Care UK Community Partnerships Ltd

Greville House

Inspection report

Greville House
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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

Overall summary

We carried out an inspection of Greville House on 19 October 2015. The inspection was unannounced. At the previous inspection of 26 September 2014 the home had met all the regulations we inspected

Greville House is a home for up to 59 older people, including people requiring nursing care. At the time of our inspection there were 53 people living in the home. The home has dedicated nursing, dementia, residential and rehabilitation wings and is over three floors.

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 2008 and associated Regulations about how the service is run.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the service and they would not

Summary of findings

be afraid to tell someone if they had any concerns about their safety or wellbeing. Staff were able to demonstrate a sound understanding of procedures to follow if they had any concerns about someone.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

There were enough staff on duty to care for people, with between three and four care staff per floor, together with a team leader. Staff had been trained to use specialised equipment, such as hoists, safely. Specialist assessments had been completed in relation to complex moving and handling issues, for example, with the support of occupational therapists.

The provider had a Service User Guide which emphasised the rights of people to be treated with dignity, to have privacy and to be able to exercise choice. This was also reflected in the home's policies and procedures and formed the basis for staff training.

The provider ensured that people's independence and choice was promoted. People told us that they had been involved in making decisions and there was good communication between staff and themselves. They also confirmed that their consent was asked for before doing anything, such as going somewhere, or receiving medicines.

We saw that people's health, nutrition, fluids and weight were regularly monitored. There were well established links with GP services offering a single point of access for people. This included dieticians, occupational therapists, physiotherapists and social services. Medicines were administered and managed appropriately.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences.

Staff spoke with people in a professional and friendly manner and were able to demonstrate an understanding of each person's needs. Keyworkers and named nurses were allocated to people in order to have a consistent and up to date knowledge of each person's health and well-being.

People said they were able to get up and go to bed at a time that suits them and were able to enjoy activities and interests that suited them. People's views on the range of interesting activities were mixed. The home also supported people to maintain relationships with family, relatives and friends.

The home's philosophy placed great importance on ensuring that people who live at the home continued to lead as normal a life as they were able. The activity co-coordinators and staff spent time getting to know the individual, their background and life history.

In order to listen to and learn from people's experiences the home had monthly meetings with people, the latest meetings having been held in September 2015. There were also relatives meetings held in June 2015 with a further one planned for December 2015.

The provider had an effective system to regularly assess and monitor the quality of service that people received. Audits were carried out monthly and a satisfaction survey sent out in September 2015. Records and other important data were held securely and confidentially.

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?

Good

The service was safe.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Staff were familiar with procedures on how to report concerns.

Risks to people's safety and health were assessed and monitored in a way that protected them without placing restrictions on their freedom or choice. There were sufficient numbers of staff on duty.

Medicines, including controlled medicines, were safely and securely stored in a locked medication cupboard. Medicines were administered safely and audits were carried out regularly to ensure people were receiving medicines appropriately.

Is the service effective?

Good

The service was effective. People were cared for by staff who had sufficient skills and knowledge regarding their role.

People's consent to care was sought and the staff and manager had a clear understanding of matters relating to mental capacity, informed consent and making decisions in people's best interests in line with the relevant requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to eat and drink and to maintain a balanced diet through flexible mealtimes. The catering staff were able to demonstrate a good understanding of people's dietary needs whilst ensuring that people had different options to choose from at mealtimes.

People were supported to maintain good health by having their daily health monitored as well as having regular access to a GP.

Is the service caring?

Good

The service was caring. People were cared for by staff in a professional and kind manner.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences.

People's needs in respect of their age, disability, gender, race, religion and belief were understood by the staff and met in a caring way. Staff ensured people's dignity was respected and contact with relatives, friends and families was encouraged and supported.

Is the service responsive?

Good

The service was responsive. People received care that was tailored to their needs.

The activities officer had a full programme of activities for people which were prominently advertised and displayed.

Summary of findings

The home had a complaints procedure that was understood by people. People told us they knew how to make a complaint and would do so if required.

Is the service well-led?

Good

The service was well-led. The provider had an effective system to regularly assess and monitor the quality of service that people received.

There was an open culture in the home that encouraged people and staff to share views and ideas and to contribute to the development of the service.

