Greystones Nursing Home Ltd

Greystones Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 4 August 2016 and was unannounced.

At the last inspection on 26 January 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We identified ten regulatory breaches which related to safeguarding, staffing, recruitment, consent, dignity and respect, safe care and treatment including medicines, person-centred care, premises, complaints and good governance. We issued warning notices for the breaches of safeguarding, person centred care and safe care and treatment with a compliance date of 15 March 2016 and for the premises and good governance with a compliance date of 29 March 2016. We issued requirement notices for the other breaches. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Greystones Nursing Home provides nursing and personal care for up to 25 people, some of who are living with dementia or have mental health needs. There were 22 people using the service when we inspected. Accommodation is provided in single and shared bedrooms over three floors. There is a passenger lift to the first floor and chair lift access to the second floor. There is a lounge, dining room and smoking room on the ground floor.

The home has 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.

Overall we found significant improvements had been made since our last inspection.

People told us they felt safe and we found there were enough staff on duty to meet people's needs. Staffing levels were kept under review and adjusted according to people's dependencies and needs.

Recruitment procedures had improved which helped ensure staff were suitable to work in the care service. However, records needed to reflect decision making where issues had been identified in criminal record checks. Staff received the training and support they required to carry out their roles and meet people's needs.

Staff understood safeguarding procedures and how to report any concerns. Safeguarding incidents had been identified and referred to the local safeguarding team and notified to the Commission. Risks to people were assessed and managed to ensure people's safety and well-being.

Medicines management systems had improved and were being monitored through regular audits. This helped to ensure people received their medicines when they needed them. Some issues around administration practices were identified, however, these related to one staff member and were being

addressed by the registered manager.

Standards of cleanliness had improved and we found the home was well maintained. Some areas of the home had been refurbished and this was ongoing. Work had started on making the environment more dementia friendly with the use of signage and colours to help people living with dementia find their way around the home more easily.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

People told us they enjoyed the food. We saw people were offered choices and given the support they required from staff. People's weights were monitored to ensure they received enough to eat and drink.

People and relatives praised the staff who they described as 'good' and 'kind'. We saw staff treated people with respect and ensured their privacy and dignity was maintained.

Care records had improved and this process was ongoing to ensure all the care files were up-to-date and accurately reflected the care people needed.

People were provided with activities in-house and supported to go out in the community. People knew how to make a complaint and we saw any complaints raised were dealt with appropriately.

People and staff praised the management and leadership of the home. Effective quality assurance systems were in place although these needed to be fully embedded to ensure continuous service improvement. We need to be assured the improvements made will be sustained and developed further to make sure people consistently receive high quality care.

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 always safe.

Overall medicine management systems were safe, although issues around administration practices were identified. These related to one staff member and were being addressed by the registered manager.

People felt safe and there were enough staff to meet people's needs. Risks were assessed with management plans in place to keep people safe. Overall staff recruitment processes ensured staff were suitable for the role. However, the records need to reflect decision making where issues had been identified in criminal record checks.

Improvements had been made to the environment which was clean and well maintained. Many areas of the home had been refurbished and this programme was ongoing.

Is the service effective?

Good

The service was effective.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) applications had been made and some authorisations were in place.

Staff received the training and support they required to fulfil their roles.

People enjoyed the meals and were provided with a choice of different foods. People's nutritional needs were met.

People had access to healthcare services. Adaptations had been made to help people living with dementia find their way around the home.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected. People praised the

care they received and the kindness of the staff.

Staff were caring, considerate and attentive and there was a relaxed and friendly atmosphere in the home.

Is the service responsive?

Good

The service was responsive.

Care records had improved and showed the support people needed and their preferences. However this process was ongoing to ensure all the care files were up-to-date and accurate.

People were provided with activities in-house and supported to go out in the community.

A system was in place to record, investigate and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements had been made to address the issues identified at the previous inspection and quality assurance systems were in place.

However, we needed to see evidence of sustainability and continued improvements before we could conclude the service was well-led.

Greystones Nursing 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 4 August 2016 and was unannounced. An inspector and a specialist professional advisor who was a specialist in mental health carried out the inspection.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

The provider completed a Provider Information Return (PIR) before the inspection. 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 reviewed this information prior to the inspection.

We spoke with six people who were using the service, one relative, two nurses, three care staff, the cook and the registered manager.

We looked at four people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

We found improvements had been made in all areas covered in this domain and there were no regulatory breaches.

