Buckland Rest Homes Limited

Greenbanks Care Home

Inspection report

29 London Road
Liphook
Hampshire
GU30 7AP

Tel: 01428727343

Date of inspection visit:
05 April 2018
06 April 2018

Date of publication:
07 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 April 2018 and was unannounced. At the last inspection on 30 November 2016 the home was rated as good. At this inspection the home was rated requires improvement. This inspection was brought forward due to concerns being raised by professionals regarding the quality of care since the home changed from a nursing home to a care home without nursing.

Greenbanks Care Home is a care home for people who require personal care. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Greenbanks Care Home provides care to a maximum of 25 older people who require care support and may be living with dementia. The home is located in the small village of Liphook in Hampshire. At the time of the inspection there were 22 people living at the home.

We identified breaches of one Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one breach of Care Quality Commission (Registration) Regulations 2009. You can see what action we have taken at the back of the full version of the report.

The provider had a recruitment process to make sure the staff they employed were suitable to work in a care setting, however these were not always consistent and some staff had commenced employment without the required checks being completed.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making every day decisions where possible, however best practice decisions were not consistently recorded or evidenced.

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

There was guidance in place to protect people from risks to their safety and welfare, this included the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely and where there were any short falls these were covered internally or with agency staff.

Risks to people were assessed and action was taken to minimise any avoidable harm to people. Staff were trained to know the signs of abuse and how to report these in line with policy and procedures.

Medicines were managed safely and recorded accurately. Staff who administered medicines were

appropriately trained and had regular checks to assess competency, however there were some issues with regards to medicine storage, this was addressed while we were there.

Staff raised concerns with regard to safety incidents, concerns and near misses, and reported them accordingly. The registered manager analysed incidents and accidents to identify trends and implement measures to prevent a further occurrence.

People were supported by staff. It was recognised that staff required additional training to meet individual's needs. The registered manager was in the process of and had begun to implement additional training in specialist areas such as diabetes. People were supported to have a balanced diet that promoted healthy eating and the correct nutrition.

The registered manager ensured people were referred promptly to appropriate healthcare professionals whenever their needs changed and worked closely with a local GP to assess people's healthcare needs.

People experienced good continuity and consistency of care from staff who were kind and compassionate. The registered manager had created an inclusive, friendly atmosphere at the home. People were relaxed and comfortable in the presence of staff who invested time to develop relationships with them.

People's independence was promoted by staff who encouraged them to do as much for themselves as possible. Staff treated people with dignity and respect and were sensitive to their needs regarding equality, diversity and their human rights.

Practical arrangements including staff rotas were organised so that staff had time to listen to people, answer their questions, provide information, and involve people in decisions.

The service involved people and their relatives in developing their support plans which were detailed and personalised to ensure their individual preferences were known. People were supported to complete stimulating activities of their choice, which had a positive impact on their well-being.

People had end of life care plans and were supported with the help of specialist nurses to be comfortable at this time, people's wishes and preferences were respected and adhered to where possible.

Arrangements were in place to obtain the views of people and their relatives and a complaints procedure was available for people and their relatives to use if they had the need.

The registered manager provided support to staff. The safety and quality of the support people received were monitored and any identified shortfalls were acted upon to drive recognised improvement of the service. However due to a vacancy within the management team it had been difficult for the provider to fulfil all of their duties effectively, this resulted in some areas being poorly managed such as CQC not being notified of specific incidents and that staff had a delay in required training.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider did not do the relevant checks consistently to employ sufficient, suitable staff to keep people safe.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

People received their medicines as prescribed and according to their preferences.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had training and on-going support in their role, however improvements and further training needed to be put in place to ensure staff were competent and consistent when providing care.

People had access to healthcare services as required.

People were supported with a diet appropriate to their needs and preferences, however there had been some concerns regarding the management of diabetes through diet.

Staff worked in partnership with other services to help ensure people received effective care.

The provider was in the process of making adaptations to the service to meet people's needs.

Staff respected people's legal rights and freedoms.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and dignity at all times. Staff interacted positively and patiently with people.

Staff understood people's needs and were caring and attentive.

People's dignity was maintained and staff and their privacy was respected.

Staff understood equality and diversity and treated people as individuals.

Is the service responsive?

Good

The service was responsive.

People's care and support met their needs and took account of their preferences.

People's complaints and concerns were investigated and dealt with accordingly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider failed to notify the Care Quality Commission of incidents.

People were supported by a service that used quality assurance processes to monitor the service people received although this was not always consistent.

Incidents were used as learning opportunities to drive improvements within the service.