Management was visible at all levels with clear lines of accountability and delegation. The home was meeting the requirements of registration by ensuring that conditions of registration and the submission of notifications were met.

The quality of the service was monitored through regular audits, meetings between staff, people who used the service and their relatives. Records were accurately maintained and stored securely.

Greville 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 October 2015 and was unannounced.

The inspection team was made up of two inspectors, a specialist advisor on nursing care and one 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. Our expert by experience had older people as their area of expertise.

Before the inspection we looked at information about the home that we had. This included previous inspection reports, information returns by the provider and correspondence and notifications.

During the inspection we spoke with 23 people living in the home and five relatives. We spoke to the manager, and nine members of staff. We also spoke with the Regional Director and the Clinical Governance Director as well as seeking feedback from external professionals involved with the home and the local social services.

We looked at the homes policies and procedures, six care records, including medicines administration records and six staff records.

We observed the care practice at the home, tracked the care provided to people by reviewing their records and interviewing staff.

Good

Is the service safe?

Our findings

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Comments included, "I'm well looked after" and "If you want to get old, get old here."

A relative told us that their family member felt "safe and happy". Another relative said, "[My relative] is reasonably safe. The home is warm and she's clean and gets fed."

Staff demonstrated a clear understanding of the types of abuse that could occur, the signs they would look for, and what they would do if they thought someone was at risk of abuse including who they would report any safeguarding concerns to. One member of staff said, "I have had training on safeguarding. If I thought someone was being abused I would report it to the manager. We have a whistle blowing policy and I would use that if I had to." Another told us, "It is about protecting the service user all the time, looking out for out of the ordinary behaviour or body marks."

The manager informed us that all staff had attended training on safeguarding adults from abuse. Staff training records we looked at confirmed this. The provider had notified the CQC regarding safeguarding alerts during the previous 12 months and had ensured correct procedures were followed. The provider had responded appropriately to any allegation of abuse with the aim of keeping people safe.

The provider had a staff recruitment and selection policy and procedure. Recruitment procedures ensured that people were protected from having unsuitable staff working at the service. Staff records showed that there was a safe and robust recruitment process in place. There were completed application forms which included references to applicants' previous health and social care experience, qualifications, employment history and explanations for any breaks in employment. Each record had a recent photograph of the persons, two employment references and a health declaration. There were also Disclosure and Barring Service certificates (DBS) on records. Staff confirmed they were not allowed to work until their DBS had come through. This meant staff were considered safe to work with people who used the service.

There were enough staff on duty to care for people, with between three and four care staff per floor, together with a team leader and nurses where nurses were required. Staff had been trained to use specialised equipment, such as hoists, safely. Specialist assessments had been completed in relation to complex moving and handling issues, for example, with the support of occupational therapists. The same arrangement applied at night, with a mix of nursing staff, team leaders and carers on waking night duty. One care staff told us, "We all cooperate here and pull together to do the work." Another told us, "There are enough staff on this floor, everyone is looked after."

We looked at staff duty rosters for the home for the week before the inspection took place and the current week and saw that these reflected what we observed and what we had been told.

Risk assessments were in place on individual people's records. For example, where a person had a disability, the risk assessment referred to specific ways of minimising risk to that person by working with them in a certain way. We observed a nurse reviewing a person's care plan following a fall which had occurred the previous night. We looked at the electronic recording system and saw health care professionals had been called for advice and the person was on the GP list to be seen later that same day. This information was clearly recorded in the person's electronic care file and we were told that this would be printed off and placed on the paper file. In all of the care plans we found that people's skin integrity was assessed and risk assessments were in place and regularly reviewed.

People were free to move safely from one from one area of the home to another including an outdoor secured garden. Elsewhere the premises were clean and free from hazards. There were combination locks on door leading to the exit and between floors, and the combination number was clearly displayed for those who were able to make use of it. This ensured that people were kept safe whilst encouring independence and freedom of choice and movement for those who were able.

Medicines were administered safely. We spoke to a nurse about how medicines were managed. They told us that trained nurses and senior care workers administered medicines to people using the service. We were shown a medicines audit in which a nurse audits one person's

Good

Is the service safe?

medicines each day. This included a medication count to ensure there was enough medication to last the cycle and a check that the Medicines Administration Chart (MAR) was completed appropriately.

