriate training in the administration of medication. This ensured people's health was supported by the safe administration of medicines.

We saw that medicines were kept securely in the locked treatment room. Daily fridge and room temperatures were maintained within the recommended guidance. Medicines stored in the fridge were dated when opened to ensure medicines were effective as they needed to be used within the recommended 28 days of opening. We saw that there were arrangements in place for discarding medicines that were no longer required.

Requires Improvement

Is the service effective?

Our findings

One member of staff told us, "I love it, we get really good training, and I had a good induction". Another member of staff told us, "I had a week's induction when I started which was really good and we get on-going training".

Records showed that staff had accessed a range of training that was specific to the needs of the people living at the service. These records showed staff had completed training in relation to the safeguarding of adults, manual handling, infection control, food hygiene, dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards. We saw evidence that all care staff were trained in all areas so that they shared the same knowledge and skills in order to provide effective care and support to the people living at the service.

Newly recruited staff received a week long induction within the service and all staff were due to commence the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. These standards ensure that the care staff are caring, compassionate and provide quality care to the people using their service.

The registered manager informed us that staff had regular supervisions, and that these were individual supervisions where any issues regarding the people living at the service, the team or personal were discussed as well as development needs. There were also group supervisions which could incorporate training or a reflection on a specific incident. One member of staff told us they found one to one supervision useful as they received constructive feedback which enabled them to make improvements to their practices where required.

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 make 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).

People were protected under the Deprivation of Liberty Safeguards (DoLS). We found that appropriate referrals had been made where people were thought to not have capacity to make certain decisions and had restrictions placed upon them.

We checked whether the service was working within the principles of the MCA.

We saw that staff had completed training in MCA and DoLS and we saw that staff sought verbal consent

before they supported people living at the service. Staff told us that they understood their role to protect people who lacked the mental capacity to make certain decisions about their own wellbeing or have restrictions placed upon them.

We found conflicting information in people's mental capacity assessments. In some instances it was documented that people had capacity but the pre-admission documentation stated they lacked capacity. In one plan of care it stated the person lacked capacity to make future decisions but on another document it was recorded that the person was able to discuss their future decisions and, therefore this would suggest that the person did have capacity to make these decisions.

We did see evidence of decision specific assessments in relation to covert medications, however in plans of care we saw summary sheets of people's capacity in relation to aspects of their care was indicated by V for variable capacity, L for lacked capacity, and H for has capacity. These were not supported by any decision specific assessments, or evidence of how these decisions were reached. The registered manager informed us that they were planning to discuss this with the provider as they were aware that further action is needed to ensure documentation is kept with the plans of care, to reflect the assessment of the person's mental capacity, best interest meeting and DoLs authorisations.

One relative told us, "I've been here at breakfast, lunch and tea and they look really good. This year we've decided to have our Christmas dinner with dad here". Another relative told us, "The food is good, I have my lunch here every day and I will choose for my wife as I know her likes and dislikes".

Staff and relatives informed us there had been issues with meals and food in the past. The registered manager told us they were aware of this and had been addressing the problem. A new chef had recently been employed at the service and a catering focus group had been arranged. The first meeting was held on the day of our inspection and one relative informed us that it had been useful and productive.

We saw that people were offered a choice of food and drinks at meal times and asked if they would like more when they had finished. We saw that staff cross checked meal requirements against nutritional charts to ensure people's specific dietary needs were met. People were able to sit where they chose to eat their meals and were appropriately supported by all the staff.

Plans of care showed that each person had a nutritional risk assessment and a nutritional screening tool. These were used to identify the level of support that people required. We spoke with the dietician who visited the service on a regular basis and they informed us that staff were not always completing the nutritional risk screening tool, or food record charts correctly. The dietician had been providing training to the staff but felt there were still improvements to be made. This meant that people living at the service who were at risk of poor nutrition may not be supported effectively in order to meet their nutritional needs.

We saw that where there were concerns about people's food or fluid intake, or they had difficulty swallowing or a risk of choking they were referred to the appropriate healthcare professionals, such as the dietician or the speech and language therapist (SALT). Recommendations to manage nutritional risks were included in people's plans of care and we observed staff following guidance in supporting people with their meals. For example, we saw that one person had been identified as a risk of choking. We saw that this person was provided with a smooth diet and the appropriate aids to support them with their meal.

Information in people's plans of care showed that referrals were made to healthcare professionals in a timely manner. Visits from healthcare professionals included GPs, opticians, occupational therapists, dieticians and speech and language therapists. One relative informed us, "I'm here every day and if she

[their relative] needs to see the doctor or nurse then that's what happens". Another relative told us, "The staff are straight on the phone if he's not well, they will also call me in case I need to be here when the doctor comes".

