

Bupa Care Homes (CFHCare) Limited

Grey Ferrers Nursing and Residential Home

Inspection report

5 Priestley Road, Off Blackmore Drive
Braunstone, Leicester, LE3 1LF
Tel: 0116 247 0999

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Good



Overall summary

This inspection took place on 22 January 2015 and was unannounced, we returned announced on 26 January 2015.

At the last inspection on 30 and 31 July 2014 we asked the provider to take action to make improvements. The provider was not meeting five of the Health and Social Care Act 2008 Regulations. These related to care and welfare, safeguarding people from abuse, management of medicines, staffing numbers and assessing and

monitoring service provision. The provider sent us an action plan to tell us the improvements they were going to make. At this inspection we found that these improvements had been made.

Grey Ferrers Nursing Home has four separate units. 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 112 people using the service.

The service is required to have a registered manager in post. A registered manager is a person who has registered

Summary of findings

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. At the time of the inspection a registered manager was in post.

People told us they felt safe. Staff understood their responsibilities about safeguarding people from abuse. They knew how to raise and report concerns. Some staff did not fully understand what constitutes restraint and were not following best practice guidance. We found that recording when people had been given their medicines was not up to date on one unit and some medicines were not being stored at the correct temperatures. This put people at risk of not receiving their medicines in a safe way.

Risk was assessed and management plans were in place to help keep people safe. The provider used safe systems when new staff were recruited. All new staff completed training before working in the home.

Staff received the training and support they required to meet people's needs. Staff knew how best to

communicate with people and offered people choice. Legislation for gaining consent from people who did not have capacity was not always followed and this put people at risk of having their liberty deprived unlawfully. People liked the meals provided. Staff referred people to health care professionals such as doctors or specialist nurses as soon as this was required.

People were treated in a kind and caring way. Staff maintained people's privacy and dignity. There was a range of social and recreational activities on offer but people were not enabled to follow their chosen hobbies or interests. During the inspection we observed that some people were not engaged with any activity and did not have any interaction with staff for 45 minutes.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

Quality monitoring and complaint handling systems were effective and demonstrated that learning and improvement was on-going. There was a management and support structure at the service and staff were clear about their roles and responsibilities.

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 not consistently safe.

People who lived in the home were put at risk because policies and procedures about restraint were not in place and some staff did not fully understand what constituted restraint. Some areas of the service had not been maintained to a good enough standard. Staff did not always follow safe practice guidance when managing people's medicines.

Staff knew how to report abuse and who to report it to.

Requires Improvement



Is the service effective?

Some aspects of the service were not effective. Requirements about gaining consent from people who lack capacity to make a decision were not always followed and some staff were not clear about what was expected of them. Some people did not get the support they needed to eat their meal.

Staff knew about people's needs and preferences and how best to communicate with people. They were supported by managers and had received most of the training they required.

Requires Improvement



Is the service caring?

This service was caring. People told us that they were well cared for and we saw that the staff were caring and people were treated in a kind and compassionate way. The staff were friendly, patient and discreet when providing support to people.

People were treated with respect and their independence, privacy and dignity were promoted. People and their families were included in making decisions about their care. The staff in the home were knowledgeable about the support people required and about how they wanted their care to be provided.

Good



Is the service responsive?

Some aspects of the service were not responsive. Some people were not engaged with activity or staff interaction for a long time. While staff took time to find out about people's social and cultural needs, this information was not used to enable people to follow their chosen interests and hobbies.

Staff communicated with people and their relatives in an effective way. There was a robust system in place to manage complaints and learn and improve.

Requires Improvement



Is the service well-led?

The service was well-led.

Good



Summary of findings

Systems were in place to effectively monitor the quality of service provision. There was a registered manager and a supporting management team. Staff were well supported by the registered manager and there were good systems in place for staff to discuss their practice and to report concerns about other staff members.

People and their relatives were asked for their opinions of the service and their comments were acted on.

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 22 January 2015 and was unannounced. We returned on 26 January 2015 announced. The inspection was completed by three inspectors.

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 also reviewed additional information the provider had sent us such as

safeguarding notifications, these are made for serious incidents which the provider must inform us about. At the time of our inspection the service was subject to a large scale investigation undertaken by the local authority because of concerns that had been raised.

