Anchor Trust

# Greenacres

## Inspection report

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| 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? | **Requires improvement** |

## Overall summary

Greenacres is a care home without nursing that provides accommodation and support for up to 62 people who are elderly and some are living with dementia. The home is purpose built and divided into five units. Each unit has its own lounge, dining area and kitchenette. On the day of our inspection there were 49 people living in the home.

This inspection too place on 25 March2015 and was unannounced.

The home did not have a registered manager in post on the day of our inspection. The home was being managed by a provider manager until a permanent manager is appointed. A registered manager is a person who has been 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.

People were at risk of becoming ill because the heated trolley used to keep food in was not in good working order.

# Summary of findings

People were well cared for and the atmosphere in the home was relaxed and happy. People told they were treated well by staff who were kind and caring. People's privacy and dignity was maintained and we saw staff knocked on people's doors before they entered. We saw a person was able to have a key to their bedroom to promote their privacy and manage their personal space.

Staff had undertaken training regarding safeguarding adults and were aware of what procedures to follow if they suspected abuse was taking place. There was a copy of Surrey's multi-agency safeguarding procedures available in the home for information. We saw staff were trained to carry out their roles and keep the people they supported safe.

Risk assessments were in place for all identified risks.

Care was provided to people according to their agreed care plan. People had their needs assessed before being admitted to the home and care plans were drawn up from the information obtained from these assessments, input from people and their relatives. The assessment tool had been modified to ensure that the manager did not admit people who required nursing care. People's decisions about their care were included in their care plan.

People's health care needs were being met. People were registered with a local GP and also had visits from other health care professionals. Regular health checks were undertaken and appropriate referrals made when required. End of life care plans were also in place.

People have sufficient food and drink.

We looked at the medicine policy and found all staff gave medicine to people in accordance with this policy. Medicines were managed safely and people received their medicine in a safe and timely way.

There were enough staff working in the home on the day of our inspection to meet people's needs.

Staff recruitment procedures were safe and the employment files contained all the relevant checks to help ensure only the appropriate people were employed to work in the home.

People were engaged in a range of activities on individual units throughout the day. These included coffee groups, a "knit and natter" group and various board and quiz games.

Systems were in place to monitor the service being provided. Regular audits were undertaken and annual surveys carried to monitor the quality of service provision.

People had been provided with a complaints procedure and were confident that any complaints would be handled appropriately.

Procedures were in place to manager foreseeable emergencies.

During the inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010. You can see what action we told the provider to take at the back of the full version of the report. the

# 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 is safe

The provider had appropriate arrangements in place to safeguard people from potential harm or abuse.

Medicines protocols were effective and people received their medicines safely according to their medicines plan.

Staff recruitment procedures were robust to help ensure the safety and welfare of people.

There were sufficient staff employed to meet people's needs.

**Good**

**Is the service effective?**
The service was not always effective.

People were at risk of becoming ill because the heated trolley used to keep food in was not in good working order.

The provider and staff had a good understanding of the Mental Capacity Act 2005.

People received adequate nutrition and hydration which included people's choice, preference and met their assessed need.

Staff had the appropriate training and supervision to undertake their roles.

**Requires improvement**

**Is the service caring?**
The service is caring.

People were cared for a staff team who were caring and kind.

People were involved in decision making whenever possible.

People were treated with dignity and respect. Staff spoke with people in a polite and kind way.

Privacy was respected and staff knocked on doors before they entered.

**Good**

**Is the service responsive?**
The service was responsive.

People received personalised care that was responsive to their needs.

People's concerns and complaints were listened to and responded to according to the complaints procedure in place.

People were encouraged to participate in activities.

**Good**

# Summary of findings

**Is the service well-led?**

The service was well led by a provider regional manager.

The appointee manager had a good understanding of the home's aims and objective and the needs of the people who lived there.

There were systems in place to monitor the quality of the service being provided and regular audits and customer satisfaction questionnaires were used to monitor progress.

**Requires improvement**

# Greenacres

**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 was an unannounced inspection, which took place on 25 March 2015. The inspection team was made up of two inspectors and an expert by experience. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience in caring for someone living with dementia.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is an account of significant events that occur in the service.

