Greensleeves Homes Trust

# Viera Gray House

## Inspection report

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London
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This was an unannounced inspection that took place on 2 and 3 February 2016.

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

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

This was the first inspection following the change of ownership to a new provider. At this inspection the home met the regulations inspected against.

People and their relatives said the home provided a good service, there was no discernible difference in the standards of care by the new providers and they enjoyed living at Viera Grey House. Many of the staff had been retained and were friendly, caring, attentive and provided the care and support people needed and in a way they liked. They thought the home's atmosphere was relaxed and enjoyable.

The new providers were using the same recording systems as they gradually introduced new ones to promote continuity of care for people as staff were familiar with the systems in place. We looked at a sample of records that were clearly recorded, comprehensive, regularly reviewed and up to date. This enabled staff to continue to perform their duties well. People and their relatives were encouraged to discuss health needs with staff if they wished and they had access to community based health professionals, as required. They were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. People said there was a variety of well-presented meal choices, the quality of the food was good and it was the type of food they liked.

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

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

## 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 said they were safe. Staff followed effective safeguarding and risk assessment procedures. The home had appropriate numbers of skilled staff, who were appropriately recruited.

People's medicine was administered safely and records were up to date. Medicine was audited, safely stored and disposed of if no longer required.

### Is the service effective?

Good

The service was effective.

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

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

### Is the service caring?

Good

The service was caring.

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

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

### Is the service responsive?

Good

The service was responsive.

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

## Is the service well-led?

Good

The service was well-led.

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

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

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

# Viera Gray House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection and took place on 2 and 3 February 2016.

This inspection was carried out by one inspector.

There were 35 people living at the home, during the inspection. We spoke with nine people, two relatives, six staff and the registered manager. We also spoke to the GP attached to the home.

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

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

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

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

Good

# Is the service safe?

## Our findings

People and their relatives said the service was safe. One person told us, "I feel safe living here." Another person said, "There are plenty of staff to look after me." Relatives told us that the home had a family atmosphere that involved not just their family members. Everyone knew one another, had conversations with other people's relatives and this created a safe environment. A relative said, "This is a very safe environment, very much so."

There were policies and procedures for protecting people from abuse and harm and staff had been trained in them. We asked staff what they understood by abuse and what they would do if they encountered it. Their response followed the procedures. Staff told us that protecting people from harm, abuse and safeguarding was included in their induction and refresher training. This was with the previous provider, although the procedures were the same. Staff were aware of how to raise a safeguarding alert and the circumstances under which this would be necessary. Safeguarding information was provided in the staff handbook and a safeguarding pathway with local authority contact numbers was on display. There was no current safeguarding activity regarding the home. Previous safeguarding issues had been appropriately reported, investigated, recorded and learnt from.

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

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

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

During our visit there were sufficient staff to meet people's needs and the numbers reflected those recorded

on the staff rota. Staff also thought there were enough of them to meet people's needs. We saw that people's needs were safely met. The manager told us that the staff rota was flexible to meet people's needs and if extra staff were required to cover vacancies, holidays and sickness, this was done internally within the staff team.

Medicine was safely administered by staff who were appropriately trained and this training was refreshed annually. They also had access to updated guidance. The medicine records were colour co-ordinated to denote different times of the day when medicine administration was required. The medicine for all people using the service was checked and found to be fully completed and up to date. This included the controlled drugs register that had each entry counter signed by two staff members authorised and qualified to do so. Medicine kept by the home was regularly monitored at each shift handover and audited. There were also body maps showing the areas where creams and ointments were required to be administered. Medicine was safely stored in locked facilities and the temperature of designated fridges where medicine was stored was regularly checked and recorded. Any medicine no longer required was appropriately disposed.