We spoke with seven people who used the service and five visiting relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the deputy manager, the clinical services manager and one of the provider's area managers. We spoke with two unit managers, three qualified nurses and six care staff. We looked at the care records of nine people who used the service and other documentation about how the home was managed. This included policies and procedures, records of staff training and records associated with quality assurance processes.

Is the service safe?

Our findings

At our last inspection we identified some concerns with safeguarding people from abuse because staff had not always followed policy and procedure for safeguarding and were not clear about managing behaviours that presented a risk. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that improvements had been made.

People and their relatives told us they felt safe. A relative told us that staff were always vigilant and kept people safe. They said “I ask them (their family member) if they are happy and they always say yes.”

Staff knew how to recognise the signs of abuse and knew what action to take in the event of suspected abuse. This included contacting other authorities such as CQC, the local authority safeguarding team and the police. Staff had received training about this and there was information packs on each unit that staff could access. Records showed the provider made appropriate safeguarding referrals when abuse was suspected. A safeguarding pack was available on each of the units so that staff had easy access to procedures and telephone numbers of authorities such as the local authority safeguarding team.

Staff we spoke with were clear that they did not use physical restraint. However, we saw that one person was sitting in a reclining chair with their feet elevated. The person was leaning over the side of the chair and had their hands on the floor and were trying to get up but could not. Staff did not intervene until alerted to this by the inspectors. Staff told us this person liked to walk around the building and that the reclining chair was not this person's chair. Staff had not recognised that the reclining chair was preventing the person from getting up and therefore was restraining them. We asked to see the provider's policy about restraint. We were told the provider did not have a policy about restraint but were shown a policy for Bupa Care Homes (Scotland).

We recommended that the provider ensures that staff are familiar with best practice guidance about the use of restraint so they are able to recognise all forms of restraint and protect people's safety and human rights.

We observed staff using hoists and other equipment to help people with mobility problems. They did this in a safe way and made sure the person was safe and reassured. Some people displayed behaviour that put themselves or others at risk. Staff responded appropriately and effectively communicated with the person so that risk was reduced. One person required a staff member with them throughout the day because they were at a high risk of falls. The staff member provided support to this person in an appropriate and least restrictive way. Records showed that this person had sustained injury and had a number of falls before the increased staff support was put in place.

Risks were assessed when people moved in and this was evaluated at least monthly. For example, people had their risk of falling and risk of developing pressure sores assessed. Management plans were in place where risk was identified. One person had been assessed as at high risk of developing a pressure sore and the care plan instructed staff to visually check pressure areas each day. Another person who had fallen had been referred to a falls clinic.

Equipment that we saw such as hoists and slings were in safe working order and has been checked and maintained. Some of the units were in need of redecoration because of scratched paintwork and stained carpets. The registered manager was aware of these shortfalls and was seeking funding from the provider to improve the décor. The provider had a contract with a waste management company. Some of the clinical waste bins were not locked as they should be. If left unlocked these bins could present a hazard to people. The registered manager took immediate action about this.

At our last inspection we identified some concerns with staffing numbers. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection whilst we found improvements had been made.

People told us there were enough staff on duty. A relative told us there was always a member of staff available to speak with. Some staff felt there were not enough staff on duty and this resulted in delay in getting people up in the morning. We spoke with the registered manager about staffing numbers. We were informed that that numbers were calculated using a staffing tool based on the dependency needs of people who used the service. A

Is the service safe?

weekly unit managers' meeting was held to discuss the weeks staffing needs and any shortages. A text system had been introduced to contact staff in the event of late notice staff absences. Staff were recruited only after satisfactory checks about their suitability to work at the service. The provider had clear disciplinary policies and procedures and used these where unsafe practice was identified.

At our last inspection we identified some concerns with the management of people's medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection whilst we found improvements had been made.

We observed staff administering and assisting people with their medicines. People were assisted appropriately and given the time they needed. Staff stayed with the person to ensure the medicine was taken in a safe way. The majority of medicines were stored in a safe way, a medicine fridge on one of the units was running at temperatures above acceptable limits. The registered manager took immediate action about this and ordered a new medicine fridge.