During the visit we spoke with 14 people, six family members, eight staff, two health care professionals, the hairdresser, and three members of the management team. We spoke with two care managers following the inspection.

We looked at eight care plans, eight risk assessments, four staff employment files and records relating the management of the home.

We observed the interaction between people and staff and spent time on three units observing lunch.

The last inspection of this home was on 3 January 2014 where we found our standards were being met and no concerns were identified.

Good

# Is the service safe?

## Our findings

People told us they felt safe. We were told "Staff are at hand to help me, all I have to do is ring my bell". "I came into the home when things got too unsafe at home and I was unable to look after myself", and "I don't fall anymore which is a blessing".

Staff told us they would be able to recognise the signs of abuse and were aware of the different types of abuse. We saw staff had undertaken training about safeguarding adults as part of their induction training, and this was updated annually. One staff member said "If I was worried about anything or if I saw anyone being ill-treated I would report this to my line manager immediately".

There was a safeguarding policy in place which provided staff with step by step guidance to follow and all staff were familiar with this policy. This ensured that people were protected from harm and abuse. A relative said, "I was told about safeguarding by the manager when I came to look around and because they were so open it influenced my decision to move my family member".

Risk assessments had been undertaken to identify any risks to people. When individual risks had been identified management plans were drawn up with guidance for staff to follow in order to keep people safe. For example a person required a walking aid to walk but was prone to forget this due to their dementia. Staff followed guidance outlined in a risk assessment to manage this in order minimise restriction on their independence. Another person smoked and this was managed sensitively with a member of staff sitting with them as they required supervision to keep them safe. When a person was at risk of choking a soft diet was provided and fluids were thickened to minimise the risk. People who were at risk of developing pressure ulcers had a skin integrity assessment called a Waterlow score which classified the risk and appropriate pressure relieving equipment was provided. Assessments were reviewed at least monthly or more frequently if people's needs changed. A relative said, "They are very open with me and tell me exactly why they are doing things as Mum had to have bed rails to keep her safe during the night".

There were enough staff on duty during our inspection to meet people's needs. There were two care staff on each unit and two team leaders "floating" between the five units.

We looked at the staff duty rotas for the previous month and we saw there were two staff provided on each unit and two team leaders to cover between units which was sufficient to meet people's needs.

The home also employed a team of domestic staff over seven days and we saw the home was clean and fresh. There were catering, maintenance, laundry, activity coordinators and an administrator to further support people.

There was a safe recruitment process in place and the required checks were undertaken before staff started work. We looked at staff employment files and noted that staff had been recruited safely. This included two written references, a past employment history, a health screening questionnaire and a satisfactory Disclosure and Barring Service (DBS) checks.

People received their medicines safely. There was a policy in place for medicines administration. Staff who had responsibility for the administration of medicines had signed this policy indicating they had read and understood this. Staff had received training in medicines safety awareness which was updated annually. Medicines were stored safely and securely on the individual units. A fridge was available for medicines that had to be stored below room temperature, for example insulin, eye drops and creams.

Appropriate arrangements were in place in relation to the recording of medicine. The service used the medication administration record (MAR) chart to record medicines taken by people. We noted appropriate codes were used to denote when people did not take their medicines.

For example if they refused, if they were on leave or in hospital. The MAR charts included information about people's allergies, if they required PRN (when required) medicines and a photograph for identification. The majority of medicines were administered using the monitored dose system (MDS) from blister packs.

Appropriate arrangements were in place in relation to the safe recording of medicines.

We spoke with a team leader who was able to clearly explain how medicines were ordered and counted in to

Good

# Is the service safe?

and out the service. The process explained was safe and effective and provided clear audit trails. A pharmacy visit had taken place during February 2015 no issues had been identified.

