Greensleeves Homes Trust

Viera Gray House

Inspection report

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20 March 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 16 and 20 March 2018.

Viera Grey House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation for frail elderly people some of whom may have dementia. It is located in Barnes.

The home had a registered manager. A registered manager is a person who has registered with the CQC 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.

At the last inspection in February 2016 all the key questions of safe, effective, caring, responsive and well-led were rated good. The overall rating was good.

People and their relatives said the home supplied very good care and support in a friendly and relaxed atmosphere. There were suitable numbers of staff to meet people's needs and they did so in a respectful, compassionate and kind way.

The home's recording systems were thorough, comprehensive and up to date with regularly reviewed information presented in a clear and easy to understand way.

People and their relatives were encouraged to discuss health needs and had access to community based health professionals as required as well as care staff. People's diets were balanced, protected them from nutrition and hydration associated risks and also met their likes, dislikes and preferences. Most people and their relatives told us the meals provided were of good quality and there were choices available. Staff prompted people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy their meals.

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

Staff had a thorough knowledge of the people they supported and appropriate skills and training to meet people's needs competently. They provided people with individualised care that was provided in a professional, friendly and supportive way.

Staff were aware of their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognising and respecting people's differences.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation.

Staff said the registered manager and organisation provided good support and there were opportunities for career advancement.

People and their relatives thought the registered manager and staff were approachable, responsive and encouraged feedback from people.

The home had systems that consistently monitored and assessed the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 'The service remains Good.'	**Good**
Is the service effective? 'The service remains Good.'	**Good**
Is the service caring? 'The service remains Good.'	**Good**
Is the service responsive? 'The service remains Good.'	**Good**
Is the service well-led? 'The service remains Good.'	**Good**

Viera Gray House

Detailed findings

Background to this inspection

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

This was an unannounced inspection and took place on 16 and 20 March 2018.

This inspection was carried out by one inspector and over two days and an inspection manager who was present on the second day.

There were 37 people living at the home. We spoke with 13 people, six relatives, ten staff, the registered manager and healthcare professionals whom had knowledge of the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

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

We looked at the personal care and support plans for four people and three staff files.

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

Good

Is the service safe?

Our findings

People said that the home was a safe place to live with an atmosphere that was welcoming and relaxed. One person told us, "It's very quiet, calming and peaceful." Another person said, "In general I accept it here. It's different when you're old, you feel powerless. I'm not looking for another place to live." A relative commented, "Very secure."

There was a suitable staff complement to ensure that people received the care they required safely and made them feel safe. The number of staff on duty matched the staff rota. This meant the home was able to meet people's needs in a safe, enjoyable and unrushed way and this was demonstrated by people's positive body language and responses to staff. The home was currently recruiting to three vacant care worker posts with interviews being held the week after our visit.

Staff were aware of how to raise a safeguarding alert, had received safeguarding training and were provided with a handbook containing safeguarding information. There were no current safeguarding alerts. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. Staff were aware of the procedure to follow and agencies to contact to make sure people were safe.

There were provider policies and procedures regarding protecting people from abuse and harm, that staff had access to and were trained in. They reflected this in their positive care practices during our visit. Staff gave us their interpretation of what constituted abuse and the action to take if encountered. Their responses followed the provider's policies and procedures. Staff said their induction and refresher training included protecting people from harm and abuse and was a very important part of their roles.

People were enabled to enjoy their lives safely, by risk assessments that the home carried out. These assessments included all aspects of people's lives including their health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Staff shared relevant information during shift handovers, staff meetings and when risks arose. Risk assessments were also used to learn lessons if something had gone wrong. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and understood.

The building risk assessments were very comprehensive, regularly reviewed and updated. The home's equipment was also regularly checked and serviced. There was a fire evacuation plan.

Staff had received infection control and food hygiene and handling training that was reflected in their working practices and the home carried out infection control checks as part of their quality assurance auditing. The home also held a plentiful stock of equipment that included gloves and aprons for giving personal care. This helped to minimise the risk of infection. There were also monthly infection control audits.

The staff were recruited using a thorough procedure with all stages of the process recorded. This included advertising the post, providing a job description and person specification and short-listing prospective staff

for interview. The interview contained scenario based questions to identify people's communication skills, attitude towards care and knowledge of the type of service the home provided. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a three month probationary period, during which new staff were able to shadow more experienced ones. The home had disciplinary policies and procedures that staff confirmed they understood.