Protocols were not always in place about when staff should administer medicines prescribed on an as required basis. These protocols would have helped to ensure that staff knew in what circumstances the medicine should be administered or offered.

There were some missing signatures on administration charts and there was not a clear audit trail of the amount of medicine received into the service. This meant it was difficult for the manager to be assured that people had received the medicine that they had been prescribed..

Staff responsible for administering medicines had received training and had their competency assessed. The providers policy stated that competency should be assessed annually but some staff had not been assessed for more than a year. At the time of our visit there was nobody managing their own medicines but the provider had policies and procedures in place should this be requested. Senior managers carried out audits on each of the units to check that people's medicines were managed in a safe way.

We recommend that the service consider current guidance on managing medicines in care homes (NICE 2014)

Is the service effective?

Our findings

At our last inspection we identified some concerns with the care and welfare of people who used the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection whilst we found improvements had been made.

We observed that staff communicated with people in an effective way. Staff managed behaviour that could be risky in an effective way and offered reassurance to people in distress. For example, staff gave people time and did not rush them. We saw staff upholding people's right to make choices while also gently encouraging them to stay safe. Staff had received dementia training and the provider had recently updated the dementia training provided. This training was developed with input from an Admiral Nurse (specialist dementia nurse). A relative told us that staff knew how to do their jobs and communicated effectively. One person had arrived from their home with a pressure sore. This had now healed. Staff had used effective dressings and had prevented further pressure sores developing. Link nurse roles had been developed so that staff could keep up to date with best practice guidance. For example, there was an infection control link nurse who attended sector specific training about infection control. They had used this training to develop further guidance for staff about infection control.

There was an on-going programme of staff training and supervision. Staff told us they had received the training they required and had supervision. Records showed that the vast majority of staff had received the training they required to meet people's needs and to keep them safe. All new staff completed induction training when they first began working at the service. More than half of care staff had completed a nationally recognised qualification in care. Staff had opportunities to discuss their learning and development needs with their line manager during supervision sessions. We were given examples of how staff supervision had been used to identify staff training needs and to manage the performance of staff.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to their care and treatment. It also ensures people are not unlawfully

restricted of their freedom or liberty. Some people lacked capacity to consent to their care and treatment. We saw examples where people's capacity to consent had been assessed. The assessments were not decision specific and did not specify the best interest decision made.

Assessments must be decision specific because a person may be able to make a decision for one aspect of their life but not for another. Staff had written 'care given in the persons best interest' but had not specified what this was or how the decision was arrived at. We spoke with the registered manager about this, they were aware of this shortfall and had begun to take action about it. We were shown care documentation that was about to be introduced and implemented at the service. The new documentation included mental capacity assessments and best interest decision recording for different aspects of care and treatment. Staff were in the process of receiving training about MCA and DoLS and about the new documentation and how to use it.

Where people had to have their liberty deprived in order to keep them safe, this had been authorised by a member of the DoLS team. The registered manager was in the process of identifying people who may have required a referral to the DoLS team and was making appropriate referrals. When assessing people's capacity and making best interest decisions it is important to involve people who are important to the person. We were informed of one instance where a person's family member had not been informed about the DoLS or involved in the process. This was despite the relative holding a lasting power of attorney. We spoke with the registered manager who was aware of this issue and making changes to ensure it would not happen again. Some staff had a basic understanding about DoLS and were not clear about who had a DoLS authorisation in place. It is important that staff have this information so that they can apply the deprivation in the least restrictive way and in accordance with any conditions set.

Most people told us they enjoyed the food. One person said "I really can't grumble about the food". We observed the lunchtime meal and saw that people were mostly assisted in an appropriate way when this was required. One person preferred to eat their soup from a large bowl and this helped them to maintain some independence. Another person was sitting at the table in a wheelchair and had some difficulty getting their soup to their mouth because they were too far away from the table. We saw that the pureed food was not at the correct consistency. We spoke

Is the service effective?

with the registered manager about this, they were aware of this shortfall and had arranged additional training for staff from a speech and language therapist. Night boxes containing a range of snacks were available on each unit so that people had access to snacks at night. We observed staff offering people food and drinks throughout the day and people felt able to ask for a cup of tea or coffee when they wanted one.