The service had sufficient arrangements in place to provide safe and appropriate care through all reasonable foreseeable emergencies. For example staff had undertaken emergency first aid training and fire safety and were aware of the procedures to follow if required. Protocols were in place for staff to follow in the event of utility failure, adverse weather conditions and an outbreak of infection

Requires improvement

# Is the service effective?

## Our findings

Meals were brought to the units in heated trolleys. Three people told us on Daffodil unit their chips were cold. We noted the switch on the trolley that regulated the heat at which food is kept and stored was missing and therefore the trolley was not maintaining food at the correct temperature. This meant that people were at risk of becoming ill due to equipment in the home not being maintained. The manager informed the kitchen staff immediately and this was repaired before we left the home.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (e) Premises and equipment

People told us they received care and support from staff who understood their needs. One person said "I like to have a shower and staff give me plenty of time in the morning and I am never rushed." A relative said "Mum always looks clean and well cared for".

There was a comprehensive staff training programme in place to ensure that staff had the knowledge and skills to undertake their roles and responsibilities. A staff member told us they had undertaken a full induction training programme in addition to completing an induction workbook. They worked with a senior member of staff until they were assessed as competent to undertake their role. Other training included first aid, manual handling, continence care, and food hygiene, safeguarding adults, management of medicine, fire safety awareness, and infection control and dementia awareness. Training was delivered either face to face or by e- learning. Electronic records were kept of the training provided and when this was required to be updated. A staff member said, "We are always training and I like this as it makes my job interesting". Staff felt they received sufficient training to meet people's needs.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was aware of the changes in DoLS practices and had policies and procedures regarding the Mental Capacity Act 2005 and DoLS. Some people had capacity and were able to make decisions for themselves and manage their affairs. We saw some people were able to make decisions regarding every day routines for example, personal care, menus, and activities, but required support with some other skills like finance management and consent to care and treatment. People's need for a best interest decision where they may have lacked capacity to make their own decisions had been considered and we saw the provider had made DoLS applications to the local authority for people who required this.

Staff told us they had regular supervision with their line manager. This was a process where they were able to discuss their roles and responsibilities, the standard of their work and their training requirements. They also had an annual appraisal of performance when strengths and needs were recognised and a further development was facilitated to promote best practice.

People told us they received appropriate health care support. One person said "My GP is very good and he will always explain what the problem is". And another told us "I cannot fault the care I get here from my doctor and district nurses."

Care records showed people's health care needs were monitored and action taken to ensure these were assessed by the appropriate health care professionals. People were registered with local GPs who visited the home weekly or more frequently when required. During our visit we saw following prompt action from the provider the GP arrange for someone to be admitted to hospital. Appointments with other health care professionals were arranged through referrals from the GP. Staff recorded visits from health care professionals in the appropriate section of their care plan. This included any medicines or treatment prescribed and details of any appointments made. We saw people had access to a dentist, chiropodist and optician when required. One health care professional we spoke with felt staff were professional and efficient.

Concerns were raised by a health care professional before our inspection that the home was unable to meet the health care needs of some people who lived there, and because of this two people were admitted to local hospitals in a poor state of health. The manager explained that these people's needs had changed prior to their admission to hospital and they now required nursing care and would be going to an appropriate nursing home on discharge from hospital. Assessments have now been modified to ensure the service does not admit people to the home with complex health care needs that they are unable to meet.

Requires improvement

# Is the service effective?

Staff had a good understanding of people's care needs. We watched staff support a person to walk with support to the dining room for lunch. This person told us "I was unable to do this when I came here they are really marvellous." We saw someone was anxious and wandering about the unit when staff offered to take them to the bathroom. They said "It is usually a sign they want to use the bathroom or go for a little walk." And "You get to know people after a while and what their needs are." When coffee and biscuits were being served a member of staff offered a person some diabetic biscuits. They told us "these are his own as he is not allowed ordinary ones and we wouldn't want him to miss out".

We saw people could move about the home freely and we saw someone on the ground floor having coffee with friends and saw them again joining activities on the first floor.

People told us the food was good and they enjoyed their meals. Comments included "I can choose what I want and it is usually the best choice". I like the puddings best" and "The food has deteriorated since I came but however last night's vegetable curry with chutney was lovely"

Records showed people's nutritional needs and preferences had been assessed using a nutritional screening tool (MUST). Catering staff had a list of people's likes and dislikes and details of people who required a special diet for example, soft diet, pureed meals, diabetic diet or people who needed a weight gain or weight loss diet. Menus were displayed in the dining rooms and we read there was choice offered to people. Fluid input and output charts were maintained for people who required this. Weight was recorded monthly and any issues were brought to the attention of the head of care and action taken.