We observed a medicine round and saw how one nurse checked the medicines against the person's chart and provided water for the person to take the medicine immediately with her watching. The medicines room was safely locked and medication stored appropriately and disposables were documented.

Where people were at risk of developing pressure damage there were appropriate procedures followed. These included overlay pressure relieving mattresses, Waterlow assessments, turning and re-positioning charts in each person's room, wound assessments and up to date policies on pressure ulcer prevention and Management based on guidance from National Institute for Health and Care Excellence (NICE).

There was documented evidence in people's notes that the Tissue Viability Nurse (TVN) had received referral for people with tissue damage and they had visited and given advice re dressings and care. Staff had received wound care training in the previous two weeks.

There was documentation evidence of visits by external professionals including dentist, podiatrist, TVN, physiotherapist, and GP.

Good

Is the service effective?

Our findings

People told us that they were happy with the care they received and felt their needs had been met. It was clear from what we saw and from speaking with staff that they understood people's care and support needs and that they knew them well.

Another person told us, "The laundry is excellent." However, some people and their relatives commented that sometimes beds were not made until the afternoon and that this may be due to the pressure on staff.

People were supported by staff with appropriate skills and experience. The staff told us they received training and support to help them carry out their work role. We spoke with staff about training, supervision and annual appraisals. Most told us they received regular supervision, but had yet to receive their annual appraisal. We saw from a recent organisational audit carried out in August 2015 that annual appraisals were identified as one of the objectives for the manager and formed part of the manager's on-going action plan. The manager had been in post for seven months at the time of inspection.

One care worker told us "I have supervision on a regular basis. I find it helpful and can discuss what I want there." However, one member of staff told us they had not had recent or regular supervision, which we confirmed when we looked at the supervision plan. We spoke with the manager about this, who acknowledged it and said "I will make sure this is prioritised."

We saw that staff had completed an induction programme which was in line with the Common Induction Standards (CIS) published by Skills for Care. The manager told us how the CIS was being replaced by the newer Care Certificate Standards for all newly recruited staff. One member of staff had just completed their training to be an in-house assessor for the Care Certificate and another was about to embark on this.

We looked at staff training the provider considered mandatory. This included safeguarding adults, health and safety, moving and handling, fire safety, and infection control. We saw that staff had also completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), dignity, dementia and pressure ulcer management. The administrator showed us the training record and explained how the system flagged up overdue training at which point the care worker's line manager was informed. Training was a mix of e-learning and face to face on site training. A care worker told us, "Training gives me a lot of confidence, which is perfect." Another said, "There are no problems with training here; I feel very equipped to do my job."

The manager and staff demonstrated a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). A DoLS authorisation is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests. Staff we spoke with told us, "It is important not to be impatient when offering a person a choice." One person told us of a recent Best Interests meeting they were part of concerning someone who lacked consent and said, "I am delighted that we reached the right decision." We subsequently saw a record of this meeting with a local authority social worker and noted how the care worker's input was central to the decision making process, based on their in-depth knowledge of the person.

Records confirmed that people's capacity to make decisions was assessed before they moved into the home and on a daily basis thereafter. Records confirmed that the home had been making requests for authorisation to restrict people's liberty in their best interests under the Deprivation of Liberty Safeguards (DoLS). DoLS requires providers to submit applications to a "Supervisory Body" if they consider a person should be deprived of their liberty in order to get the care and treatment they need. At the time of inspection 16 applications had been made to the supervisory body, which was the London Borough of Richmond social services, and 14 had been authorised.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. One person told us, "The food is very good, the chef is very sweet, goes to endless trouble to provide for us." One person said that they had become a vegetarian since coming to the home and was satisfied with the vegetarian food on offer. Staff were knowledgeable about people's dietary needs and preferences. There were several dining rooms in the care home on different floors.

Fluids were available and accessible throughout our inspection day. Menus were displayed on tables in the dining room. We observed how people were being supported and cared for at lunchtime. Some people required support with eating and some preferred to eat

Good

Is the service effective?

independently. The atmosphere in the dining room was relaxed and unrushed, we heard staff ask people if they wanted some help and if they were ready to eat. Care workers also explained to people the food they were eating and offered drinks.