Good

# Is the service effective?

## Our findings

During our visit people made decisions about their care and what they wanted to do. Staff were aware of people's needs and met them in a patient and friendly way. They provided a comfortable, relaxed atmosphere that people said they enjoyed living in. People told us they and their relatives made the decisions about the care and support they received and way that it was delivered. They said staff delivered care and support in a warm, supportive and appropriate way that people appreciated. One person said, "This is a very hard job that people (Staff) do well." Another person told us, "If I want to do something they (Staff) work around me." A relative told us, "One staff member is Romanian and spent time with my father going through a photograph album with him from visits he made there."

The new provider had retained many of the staff team who were well trained and in the process of receiving induction about the new provider and procedures. They had received annual mandatory training from the previous provider and were gradually transferring over to new systems. This meant continuity of care was maintained in a way that people using the service were accustomed to. There was a training matrix that identified when mandatory training was due. The training provided was based on the Skills for Care, 'Common Induction Standards' (2010). It included infection control, behaviour that may be challenging, medication, food hygiene, health and safety, equality and diversity and person centred care. There was also access to specialist service specific training such as dementia awareness. New staff spent time shadowing experienced staff as part of their induction to increase their knowledge of the home and people who lived there. The communication skills that staff used demonstrated that they knew people as individuals and understood the methods needed to meet people's immediate needs and make themselves understood by people. Staff meetings, one to one supervision and annual appraisals identified individual and group training needs. There were also staff training and development plans in place.

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke

with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of DoLS. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

People were given full nutritional and fluids assessments that were updated regularly using the 'Malnutritional universal screening tool' (MUST) and evidence from care records showed that nutritional and fluid intake needs of people who use the service were met. If there were concerns about people's weight or weight loss they were weighed regularly with records kept. There was information regarding the type of support people required with eating or drinking at meal times and nutritional advice and guidance was provided by staff. Nutrition and hydration was included as part of core staff training. We saw people were appropriately supported and encouraged to eat and drink by staff. If people had difficulty eating properly they were referred to a GP who prescribed appropriate food supplements. People had annual health checks. The records demonstrated that referrals were made to relevant community based health services and they were regularly liaised with. Staff said any concerns were raised and discussed with the person's GP. There was a GP practice that attended the home, although people were able to retain their own GP if they preferred. A GP from the practice visited during the inspection. They told us they thought the home provided a good service. The records we saw were up to date and fully completed. If people required a hospital visit, they were accompanied by a member of staff and written information was provided for the hospital.

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

People's consent to treatment was regularly monitored by the home and recorded in their care plans.

Good

# Is the service caring?

## Our findings

During our visit people said that they were treated with compassion, respect and their right to dignity was observed by staff and the management team. One person eating lunch dropped a little food and said sorry. People and their relatives told us that staff endeavoured to meet more than people's basic needs. This reflected in the care practices we saw with staff knocking on doors and waiting for a response before entering. Staff were courteous, discreet, considerate and kind to people when we were present and when they did not know they were being observed. One person eating lunch dropped a little food and said sorry. A staff member re-assured them saying you don't have to be sorry and the person smiled. Staff supported people, in an enabling way to make decisions. People were listened to; their opinions were valued and acted upon as required. One person we spoke to told us, "Staff are very nice, friendly and helpful." Another person said, "I am certainly happy with the staff." A relative said, "I only have praise for the staff and am very impressed."

There were numerous positive interactions between people who use the service and staff with quality time being spent on a one to one basis chatting, as well as group activities. People who required it were reassured by staff and, in the case of people with dementia this was repeated as many times as required to give them re-assurance and comfort. Staff practice demonstrated that they had a good understanding of caring for people with dementia. Staff were very familiar with how people liked to be addressed, their routines, hobbies and interests. Staff respected people's confidentiality, had discreet conversations with them and shielded them from situations that may potentially embarrass them. This included personal care that was delivered in private and staff enquired if people needed the toilet without bringing them to the attention of other people. Staff used open, positive body language and engaged with people in a skilled and friendly way treating them equally, as their equals and not talking down to them. Staff showed a genuine interest in people's lives and what they had done during them. This was supported by the life history information contained in care plans that people, their relatives and staff contributed to. This was added to and updated as more information became available. The care plans also contained people's preferences regarding end of life care.