We observed lunch and we saw people were enjoying their food in a relaxed and unhurried atmosphere. A selection of fruit juice and water was provided with their meal.

Good

# Is the service caring?

## Our findings

People told us they were very happy living in the home.

Comments included “This is a good home and I want for nothing”. And “The staff are kind and hardworking although they are rushed of their feet”. A relative said “I looked at several homes before I chose this one for Dad as it felt just right!” Another relative said “The place itself is nice and relaxed and they take good care of my family member.”

Staff provided care and support in a kind and caring way. We saw a member of the activity staff cutting a person’s finger nails. The member of staff was engaged in a meaningful discussion with the person about the clocks changing and the start of British summer time, and what this meant to them when they were younger and generated many memories about the seasons.

People’s privacy and dignity was respected and staff spoke to people in a polite and kind way. People were addressed according to their preferred name as agreed in their care plan which was usually their first name. Personal care was undertaken in people’s own rooms or in locked bathrooms.

Staff knocked on bedroom doors and waited for a reply before entering, which helped to maintain people’s dignity. We saw staff sit with people in their bedrooms or the dining areas and supporting them to eat. People were encouraged to bring ornaments and photographs into the home to make their bedrooms more personal to them. One person took great pride in showing us their room and their family photographs arranged on shelves. They said “Staff come and talk to me sometimes about these photographs which are a great comfort”.

The provider had employed a dementia care coordinator to support staff in understanding the needs of people living with dementia and provide them with appropriate training to meet those needs effectively.

People were encouraged to make choices about their daily routines. Some people chose to spend time alone and participate in activities they liked. One person said “I can sit where I like and I enjoy the garden in the good weather. We saw people were offered the choice of drinks throughout the day and appropriate help and support was provided for people who required help to drink.

Relatives told us they were welcome to visit at any time during the day and always found their family member well cared for. They could visit their relative in the privacy of their room or designated areas were available throughout the home where people could meet in private. One relative told us “I can arrange to have a meal with Mum when she does not want to go out and that is good.”

End of life arrangements had been discussed with relatives and the multidisciplinary team. We saw that advanced care plans were in place where appropriate and these were amended regularly with input from other health care professionals. Staff told us that relatives could stay all night if their loved one was nearing end of life and were encouraged to.

Good

# Is the service responsive?

## Our findings

People told us they had been consulted and included in their care planning from the beginning. One person said "Someone sat with me and spent ages asking me questions about my health, my diet and even how many pillows I liked, I could not believe it". Relatives told us they were consulted about their family member's care when people were not able to contribute themselves. Relatives told us "I was asked all about Mum's early life, where she went to school, the date of her marriage and hobbies." And "I was asked for some old family photographs and they put them outside Mum's door so she could recognise her room, what a lovely idea".

People had assessments undertaken before they were admitted to the home in order to ensure the service had the resources and expertise to meet people's needs. People told us that staff from the home came to visit them in hospital and asked them several questions about their health, what they looked and what mattered to them. Relative told us they had been involved in part of the assessment especially with their relative's life history. The care manager had been visiting a person in hospital undertaking an assessment when we arrived. They later showed us the assessment tool they used which was detailed and informative. Before they decided to accept the person they made a telephone call to the district nurse as specific clinical needs had been identified and the service wanted to confirm if this would impact on the district nursing team.

Care plans were well maintained and reviewed regularly. Each care need was supported with a plan of care and objectives to be achieved. Staff recorded daily entries in the care plans about how care was delivered on each day and how that person was feeling and if they had any visitors either family or health care professionals. This information was also communicated to the staff team at handovers to ensure continuity of care and that no important information was missed.

We saw people could move about the home freely and we saw someone on the ground floor having coffee with friends and saw them again joining activities on the first floor.

There was a wide range of activities available which were organised by two activity coordinators. When we arrived we saw people playing board games on Bluebell Unit and others were sitting reading the paper in a coffee group. There were activities available on all the units and we talked with people in the "knit and natter" group who were busy knitting for their expected great grandchildren. They said there was "Always something to do and you choose what you want." Activities included music and exercise, reminiscence, quiz, board games, one to one time, hand massage, nail painting, and crafts. One person said "I was very active once and liked line dancing I would like that here". And another told us "Exercise tomorrow and that will be a laugh".