Greenbanks Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 April 2018 and was unannounced. This inspection was brought forward due to information we received regarding serious injuries being notified to us and the change the provider made in no longer providing nursing care. There had also been some concerns raised from professionals and family members regarding this change. The inspection team consisted 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.

Before the inspection, we reviewed statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information contained within the provider's website.

Throughout the inspection we observed how staff interacted and cared for people during the day, including mealtimes, during activities and when medicines were administered. We spoke with the registered manager, five care staff, one housekeeper and one of the owners.

We reviewed four people's care records, which included their assessments, care plans, risk assessments and end of life plans. We looked at seven staff recruitment files, supervision logs and training plans. We examined the provider's records, which demonstrated how people's care reviews, staff supervisions, appraisals and required training were arranged. We also looked at the provider's policies, procedures and other records relating to the management of the service, such as staff rotas, health and safety audits, medicine management audits, infection control audits, improvement plans and minutes of staff meetings. We considered how people, relatives' and staff members' comments were used to drive improvements in the service.

Prior to and following the visit we gathered feedback from four health and social care professionals. These

health and social care professionals were involved in the support of people living at the home.

Requires Improvement

Is the service safe?

Our findings

The provider did not consistently carry out the necessary recruitment checks before staff commenced employment. Not all staff recruitment records had full employment history, proof of address, or satisfactory references from previous employers, four of the seven staff recruitment files were not complete. This meant that the provider had not taken all appropriate steps to explore potential staff's experience, character and suitability for the role. Some staff members had started work in the home before their criminal record checks were completed with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. The provider had not completed a risk assessment or put measures in place to assess the safety and minimise the risk to people of staff commencing employment without these checks.

The provider's failure to ensure that satisfactory safety checks were completed on staff prior to commencing employment was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with the care provided and made positive comments about the home and staff. One person told us "I do feel safe" and "If something happened in the night, there is always help to hand". One visitor told us, "I believe he is very safe in his room".

All of the staff we spoke with knew and could explain what they would do if they suspected abuse. All staff had undertaken safeguarding training. All were able to identify the types of abuse, which people could be at risk from. In addition, they understood the safeguarding procedures to follow should they suspect a person was being abused. They were aware that a referral to an agency, such as the local authority Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let the manager or the CQC know if I thought abuse was going on."

We looked at recent safeguarding concerns with the registered manager. These had been followed up with the local authority safeguarding team and notified CQC as required by the regulations apart from one. At the time of inspection there was one ongoing safeguarding concern but the provider was working with the local authority safeguarding team to resolve this. All staff that we spoke with were aware of the whistleblowing policy, the importance of raising any concerns about people's safety, and the legal protections in place for whistle blowers.

The provider had identified and assessed risks to people's safety and wellbeing. These included risks associated with falling and choking. Steps to manage and reduce risks were reflected in people's care plans. We observed staff delivering care in accordance with people's risk assessments, which kept them safe and met their individual needs.

The provider had systems and processes in place to ensure medicines were managed safely in accordance with current guidance and regulations. Staff were sufficiently trained and regularly assessed for their competency of administering medication.

We looked at the Medicines Administration Records (MAR) for people living at the home. We noted there were no gaps in these records. These contained relevant information, such as if the person had allergies or preferred to take their medicines in a particular way. Most medicines were safely stored in locked cupboards. However we noted that in the Medicines room that there were some medicines on the side which were not locked away, these were old medicines that required disposal. There were also some ampules of water for injection which were out of date in the cabinets; these were for people who no longer live at the home. These were disposed of while we were there and there were no other medicines storage concerns identified.

The provider had arrangements in place to make sure the premises were kept clean and hygienic. There were processes and procedures in place to reduce the risk of infection. Staff were aware of their responsibilities with respect to infection control, however we did observe a lack of infection control equipment being available or used by staff. We spoke with the provider regarding this and more equipment was provided for staff and visiting nurses from stock in the building, this had been an issue with replacing stock that had been used.

The provider had arrangements in place to learn and make improvements if things went wrong. Staff reported and recorded accidents and incidents so that they could be analysed for any trends and patterns. Where there were lessons to learn, the provider used staff meetings and supervisions to communicate them across the team.

Requires Improvement

Is the service effective?

Our findings

New staff undertook an induction programme which included completing mandatory training. Staff told us they had undertaken an induction to their role and felt supported in their role although what their experience was varied.

The registered manager discussed how they were developing a new training schedule, there was a variety of experience within the team and there had been some challenges recently regarding moving and handling and diabetes management. The registered manager had arranged training in January 2018 for diabetes management and staff were feeling more confident in this area, moving and handling training had also been arranged for the near future. The registered manager was assessing staff training needs through regular supervisions, discussions in team meetings and observations of staff in their practice.