Staff had received training in and understanding of de-escalation techniques in instances where people may display behaviour that others could interpret as challenging. These were focussed on people individually and staff had appropriate knowledge to do this successfully. Any staff actions were recorded in people's care plans.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records for all people were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited. The medicine was safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

Good

Is the service effective?

Our findings

People and their relatives made decisions about the care and support that would be provided and how it would be delivered. Staff had the skills to communicate with people generally and those with dementia, in particular in a way that enabled them to understand. This enhanced staff's ability to meet people's needs in a way that was appropriate to them. People and their relatives said that the way staff provided care and support was what was needed and was delivered in a friendly, relaxed, patient and professional way. One person said, "The staff do their best, considering the other people they look after here. I've never had to wait for long, and I know some people here need a lot more attention than I do." Another person told us, "I don't love it here, but that's not a criticism. Most of us would prefer to be at home. One's life changes and you have to manage." A relative said, "It's very nice. [My relative] has been content here from day one." Another relative told us, "Staff react to and learn from each other. They deal with things and things get done."

Staff received induction and annual mandatory training. The induction was thorough, included core training aspects and information about staff roles, responsibilities, the home's expectations of staff and the support they could expect to receive from the organisation. All aspects of the service and people were covered and new staff shadowed more experienced staff. This increased their knowledge of the home, people and provided a good standard of quality care. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards' and included dementia awareness, understanding behaviour that challenges, mediation awareness, moving and handling, first aid, fire safety and health and safety. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

Staff meetings included opportunities to identify further training needs. Quarterly supervision sessions and annual appraisals took place that were used, in part, to identify any gaps in training.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked if the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by

the provider and applications under DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout our visit.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. The records demonstrated that staff liaised and worked with relevant community health services including hospital discharge teams, GPs and district nurses, making referrals when required and sharing information.

People's care plans contained sections about health, nutrition and diet. Full nutritional assessments were carried out and regularly updated. If required weight charts were kept and staff monitored how much people had to eat and drink. We saw this during meals times with staff frequently encouraging people to keep up their hydration levels. There was person specific information regarding any support required at meal times, including any possibility of choking. Staff had also received training regarding choking and dysphagia. Dysphagia is difficulty or discomfort in swallowing, as a symptom of disease. Further training in respect of choking was also provided as part of the basic life support training.

Each person had a GP and staff said that any concerns were raised and discussed with the person's GP and relatives as appropriate. Staff provided nutritional advice. People had annual health checks. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

During our visit staff encouraged people to eat meals in a patient and supportive way. They made sure people, who needed support and encouragement to eat, received it. This was particularly people with dementia who had their needs met by staff in a patient, re-assuring and encouraging way. Staff spoke to people slowly and repeated information as many times as required so that they could understand what staff were saying and meant. This was done by some staff at eye contact level, whilst kneeling. Staff also used body language that was appropriate and that people positively responded to. People's meal choices were explained and staff revisited them as many times as people required to help them understand what they were. They also spent time explaining to people what they were eating during the course of the meal and checked they had enough to eat. This made mealtimes an enjoyable experience for people. Special diets on health, religious, cultural or other grounds were provided. Regular meetings took place between people and catering staff to discuss the quality of the meals, how they were served and choices. When asked by staff, people said they enjoyed the meals.

The meals we saw were of good quality, although some people and relatives commented that they could be improved. They looked appetising, smelt nice, were nutritious, hot and monitored to ensure they were provided at the correct temperature. Staff supported people in a timely way at mealtimes and no one had to wait for their lunch although, on the unit we observed, staff could have better apportioned their time. There were three staff in attendance and at times two were serving up food with one providing hands on support. We discussed with the management team if it would have been more effective if one staff member was serving and two supporting people. One person required support to eat their meal. The member of staff encouraged and supported them to feed themselves by placing a fork in their hand and explaining how to use it, rather than just feeding them. When this did not work, the staff member replaced the fork with a

spoon and explained this to the person. This proved far more successful and the person was able to feed themselves. One person told us, "I've had to purchase trousers with a bigger waistline this morning – that tells you something! I enjoy the food very much." Another person said, "The food varies – it can be very good but can also be mediocre. We always have a choice of three dishes, and they're usually all the sorts of foods I like to eat." A further person commented, "The food is no good – no quality or taste. They can't find a good cook. I've given up complaining and accepted it." During lunch we observed this person eating their meal, which he greatly enjoyed and couldn't stop praising." When asked they said, "Well today is an exception."