One person said I used to go the park when I first came but not as often now". This was due to decreasing mobility needs. "The hairdresser will be here tomorrow and she always brings a bit of life to the place" The activity coordinator told us activities were seasonal and a garden project would soon be arranged once the weather became warmer. They said "We have raised flower beds and people love it." All important events were included in the activity planning for example Valentine's day, sporting moments, Easter, and St Georges Day when crafts would be made according to whatever theme is going on. Birthdays were also celebrated and a birthday cake was provided by the kitchen.

People's spiritual needs were observed and visits form various clergy were arranged on request. A church service was organised every two weeks for people who wished to attend.

People knew how to make a complaint or comment on issues they were not happy about. People and their relatives were provided with a copy of the complaints procedure when they moved into the home. There was also a copy of this displayed in the main entrance. People expressed satisfaction with the service and they had not needed to implement a formal complaints process. They said if they were unhappy with any aspect of the service they would talk to a member of the management team to voice their concerns. They felt this was usually enough for any niggles or issues to be "Put right".

We looked at the complaints log and saw there had been no complaints recorded for the past year. Staff kept thank you letters and cards from relatives showing their appreciation and gratitude for the care and support provided by the management and staff.

Good

# Is the service responsive?

Transition between services was handled well. One person required an ambulance for a hospital admission. Relatives were contacted and were in the home to accompany their family member to hospital to reduce any anxiety and support communication. The service provided a hospital admission document with all relevant medical history that may be required by the hospital medical staff to promote good communication. “My relative has always had excellent care here and I have nothing but praise for the home”

Requires improvement

# Is the service well-led?

## Our findings

The home has been without a registered manager since December 2014. The home was being managed by a provider regional manager. They told us this was for the foreseeable future until the provider recruited a registered manager. Since our inspection a manager has been appointed. The regional manager had the support of a care manager who took responsibility for the clinical role within the home and five team leaders, each with a designated responsibility for example, medicines management.

People were full of praise for the regional manager and said "She is marvellous" and "Very very good". Another person said "It was strange at first as the old registered manager was here forever, but I am getting used to it now."

Staff told us they felt supported by the management arrangements in place. "It was strange when the manager left as we were used to working in a certain way, but everything has settled down now".

Relatives told us they were kept informed about their family member's care and any changes that took place. One told us "Mum had a fall and they rang me immediately so I was able to meet them in the hospital." We are always invited to events like the summer party and it is nice to meet other people."

We met the dementia care coordinator employed by the organisation that supported the management team and staff within the home. Their role was to focus on improving quality around dementia awareness and the additional support staff may need. For example if a person was prone to falls the number and frequency of these were monitored and additional support was then provided in the form of training and staff deployment to minimise these. The same applied to people who had anxiety problems or behaviour issues. The type and frequency of the behaviour was monitored and the dementia coordinator discussed with staff the triggers or possible reasons for this. They put a management plan in place to reduce the episodes. Staff said "When you understand the reason why someone is upset it is easy to deal with this". They worked as a team to find ways of minimising this and provided hands- on training for the staff to understand and manage that person's needs. This also improved the quality of care being provided in the service.

The provider had systems in place to monitor the quality of the service. This included monthly audits completed by a named member of staff, the regional manager and the regional director. Audits undertaken included reviews of care plans and risk assessments, audits of medicines, infection control and health and safety. Housekeeping audits and catering audits were undertaken and heads of department meetings took place to discuss any issues as part of the quality monitoring.

The service worked in partnership with other key organisations for example, the local authority, safeguarding teams and clinical commissioning groups to support provision of care, and service development. We had recently received minutes form a multi-agency senior strategy meeting regarding the service where we read evidence of inter organisation working to achieve the best possible outcomes for people.

The provider undertook corporate surveys annually which were coordinated by "head office". The home receives feedback on any issues of concern for improvements that may be required. We noted in the summary. "your care rating scored as one of the top preforming care homes in the organisation".

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

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>**People were at risk of becoming ill due to equipment in the home not being maintained.** |