People had their risk of malnutrition assessed and were referred to healthcare professionals such as dieticians or speech and language therapists when this was required. Some people had their food fortified with extra calories. The majority of staff knew which people required this but there were some discrepancies in the lists held by catering staff and the those held by care staff. This meant there was a risk that people would not get their meal fortified. Food and fluid charts were completed for people identified as at

risk. We saw that the optimum required amount of fluid required each day was recorded so that staff knew what to aim for. The amounts of food eaten was also recorded so that intake could be monitored. People had their risk of malnutrition assessed and their weight recorded and monitored where this was required.

We saw that people were referred to healthcare professionals when they needed this. A relative told us that staff would ask for a doctor as soon as this was needed and would also telephone and let them know. Records showed that staff requested a doctor's visit when people were unwell or a speech and language therapist when people had swallowing difficulties. Care staff we spoke with knew when they should report concerns about people's health and felt sure that the nurse in charge of the unit would take appropriate action.

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. A relative said “Yes definitely (caring). It’s nice to have friendly faces around. Last time I was here (the activities coordinator) was writing a poem with my relative to put on their door. I thought that was nice.” Another relative said “Staff are caring, they make sure everyone is ok.”

Throughout our inspection we saw that people were treated with respect and in a kind and caring way. Staff were friendly and patient. One person was distressed and shouting. Staff quickly responded to them and offered effective reassurance. Another person required a staff member with them at all times in order to keep them safe. We saw that staff carried out this role discreetly and sensitively. Staff knew about people’s individual needs and the best way to communicate with them. We saw that this had a positive effect on a person’s mood. Care plans were in place about the most effective way to communicate. For example one person required staff to speak with them in short simple sentences because of their cognitive impairment. Staff had arranged a hearing test for another person.

Two relatives told us that their family member’s personal items sometimes went missing. This included clothing and toiletries. We discussed this with the registered manager who acknowledged there had been concerns raised about these issues. They had begun to take action to address this.

On the Bradgate Unit, care plans for people receiving end of life care demonstrated that people or their relatives had been involved and consulted about their care and support. A relative said “The staff are very friendly, they keep me updated.” Staff ensured that anticipatory medicines were

prescribed and available in readiness for people experiencing pain or distress. Records showed that people’s relatives were kept informed about changes and consulted about care and support where this was appropriate. Family meetings were held so that relatives could have their say and provide feedback. Information about advocacy services was available so that people who required this could seek independent advice and support.

Staff described how they involved people in decision making about their care and support. They told us that people were always offered a choice. Many people who used the service had dementia and associated communication difficulties. Information that was important to the person was recorded so that staff could get to know people and their needs and preferences even when the person may not be able to clearly communicate.

People said they had their privacy and dignity respected. We saw one person being calmly and gently persuaded to go with staff in order to be assisted with their hygiene. This was done in a way that maintained their dignity. People told us that staff knocked on their doors before entering and treated them respectfully. Dignity in care was covered in the provider’s induction training. All staff undertook this training when they first began working at the service.

We were informed that the provider had introduced an award for staff who showed real care and compassion. This award was designed to encourage ‘caring’ and to improve the quality of people’s lives. Staff we spoke with demonstrated a caring attitude and told us how they made people feel like they matter. A staff member said “We make sure people are safe and make it like a home from home.” Another told us that staff cared about people and worked together as a team.

Is the service responsive?

Our findings

People had their needs assessed before they began using the service. Care plans included information that was important to the person. For example, a document known as the map of life set out significant events and important people in their lives. This meant that staff were able to get to know people and their preferences. People and their relatives told us that staff knew how to meet their needs. A person said “I like it here very much.” A relative told us that staff were approachable and always let them know of any changes. A plan of care was in place for each assessed need. A visitor told us their relatives preferences were met by staff. We were shown new care planning documentation known as ‘my day, my life’ that was due to be introduced. The new documentation was designed so that care and support could be planned in a personalised way.