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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked to confirm the service was working within the principles of the MCA, and was meeting all conditions on authorisations to deprive a person of their liberty. We found that applications had been made for people who met the criteria for Deprivation of Liberty Safeguards, however there was little evidence of best interest decisions or meetings being held, an example of evidence would be meeting minutes between the home and relatives that document decisions made and the reasons for them.

We recommend that the provider ensures that they are able to demonstrate that an appropriate best interest decision making process has been followed for example keeping minutes of a best interest meeting with relatives.

Staff carried a small laminated Pocket learning aid memoir which covered safeguarding, MCA and Best interest decisions to refer to.

People and relatives told us that people received care and support that met their needs and that they were given choices about the care they received. One person told us, "If I'm not well they will call the GP, I get my blood pressure checked regularly."

The registered manager carried out assessments, which were comprehensive and included the person's medical history. The person's needs were identified with their input and a person centred care plan created, which was reviewed and updated regularly. This included details of their eating and drinking preferences, personal care, and likes and dislikes. Assessments, risk assessments and care plans were person centred

following national guidance.

People were supported to have enough to eat and drink and were encouraged to maintain a balanced, healthy diet. We observed the provision of meals during breakfast, lunch and dinnertime. Staff provided appropriate support to enable people to eat and drink at their own pace. If people required a particular food for example to help control diabetes this was put in place. There was a food and fluid charts for staff to use where they identified any concerns about a person's food or fluid intake. This helped to monitor people's food and fluid intake if they were at risk of malnutrition or dehydration.

The provider had developed a good working relationship with local healthcare providers. Records showed people had access to other healthcare services when needed. There were records of visits by GPs, district nurses, and other specialists, such as a podiatrist. Health and social care professionals told us the standard of care was good although they had had concerns regarding the recent change from nursing care to care, they did however say that this seemed to be improving.

The provider had built a good relationship with a local GP and pharmacy who worked together to ensure people's healthcare needs were assessed and where appropriate they were referred to other specialist healthcare services. The registered manager stated that support was given to people to take them to healthcare appointments if they were unable to do so independently.

The home was currently being refurbished. This did cause some disruption and temporarily the design of the home had made some access limited. For example one of the staircases was closed, there was still access to upstairs via a second staircase and a lift. Some rooms had been refurbished to a good standard and people had had a choice of style and décor to meet their individual requirements, these rooms had en-suite bathrooms with sensor lighting so people could see their way if they got up in the night.

Good

Is the service caring?

Our findings

People, staff, relatives and visitors gave us positive feedback about the quality of care at the home. People were supported by staff who demonstrated kindness and compassion to the people they supported. One person told us, "Staff are nice and caring". Feedback from relatives was positive. One relative told us, "I can't speak highly enough about the care here, it's a great place." One relative told us, "We can speak to any member of staff at any time and they are very open with us, very accessible".

There was a calm atmosphere in the home, it was evident there was person centred care being delivered there. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. It was evident staff saw people as individuals. We observed staff being kind, caring, and respectful.

There was one person who was anxious having strangers in the home following an emotionally difficult week. The registered manager and staff were seen to comfort this person and arranged for the inspection team to not approach the person's room. All members of staff made sure they tried to reassure the person each time they passed their room.

Records showed people and where appropriate their relatives were involved in planning and reviewing their care and support. People's preferences and wishes were recorded in their care plans and staff acted accordingly to meet those wishes. One example was that a person wished to not go to hospital unless it was absolutely necessary. The registered manager arranged for community nurses to visit regularly as well as the GP to minimise the chance of a hospital admission. Relatives were involved in decision making with regards to the content of people's care plans should they lack capacity to do so for themselves.

We saw staff treating people with dignity and respecting their privacy. Staff knocked on people's doors before entering their rooms. Staff showed an awareness of the need to protect people's dignity; we saw one member of staff adjusting a person's clothes as they were going to be moved by a hoist to ensure they were suitably covered, the staff member also used a privacy screen to minimise the risk of any other people seeing. Another described how they would cover people appropriately when delivering personal care and told us, "People need their privacy and to be respected, I always knock before entering and ensure their dignity is respected as much as possible when carrying out personal care". One person told us, "I am given privacy in my room, they shut the door and draw the curtains."

Good

Is the service responsive?

Our findings

People received assistance with their personal care that met their needs and took into account their preferences and wishes. One relative told us, "Any concerns I have I can speak with the manager and it will be addressed, they are very responsive."