The home was clean, well decorated, well-maintained and with no unpleasant odours. The layout was conducive to providing people with a homely atmosphere with suitable communal and personal accommodation. This meant people had the space to socialise as much or as little as they wished.

Good

Is the service caring?

Our findings

One person said, "The staff have enormous kindness and tolerance. People are accommodated – I saw one lady get her breakfast at midday as that was what she wanted. You can't do that in lots of these homes, things are regimented. They're not regimented here." Another person told us, "Staff are very considerate, and always treat me with dignity and respect. I have absolutely nothing to complain about." A further person commented, "The staff are very kind, although I'm sure they think I'm rude!" A relative said, "A very caring attitude and feeling of respect by everybody for everybody." Another relative told us "Lovely staff, well impressed and [relative] is very happy here." A further relative commented, "The staff are very caring – they are brilliant, couldn't ask for anything better."

People received a service based on treating them with dignity, compassion and respect. Staff were attentive and responded to people promptly, addressing people by their preferred name, title or nickname. They knocked on people's bedroom doors and waited for a response before entering.

Staff received equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognizing and respecting people's differences. This was reflected in staff demonstrating positive care practices and confirmed by people and their relatives. People said staff never talked down to them and they were treated very respectfully, equally and as equals. One person told us, "Here no one is excluded."

People and their relatives confirmed that staff acknowledged them and listened to and valued their views and opinions. They said staff always said hello and everyone was treated with respect and patience. This was done whilst delivering support in a friendly, caring and helpful way.

Staff worked very hard to make sure people's needs were met and this was demonstrated by the way they delivered care and their work ethic. People said nothing was too much trouble. Staff stimulated and encouraged people to have conversations with each other as well as staff in a patient and skilled way. They applied their knowledge of people as individuals and their needs and preferences to enable them to lead happy and rewarding lives. This was individually and as a team. People were treated with kindness and understanding with staff taking a real interest in them, chatting about their respective families and events. The staff approach to care was supported and underpinned by the life history information contained in people's care plans that people, their relatives and staff contributed to and regularly updated.

There was an advocacy service available that people had access to if required.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

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

Good

Is the service responsive?

Our findings

People told us the registered manager, staff and organisation asked for their opinions and suggestions regarding how support was delivered and all aspects of living at the home. They did this formally through meetings and informally during casual conversations. People and their relatives were invited to general home meetings and those specific to themselves. The meetings were minuted and people were supported to put their views forward. Staff made themselves available to people and their visitors if they wished to discuss any problems or if they just wanted a chat. This meant that people were able to decide the support they wanted and staff delivered support in a friendly, thoughtful, timely and appropriate way that people enjoyed. One person said, "There are lots of activities, every day there is something going on." Another person told us, "I go out by myself, for a walk to the wetlands or the Thames. I do my own shopping. I go out for an hour or two, most days." The person had a fridge in their room for snacks. A further person said, "When they make me a cup of tea they always know how I like it. It's the little things, you know?" A relative said, "We visit [our relative] twice a week. We are always welcomed and made to feel comfortable."

The written information about the home was in an easy to understand format. It was in sufficient detail to enable people to understand the type of care and support they could expect. It also laid out the home's expectations of them.

People could visit the home as many times as they wished before deciding if they wanted to move in and were fully consulted and involved in the decision-making process. The visits were also used to identify if people would fit in with those already living at Viera Grey House. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person. A lot of people had referred themselves or referrals were made by their families. This was because they had first experienced a short stay at the home prior to moving in permanently or knew other people who lived there. A relative told us, "This is a wonderful local resource; I have both my parents living here."

The home carried out assessments of people's needs with them and their relatives, and if it was identified that needs could be met people and their relatives were invited to visit. People's assessments were the basis of their initial care plans. If a service was commissioned by a local authority or the NHS, assessment information was requested from these organisations or from a care home if they had been transferred.

Care plans were focussed on people as individuals and were live documents that contained their social and life history. They included people's interests and hobbies and were added to, with staff when new information became available. The information gave people an opportunity to identify activities they may wish to do. People had their needs regularly reviewed, re-assessed with them and their care plans updated to meet their changing needs. People set goals with staff to meet their needs that were also reviewed and daily notes fed into the care plans. The daily notes confirmed that identified activity goals took place. People were encouraged to take ownership of their care plans and contribute to them when they wished. Care plan goals were underpinned by assessments of risk to people.