Staff informed us that any instructions or guidance given by the health care professionals was communicated to others during the handover meeting, for example, increased monitoring of a person, or a change of food consistency due to swallowing difficulties. We saw that people's plans of care were updated to reflect these changes.

Good

Is the service caring?

Our findings

One person living at the service told us, "The staff are just lovely, I can have a laugh and a joke with them", another person said, "Nothing is too much trouble for the staff and sometimes they just know what you need and do it without you even having to ask".

Relatives we spoke with told us the staff were kind and caring, one relative said, "I am so grateful she [their relative] is here, she gets such good attention from the staff, they know exactly what to do for her", another relative told us, "The staff here are very kind and patient". Another comment received from a relative was, "The staff are very caring, they are always smiling and happy which makes the people living here happy".

Our observations showed staff sitting and talking with people. Staff spoke in a kind and reassuring manner. We saw staff being caring and affectionate with people, such as holding their hands. People living at the service were observed to be laughing, chatting and singing with the staff.

We saw that staff called people living at the service by their first names and we were informed that these were the names that either the people themselves, or their relatives had requested they be called by. We saw that staff communicated with people effectively and used different ways to offer support. For example, we saw staff were at the same eye level with people who were seated and they spoke clearly, giving people time to process information and reply. Staff were kind and polite when they spoke with people and did not rush them to give responses or make decisions.

We observed a person become distressed, we saw that staff responded to them in a calm and reassuring manner and remained with the person until they were feeling happier. We saw in the same person's plan of care that it identified what triggers may cause them to become distressed and what staff could do to minimise this. This showed that staff were able to respond appropriately to people in a positive and caring way, whilst also reducing people's distress.

Relatives told us that they were involved in assessments and planning of their family member's care. One relative told us they were kept informed of changes and staff would discuss how those needs were being met.

Staff we spoke with knew about people's interests and preferences and wherever possible supported people to make decisions about their care and support needs. Plans of care showed that preferences such as choices of clothing were recorded for staff to be aware. Daily records completed by staff included information about the support people received including one to one support, involvement in activities, nutritional needs and contact with relatives, friends or professionals.

We saw that staff encouraged people living at the service to be as independent as possible and that they offered assistance at an appropriate pace. For example, we saw a member of staff who was supporting a person to eat their dinner ask if they had finished what they were eating before offering them more food.

People told us that staff treated people living at the service with dignity and respect. One relative said, "Staff respect both of us and treat us well".

We saw that staff received training in the promotion of dignity and respect. They were able to give us examples of the steps taken to maintain a person's dignity when they were supported to maintain their personal hygiene. For example, because all the bedrooms were on the ground floor it was important for them to ensure that the curtains were drawn to maintain the person's privacy and dignity. We saw staff cover ladies with a blanket when they were being hoisted in order to maintain their modesty.

During the inspection we saw staff knock on people's bedroom doors and only entered when permitted to do so. If no response was heard then staff would announce themselves and then enter. We saw staff act quickly when a person asked to use the toilet in order for their dignity to be maintained.

The registered manager informed us that they had sourced funding for all care staff to become dignity champions, (a member of staff who pledges to challenge poor care, act as a good role model and educate those working around them). This was to ensure that all staff would be able to make changes to bring better dignity to those using the service.

Peoples records contained information about their end of life care. The registered manager informed us that there would be a new end of life care plan introduced in the near future as it had recently been piloted in one of the providers other locations. They informed us that the new care plan would be more detailed, informative, and person centred. The current care plans contained information such as DNAR (do not attempt resuscitation) decisions, family involvement , and also medication required. This showed that the service supported people at the end of their life to have a comfortable, dignified, and pain free death.

Good

Is the service responsive?

Our findings

People's plans of care were detailed and informative. They provided staff with clear guidance on each person's individual care needs and were updated regularly to help ensure the information was accurate and to reflect the changes in the person's needs. These changes were communicated daily during staff handovers.

One relative informed us that they had been involved with the planning of their relatives care when they were admitted to the service. Plans of care were developed from people's assessment of needs. There was written documentation to say that family had been involved with the planning of care, however there were no records of on-going communication with family members to show that they had been informed of any changes. Plans of care were not signed by the person or their relative.

Plans of care reflected how people liked to receive their care and support. For example in one plan of care it clearly stated how a person who had some communication difficulties found it easier to understand staff if they positioned themselves directly in eye contact and did not speak more than five words at a time.

Staff were able to tell us detailed information about people's preferred daily routines, interests, likes and dislikes, this enabled staff to provide consistent care and support that was responsive to their individual needs. This information was not as detailed in people's plans of care. One unit manger informed us that they were aware of this and planned to involve staff in the care planning process to ensure that plans were more person centred.

Activities and interests were evident to meet the individual's needs. A person living at the service told us, "I like the Saturday cooking. We make cakes like my mum used to make and the smell is amazing. I used to be a good cook". Staff told us that one person living at the service had been accompanied to a football match a few weeks previously as they were a keen football supporter. Another person living at the service had a shed outside which they and their family member had built together.