The home's approach to delivering care and support was focused on each person as an individual and staff were trained to promote a person centred approach that was reflected in their care practices. People were treated as individuals in their own right rather than a task to be completed. A staff member said that staff rotated work on the different units and this, combined with the size of the home made it easier to be aware of every person using the service and become more familiar with their needs, wishes, routines and preferences. One person said, "Staff all chat to me and know my name." A relative told us, "Staff are welcoming, pleasant and always make me feel at home." Staff involved people in discussions about their care and care plans were developed with them and had been signed by people or their representatives.

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

The home had a confidentiality policy and procedure that staff said they were made aware of, understood

and followed. Confidentiality was included in induction and on going training and contained in the staff handbook.

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

Good

# Is the service responsive?

## Our findings

People and their relatives told us that staff asked for their views and opinions formally and informally. One person said, "It's my birthday and I've had cards and presents." Another person told us, "I go out to the garden when the weather is nice, I do like going." A relative said, "This is a lovely, homely place."

Staff enabled people to make choices, decide things for themselves, listened to them and took action when required. They made themselves available to talk about anything people wished to discuss and gave them appropriate support to make their views understood. People were consulted about what they wanted to do and when. They were reminded of and encouraged to join in activities and staff made sure no one was left out. People were also encouraged to interact with each other as well as staff. There were regular changing daily activities that the new providers had continued with, as people using the service indicated these were what they wanted. The home did not have an activities co-ordinator as it was felt better to encourage staff to take responsibility and develop this area of their care skills. Staff said they were quite happy to take on this responsibility and we saw that it worked well. There was also a very positive input from the 'Friends of Viera Gray House' who provided and funded some of the activities. One person said, "Relatives weeded the garden area by the fish pond and wouldn't do that if they weren't happy with the place." A relative told us, "There are enough activities, he (Person using the service) tells me what he has been doing every time I visit which is often." There was a weekly activities list. The activities included exercise class, reading, music therapy, arts and crafts, visiting hairdresser, coffee and conversation sessions, visits to the Wetlands Centre, Kew Gardens, Brighton and Windsor Castle. There was also a 'Men's club' with beer, chat and televised football. The 'Friends of Viera Grey House' also operated a mobile shop at the home where people could make purchases.

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

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

information gave the home, staff and people using the service the opportunity to identify activities they may want to do. The home operated a keyworker system and the care plans were reviewed by the keyworker, supervisor and person using the service, if they wished, monthly.

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

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. There was also information provided to contact an Ombudsman, if required. One person said, "If I had a complaint I would have no qualms and not be afraid to discuss them."

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

Good

# Is the service well-led?

## Our findings

The new provider's vision and values were clearly set out and not dissimilar to those of the previous provider with the focus being on the enablement of people to make their own decisions and enjoy life in a safe environment. The management and staff practices reflected this as they went about their duties. People, their relatives and staff told us there was an open door policy that made them feel comfortable in approaching the manager, management team and members of staff. They also thought it was important that continuity had been maintained with the manager and many staff being retained. One person told us, "Any problems and I just talk to the manager." Another person said, "I like the manager very much, he is extremely nice and easy to talk to." Staff told us the support they received from the home manager was excellent and the cordial relationship that existed between them and the home manager meant they felt happy and motivated. This was reflected in their happy, calm and relaxed approach to their jobs with no sign of pressure or tension. They thought that the suggestions they made to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member said, "You can turn to someone when you need to". Throughout our visit people were actively encouraged to make suggestions about the service and any improvements that could be made.

There were clear lines of communication within the new provider organisation and home with specific areas of responsibility and culpability identified. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

Records showed that safeguarding alerts and accidents and incidents were fully investigated, documented and procedures followed correctly. This included hospital admissions where information was provided and staff accompanied people using the service. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that contained performance indicators, identified how the home was performing, any areas that required improvement and those areas where the home was performing well.

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

The home maintained strong community links with regular visits from local schools and religious

organisations.