The home provided a variety of activities based on people's wishes and staff knowledge of people's likes

and dislikes. The communal activities were regularly reviewed to make sure they were focussed on what people wanted. The high uptake of group activities reflected their success and popularity. One person said, "There are simple activities such as gymnastics and talks on various topics. I don't attend all the time as they are very simple. However, I do love the outside entertainers they bring in – there was a man playing guitar last week who was world class!" During activity sessions people were encouraged to join in but not pressurised to do so.

A timetable of weekly activities was available that took into account people's interests and ability to participate with staff reminding people of what was taking place each day. The activities co-ordinator facilitated a programme of activities that people had chosen. These included 'Pet' therapy, exercise classes, coffee and conversation mornings, news and views, music therapy, painting and general knowledge quizzes. There was also visiting entertainers. People also went on excursions including one that took place the day before the inspection to Pembroke Lodge in Richmond Park. There were visits to the Wetland Centre and the London Transport Museum and two people regularly went out for lunch with friends. One person said, "There are quite a few activities and trips out, that sort of thing. They are very frequent, but I don't join in every day." A relative said, "They do all sorts of stretching exercises and that sort of thing. [My relative] can't really do much else [as their dementia is very advanced]." Other relatives told us that they thought people enjoyed the activities provided and they were appropriate. There was also a very positive input from the 'Friends of Viera Gray House' who provided and funded some of the activities.

The home provided end of life care and staff had received appropriate training from the organisation. Staff worked closely with palliative and community nurses, particularly surrounding pain management. There was specific reference to end of life in people's care plans including guidance and people's wishes. When providing end of life care, the home facilitated relatives to be involved in the care, if they wished during a distressing and sensitive period for them.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. They told us that generally staff and the management team quickly resolved any issues that people may have, without recourse to the complaints procedure. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew of their duty to enable people to make complaints or raise concerns.

Good

Is the service well-led?

Our findings

People told us the registered manager and management team operated an open door policy. This meant they felt comfortable in approaching the registered manager as well as staff. One person told us, "I have visitors who come when they can; the staff always make them feel welcome and are polite to them." Another person said, "I can say things and the manager will listen. We have meetings every three to four months or so." A further person commented, "There are meetings for all of the residents and relatives. We can complain and I know the manager will do what he can." One relative told us, "We have no concerns or complaints, the care is brilliant here." Another relative said, "The manager is charming and very helpful. We are kept well informed." People's conversation and body language demonstrated that they were comfortable in their relationships with the registered manager and staff.

The organisation's vision and values made clear what people could expect from it, the home, its staff and the home's expectations of them. Staff said they understood and embraced the vision and values and this was reflected in their working practices and positive approach to their roles. Staff said the vision and values were described and explained as part of their induction training and revisited during staff meetings.

The people living at the home engaged with the local community in various activities such as visits from local schools, the 'Embracing Age' organisation and day centres. One relative said, "We are able to participate, my niece volunteers here and I'm hoping to do some cooking with residents."
Viera Gray House was currently working with two organisations to create a sensory garden as a means of enhancing people's well-being. The home also worked with local colleges offering students the opportunity to have a pathway into the health and social care sector.

The home worked in partnership with other agencies including the local Clinical Commissioning Group.

The organisation provided staff with opportunities for personal advancement and to develop knowledge and skills. Staff had personal development plans.

There were clear lines of communication and areas of responsibilities throughout the home and organisation and staff were aware of their areas of responsibilities. Staff said they would be comfortable using the whistle-blowing procedure if they needed to.

Staff felt well supported by the registered manager and management team. They thought that the suggestions they made to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A staff member told us, "The people here take priority." Another member of staff told us, "Staff pitch in together and work well as a team."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The quality assurance system contained performance indicators that identified how the home was

performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. There were monthly head office visits that audited care plans, staff files and fire checks. The visits also entailed observation of care practices and speaking with people, staff and visitors. The home also carried out audits such as catering, complaints, health and safety and building and equipment maintenance. There was a business continuity plan. Monthly senior staff meetings took place that monitored all aspects of the service provision. Annual policy and procedure reviews were carried out.