The provider had recently implemented an electronic Person Centred software in January 2018 to record assessments and care plans. Care plans were detailed and individual to the person, with guidance for staff about how to meet the person's care needs. Care plans covered topics such as communication, mobility, eating, drinking and medicines. We also saw that care plans included details of other professionals who supported people, for example the community nurses would come and deliver nursing care to people, the care plans stated what a person's needs were from the community nurses. Where people's needs or preferences changed, this was noted in their care plans.

The provider was responsive in making adjustments to the care provided in order to meet people's needs. One example was that the registered manager had at short notice arranged for an assessment to be carried out for a person who would need a specialist wheelchair to enable her to attend an important family event.

People were supported to take part in a range of activities both within the home and externally. These included a number of regularly activities such as entertainers, music, bingo, sing alongs, balloon art, walks out and minibus trips. A new mini bus had just been purchased to enable people to go out and do external activities more often. One person told us, "I like taking part in all the activities and I like the music best of all." One relative told us, "The activities are good, they play bingo, hoop and get musicians in."

The registered manager told us people knew how to complain as this information was given to them and/or their relatives when arriving to Greenbanks care home, people and relatives confirmed this. The staff members we spoke with were clear about their responsibilities when receiving complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. There was one written complaint registered. We noted it was managed in line with the provider's policy and resolved in a timely and satisfactory manner. Records showed that when concerns were raised verbally they were investigated and addressed for people. The registered manager told us, "We do our best to resolve any concerns as quickly as possible." People reported that they felt confident raising any issues and that they would be listened to and addressed accordingly.

There were two people who required end of life care when we inspected. People who required this care had the community nursing team to meet their clinical care needs. The registered manager told us that although they did not directly take on packages of care to provide people with end of life care, if those people already within the service required this care then it was provided by staff who liaised with the community nurses and end of life care nurses, to be able to meet the individual needs of people. People did have an end of life care plans which stated their wishes and preferences. Training for staff in end of life care was being arranged.

Requires Improvement

Is the service well-led?

Our findings

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. We found that the provider and registered manager had failed to notify CQC about a number of incidents in line with their responsibilities under the regulations A notification is information about important events which the provider is required to tell us about by law. Failing to send these notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider was aware of their responsibility to send these notifications and three had not been sent.

Systems were in place to monitor the quality of the service and identify any risks or areas where the service may be able to improve. The registered manager carried out audits and fed back to the team through meetings or supervisions to facilitate learning and changes to be put in place. Audits carried out included medicine management, however this did not pick up on the medicines stored incorrectly, health and safety and environmental audits were also being carried out. However these were not always consistent or regular. The quality of the service was also assessed through supervisions and team meetings.

People and their relatives told us that they thought the service was well run. One person told us, "The manager does come round" and "I'd say she (manager) is friendly and is a listener." One visitor told us, "I would have my Mum here if necessary" and "I have nothing but praise for this place. It's the little things they do that stick out." One relative told us, "Overall, we are happy with the care he is getting, but its early days yet (4 weeks)" and "We have peace of mind knowing he is here."

Spot checks and general care competency assessments had been recently introduced to improve the quality assurance process within the home; this was due to a number of staff competency and training needs being identified. The provider recognised that improvements were needed with regards to consistency and confidence in staff. A business improvement plan had been created and this was a working progress.

Regular team meetings and residents' meetings were being held to enable sharing of information and to gain feedback. Feedback was used to implement positive changes in the service. The operations director met with the registered manager weekly to give support, an improvement plan was in place to monitor the progress of the service which had been improving since the new registered manager had been in post. The operational director audited the service twice a year.

Regular meetings were held with both the day staff and the night staff to enable them to express their views on the service and to be informed of updates. Staff were observed to uphold the provider's values across the course of the inspection in the provision of people's care. Staff were aware of the whistle blowing procedure and understood how to report any concerns.

Measures were in place to monitor incidents people experienced and to ensure appropriate actions had been taken for people. The registered manager analysed any incidents that occurred, identified the cause

and made a person centred plan to avoid re-occurrence. Records showed that following incidents relevant measures had been taken for people such as the provision of equipment required for a person.

There was evidence of partnership working within the service. Social workers, community nurses and GP's attended regularly. There was open communication with other agencies and where the service had concerns about a person this was communicated to the relevant agency. There were concerns raised by another agency about how quickly the provider informed them of any concerning issues; however, the registered manager stated that the service had learnt from that and would now communicate concerns in a more timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of incidents that they are required to notify us by law. This was a breach of Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures to ensure that persons employed were of good character. The provider had not protected people by ensuring that the information specified in Schedule 3 in relation to each person employed was available. This was a breach of Regulation 19.