We noted that some people who used wheelchairs were unable to get close enough to the dining table due to the design of the tables and that this sometimes caused them to have difficulty reaching their food or eating it without spilling. We discussed this with the manager and regional director who said they would prioritise this as an issue for review.

With dining areas on all three floors, there were also some inconsistencies with regard to the presentation of meals, with some dining rooms having menus and condiments and others not having these. The regional director informed us that the review of dining would be a "review of the whole dining experience" and demonstrated a commitment that everyone should be able to enjoy their meal.

The food served was cooked on the premises and delivered hot to the dining room. The chef demonstrated a good knowledge of people's dietary needs and preferences and spoke passionately about the desire to ensure people had good food. The home served food day and night and this included full meals as well as sandwiches and snacks. The chef explained that people who may be ill, or people with dementia may not always feel like a full meal during "ordinary hours", and that it was "important that we are able to give someone a hot meal when they are ready to have it".

People were happy with the support provided for their health care. One relative confirmed to us that they had contact with the doctor. At the time of our inspection the local GP was visiting and they told us that visits were made twice per week and were able also to provide visits when requested by the home. GP visits were documented in all of the care files we looked at, with more detailed descriptions written in the electronic record. People also had access to a range of health care professionals such as dentists, dieticians, opticians and podiatrists. We saw on one person's record how they were assisted to go to the dentist's surgery for treatment and on another; frequent visits were made to the optician.

Feedback we received from external professionals was positive. This included feedback from the local social services and GP services. One professional commented "I have always found the staff knowledgeable about the residents and patients and I am able to see people whenever required"

Good

Is the service caring?

Our findings

People were complimentary about the care received and the attitude of staff towards them. One person said, "They look after me very well here, the carers are OK. They realise that I like to be by myself." Another told us, "The carers are very nice." Another told us that the staff were "kind and cheerful." A visitor to the home told us, "The people here are helpful and accommodating. It's homely, friendly, welcoming, peaceful, contented and there's a good ambience, no-one ever moans to me. I have never seen any signs of neglect."

However, one person also told us, "The carers don't really chat" and a relative said that the care staff sometimes looked "so miserable and gloomy". Another relative commented that there was sometimes a lack of attention to the small detail such as "hair uncombed, toothpaste on lip, eyes not washed, slumped in chair."

The comments we received, together with our observations indicated that the home provided a caring environment most of the time. Staff understood people's care and support needs and they knew them well. One care worker told us, "It tends to be the same staff working on units. This is important for people with dementia." Another told us, "We must adopt a holistic approach to caring for people; every part of their life must be supported." A member of staff explained to us how they had recently supported a person who was dying, "We were able to care for the person right up to the time of their death, surrounded by family and in familiar surroundings."

The activities co-ordinator had ensured that the weekly activities on offer were clearly displayed. During our inspection there were games and music in the lounge and the activities organiser visited people individually in their rooms to invite them to take part. Visitors were free to visit without undue restriction.

Care plans were detailed and accessed by computer, but there were also paper back up notes in case the computer went down, which included profiles of people, their support needs and other information which would enable staff to engage meaningfully with them and their families.

People were encouraged to be involved in their own care and be actively involved in decisions about the support they received. Throughout the course of our inspection we observed staff speaking to and treating people in a respectful and dignified manner. They took their time and gave people encouragement whilst supporting them. During our inspection we heard a member of care staff who was speaking to someone in their room. The member of staff, who had not observed us, was asking the person what they would like to wear and was making some helpful suggestions on the choices available in a polite, gentle and friendly manner.

Staff told us how they maintained people's dignity and privacy whilst supporting with personal care. They did this by ensuring doors and curtains were always closed. One staff member told us, "I always explain what I am doing, and why, no matter how obvious it may seem." We saw staff answer frequently repeated questions and give people time to choose, for example, their drink or meal.

We saw on the records of two people who lacked capacity 'Do Not Attempt Resuscitation' forms, completed by the GP. However, unlike previous records which showed Best Interests meetings had been carried out there was no evidence of a Best Interests meeting on either to demonstrate that this was a decision reached following consultation with relevant parties. The registered manager told us, "Our clinical lead picked this up recently and is addressing it with the GP to ensure that due process is followed."