We saw that staff provided group activities as well as individual activities, and these varied between the four units. In one of the units we saw the activity co-ordinator ask people if they wanted to join in a giant tactile board game. We saw that people were offered prompting and encouragement when they were participating and we also saw that people's choices were respected if they chose to opt out of playing the game. In another unit we saw games of skittles and cards as well as a film to watch, and in the unit where there were people cared for in bed we saw the staff spend time with people in their rooms reading books to them or giving them hand massages. This showed that staff were responding to individual needs by engaging in one to one activities.

We saw staff spontaneously engage with people when they were alert and responsive. For example, we saw a member of staff encourage a person to read sentences from a book. We saw that the person was engaged and happy and they were smiling and laughing with the member of staff. Throughout the inspection there was music playing in each of the four units and both staff and people living at the service were singing along

to it.

People we spoke with said they felt confident to raise a concern or complaint if needed, one relative told us they had complained about a damaged item of clothing. They told us that they received an apology and were also reimbursed financially.

We saw that there was a complaints policy in the service, and the complaints procedure was displayed in all the units for people living at the service, and their visitors to see. The same complaints procedure was also given to people upon admission to the service.

There was a complaints file in each of the units and a copy in the main office. We saw that all complaints were recorded and appropriate action taken before the complaint was either closed or escalated. We saw evidence that complaints were investigated. For example, we saw one complaint about a person living at the service wearing unclean clothing. We saw that a meeting had been held for all parties and an outcome had been reached that all parties agreed with.

Good

Is the service well-led?

Our findings

The registered manager and management team encouraged people to be involved in developing the service. The registered manager worked alongside staff to ensure that the service people received was reflective of the provider's visions and values for respecting people and promoting respect and equality for all.

Staff told us they found the registered manager supportive and approachable. One member of staff told us, "The manager is really good, I think they're brilliant. We get regular supervision and can talk to them about anything that we're struggling with".

The registered manager informed us that staff morale had improved greatly over recent months, the service had introduced a staff reward scheme and staff were involved with writing the services newsletter. Regular staff meetings were held in all four units where staff were encouraged to express their views and opinions on how to improve and develop the quality of the service.

The attitude of staff and the registered manager showed they were committed to their work and to providing the best possible care. Staff told us they felt empowered to be actively involved and to be responsible and accountable for the care of the people living at the service. The registered manager and unit managers had regular meetings in order for best practice to be shared between the four units.

We saw that feedback was sought from people living at the service and also their relatives, these were in the form of surveys. We saw that there were positive comments written on the surveys which included, "My mother has thrived since joining the home. We are delighted with the support, help and skills the home provides. Well done to all the staff who are very welcoming". And also, "The residents are always nicely dressed and the rooms are clean and tidy, the units smell nice, I enjoy visiting".

There were suggestions and compliments forms available throughout the service as well as meal feedback forms. We saw comments such as, "Dinner today was very beautiful and very tasty, it was the best meal ever tasted", and also, "The cook is so much better, I hope it stays this way".

During the inspection we saw that in the units there was a display of 'What you said…..What we did', in response to feedback received. For example on one of the boards it stated that concerns had been raised regarding the food at times. Therefore a food focus group had been arranged for all to attend and discuss the food concerns.

Resident and relatives meetings were held with the registered manager approximately every two months. We saw that the registered manager had taken appropriate action to concerns raised. For example one person had reported that clothing had gone missing. In response to that there was now a system to ensure that all clothing was appropriately labelled upon admission to the service.

Quality monitoring audits were completed on a regular basis, these included checks on care plans,

medication, staff recruitment files, health and safety, housekeeping and catering. The registered manager also performed a weekly walk round the entire service and completed an improvement plan from the results of this walk round. For example, we saw that they had observed a strong odour of urine in one of the units. The action that had been taken was to arrange a meeting with maintenance to understand the reasons for this and to rectify the problem.

Quality monitoring audits were also completed in the individual units, these concentrated on medication, meeting nutritional needs and dignity, respect and involvement.
We saw evidence that action was taken as a result of the audits. For example it was identified in the medication audit that some unused medication had not been returned. We saw that this was signed and dated as being actioned.

The registered manager notified the Care Quality Commission of significant events that affected people's safety and wellbeing including any allegations of harm and abuse.

The provider's management team worked closely with the local authority and clinical commissioning group (CCG) to improve the quality of care for people living at the service. Feedback received from the local authority was positive and detailed improvements which had been made to improve and develop the quality and standards of care. This was also reflected in the services on-going sustainability plan which was updated on a regular basis by the management team. This showed that the provider would be able to continue to provide the appropriate care and support and keep people safe.