People’s cultural and social needs were assessed and recorded. People were able to follow their chosen religion. Interests and hobbies were also recorded. We saw that there was a range of activities on offer such as crafts, quizzes and other group activities. There was limited evidence that people were able to follow hobbies and interests that were important to them. On two of the units there were periods of time when people were not engaged in any activity during our visit and interactions with staff were limited to tasks such as providing a drink or assisting people to mobilise. During one SOFI observation, there was no staff interaction with five people for 45 minutes. People did not appear distressed but they were not engaged in any activity or task and were passive and withdrawn. After 45 minutes the unit manager came and spoke with each of the five people. A relative said “We’ve lost (member of staff). They used to do a lot, not so much now. There used to be chess and dominoes, not so much now.” We were informed that one unit did not have an activities organiser in post

but recruitment to this role was underway. In the meantime the registered manager asked activity staff from other units to assist. A pet rabbit had been introduced to one of the units and staff reported that some people responded well to having access to and interaction with a pet.

Relatives told us they were made to feel welcome by staff. One relative said they were able to go and make themselves a hot drink whenever they wanted to. Some people had memory boxes outside their rooms. These contained items such as photographs that were significant to the person and assisted people to orientate themselves to their room and staff to get to know the person.

The provider had policies and procedures in place about complaints. A relative said “I can’t remember if there is a complaints procedure. I would go to the girls”. Another said “I know there probably is (a complaints procedure). I’ve never had cause to use it. If it was something small I’d speak to the staff, then the unit manager or nurse. I know I can speak straight to CQC.” We were informed that a welcome pack was given to people when they moved in and this contained details about how to complain. We saw that systems were in place to ensure complaints were investigated in a timely way. Complaints were recorded on a central system and analysed at service level and also at the provider’s head office at organisational level. This meant that any trends could be picked up and appropriate action could be taken. For example, complaints had been received about the quality of some meals. The registered manager arranged for additional training to be provided in order to address this concern.

People and their relatives felt that staff were approachable. As well as making a complaint people could also provide feedback or share their experience at resident and relative meetings and could use the provider’s suggestion box.

Is the service well-led?

Our findings

At our last inspection we identified some concerns with assessing and monitoring the quality of service provision. Information about people's care was not always available, issues identified at relative and staff meetings were not always followed up and there was limited evidence about lessons learned from incidents. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that improvements had been made.

People and staff were able to attend meetings to give their feedback about the quality of the service. Questionnaires were sent out annually and action plans were developed to make changes and drive improvements. A programme of quality audit was in place and this included a monthly provider review visit from a senior manager. Records of these visits showed that action plans had been developed where shortfalls were identified. For example, action had been taken to address a staff members poor practice where this was seen to be the case.

A staff member told us that staff meetings were held monthly. They said "We all get our say and we feel listened to." Staff confirmed they received supervision and support from their line manager. They said "The unit manager is brilliant and always approachable. We see the registered manager a lot and if they are not busy they will see you straight away." Information for staff about how to raise concerns was available on each of the four units. Staff knew how to raise concerns and said they would feel comfortable doing so. During our inspection we were made aware of an incident where staff had not followed the provider's policy.

We saw that the registered manager responded to this in a way that ensured the safety of people who used the service and also supported the staff member. We were informed that staff would attend at least six supervision sessions each year and a formal appraisal of their performance.

Each unit produced monthly quality metrics about important information about each person. For example incidents and accidents and other high risk indicators such as infections or wound care. This information was then analysed by the clinical services manager and also at organisational level as part of the provider's risk monitoring system. This meant that action could be taken to reduce risk and continually improve.

There were clear lines of responsibility and accountability. Managers worked closely together and all were clear about their roles. Records were maintained of all accidents and incidents and staff were required to report all accidents and incidents to the manager on call. The clinical services manager reviewed these and developed an action plan to reduce further risk. Weekly risk review meetings were held on each of the four units. All identified risks were discussed and people's care and support needs were reviewed. This was a new system recently introduced and had not been fully embedded into practice. The registered manager completed a daily walk around each unit to check on various issues, and to speak with people and staff. This provided opportunities for people to raise any concerns and for the manager to check the quality of care provision.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.