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People's care records showed that before they moved into the home their needs were assessed through a pre-assessment process. We saw copies of these assessments in all of the care files we looked at. We also noted there was a person centred 'Life Portrait' which included in-depth information about the person and an extensive life history, including old photographs and previous employment.

The assessments led to care plans that described the support people needed in a way that was personalised and responsive to their needs. All of the care plans and risk assessments we looked at were reviewed and updated monthly and reflected any changing needs.

All up to date records were on the electronic system. The manager told us of a recently introduced review system where each person is discussed in a meeting with all relevant staff in the home, including nurse, senior carer, chef, housekeeper and activities coordinator. Any relevant information was recorded and then placed on the paper file. Families were encouraged to be part of this process and we saw that a family member signed off a copy and made further comments on a particular matter. A relative confirmed that the care plan was prepared and updated regularly.

The atmosphere in the home was calm and professional. However, some people told us the home was "nice but boring" and there was a feeling by several people and their relatives that the atmosphere could be more light-hearted and less dull. People also expressed a desire to be offered more opportunity to go out of the home.

Although some people expressed the view that they felt bored, other people had praise for the activities co-ordinator: One person told us, "The activities lady is very sweet. She's run off her feet, I can't praise her highly enough. She runs after everyone." This view was echoed by a relative of another person.

We discussed these points with the manager and the regional director. It was acknowledged that in the seven months that the manager had been in post the focus had been on ensuring clinical care was of a good standard and on the manager becoming familiarised with the culture and leadership of the home. The regional director agreed that they would reflect on how to develop the more social aspects of the home and the desire by people for more opportunities to make visits outside the home.

Other people gave their own examples of how the service responded to their individual likes and needs. For example one person told us how much enjoyment they received from the mobile farm that came to the home and that it was good to see how positively residents with dementia responded to the animals.

Another person told us how the home accommodated her meal preferences and eating times, where she was enabled to have her meal later than standard time.

The manager and staff sought the views of people and their families and managed complaints through its internal procedures which were shared with people. An audit carried out in July by a Care UK governance manager had identified that meetings for people and their relatives had not been happening regularly and that the complaints procedure was not accessible to everyone. This had led to an action plan by the home and was being actioned at the time of our inspection.

We saw that the home published a monthly newsletter which was available in reception. One person told us that they had been to a residents' meeting of her unit recently and also to a relatives' and residents' meeting in May shortly after she had come to the home.

Good

Is the service well-led?

Our findings

The provider had an effective system to regularly assess and monitor the quality of service that people received.

People were very positive about the culture and atmosphere in the home. One care worker told us, "The manager is lovely. She encourages us to go and speak with her if we are worried about something." Another said, "I have no problems with her; I think she is very fair." A member of the nursing team said, "Communication with staff has improved, but I think they could be better with relatives."

The manager had been in post for seven months and received support from a clinical governance manager and the regional director. The management of the home assured the delivery of good quality person centred care, supported learning and innovation and promoted an open and fair culture. Staff had a good understanding of the ethos of the home and quality assurance processes were in place.

The home's policies and procedures focussed on the rights of the individual person and were clearly written to enable staff to understand them and apply them. Examples included safeguarding and whistleblowing, complaints, supervision, care planning and medicines administration.

The registered manager met regularly with his senior team and had recently introduced the practice of meeting with the night care staff to ensure communication and support was available to all. The manager was supported by a senior nurse, domestic and catering staff and a business manager who were confident in their respective roles and contributed to the leadership of the home.

We saw details of regular quality audits carried out, both by the manager and by external Care UK representatives. Quality audits were based around the CQC standards. A recent audit carried out in July 2015 by Care UK concluded that the home "required improvement" overall and this was developed into an action plan for the home which was currently in place. This indicated a culture of openness and transparency and an organisation that was willing to improve. We saw evidence that the action plan was being actively addressed. Areas which had been completed had been audited and checked and timescales had been identified for areas yet to be completed.

The provider was waiting for the results of the latest survey of people's views, which had a deadline of 31 October 2015. The invitation to people was pleasantly presented to encourage participation and staff were provided with clear instructions on how to support people and how not to influence their views.

The manager and staff maintained a focus on keeping up to date with best practice through participation with groups such as provider forums, maintaining links with GP and local authority and Skills For Care.

Records in the home were held securely and confidentially.