People told us they felt safe living at the service. When we asked one person they said, "Yes I feel safe. I wouldn't stay here if I didn't." A relative we spoke with said, "I know my [relative] is safe and secure here. They are well cared for and I have no worries."

Staff we spoke with had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. One staff member said, "If I witnessed or suspected a person was being abused I would report it to the manager or the senior person on duty." Another staff member commented, "If necessary I know how to make a safeguarding referral myself". Staff had a good understanding of whistleblowing procedures and knew the processes for taking serious concerns to external agencies if they felt they were not being dealt with effectively. This showed us staff were aware of the systems in place to protect people and how to raise any concerns. Safeguarding records we reviewed showed the manager had taken appropriate action to keep people safe and made referrals to the local authority where concerns had been identified. Any safeguarding referrals had also been notified as required to the Care Quality Commission.

We found accidents and incidents were well recorded and showed the action taken in response to reduce the risk of recurrence.

Risks were managed effectively for people and covered areas such as tissue viability, how to administer medicines safely, nutrition and falls. We found risk assessments were detailed with evidence of monthly reviews which captured any changes. We saw action had been taken to minimise risks when incidents had occurred. For example, one person with a history of alcohol abuse had sustained injuries as a result of excess alcohol consumption. We noted the person had sustained four fractures in 18 months. An action plan had been agreed with the person which had resulted in a marked decline in falls and no further fractures.

Environmental risk assessments had been completed and individualised plans showed the support people required in an emergency, such as a fire. One person who was nursed in bed had a fire evacuation plan. The person's relative knew of the evacuation plan and was able to describe it in detail. They told us, "I participate in all aspects of [name] care planning and sign the consent for treatments on my [relative's] behalf." We saw contingency plans were in place if people needed to be moved out of the building in an emergency. These included co-operation from other care homes and the involvement of the voluntary and religious sectors of society.

We looked round the home with the registered manager and found improvements had been made since our last inspection. The home was clean and well maintained. The registered manager told us cleaning hours had increased and there were now cleaners on duty every day. We saw areas that we had previously identified as being in a poor state of repair had been redecorated and several of the bedrooms had new

flooring, furniture and furnishings. The registered manager told us many of the mattresses had been replaced and there was also new bed linen and towels. New windows were due to be installed by the end of August 2016. The registered manager told us these had had to be custom-made due to the age of the property. The registered manager told us the room where people smoked was out of use due to structural damage and people currently had to smoke outside. However, they advised this was a short term solution as building plans had been approved for a new extension and work was due to start imminently which would provide new and better facilities for people, including a smoking area.

We saw certificates confirming safety checks had been completed for gas installation, electrical installation, legionella and boiler maintenance. All portable electrical equipment had been tested and carried confirmation of the test and date it was carried out. The home had recently purchased a new hoist therefore no safety certificates were required for this piece of equipment.

People told us there were enough staff. One person said, "Staff look after me very well. They always seem to be there when I need them." Our observations of care and support found staff were visible and able to provide assistance where required. The registered manager showed us the staffing tool they had put in place since the last inspection, which calculated staffing levels based on people's dependency. This determined one nurse and three care workers were required during the day. The registered manager told us additional care staff came in daily to provide one to one support to people which gave individuals the opportunity to pursue activities and interests out in the community. At night there was one nurse and one care worker with an additional 'sleep in' staff member who was on call if further support was required. The rotas we looked at confirmed these staffing levels were maintained. The registered manager told us they used tool monthly to review staffing levels or more frequently if people's needs changed.

We looked at the recruitment process for three staff. Records showed prospective staff completed an application form which detailed their employment history and qualifications. Checks on staff character were undertaken to ensure they were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check, obtaining references and ensuring an interview was held. We saw evidence which showed the registration of nursing staff was checked to ensure it was valid and up-to-date. However, we found one staff member's DBS identified previous convictions yet there was no evidence to show that this had been discussed or taken into consideration as part of the recruitment procedure. We raised this with the registered manager who told us they would deal with this straightaway.

Safe medicine systems were in place which ensured people received their medicines as prescribed. One person told us, "I get my medicines when I need them, they make sure of that." We spoke with a relative who said, "I visit three or four times a week and find all [name] medicines are administered on time. They always ask if [name] needs any pain relief".

Medicines were administered by nursing staff. People's ability to self-medicate was assessed and discussions with the registered manager showed five people had the potential to administer their own medicines. However, these people had consented to staff administering their medicines either through personal choice or for medical reasons such as visual impairment.

We looked at the medicine administration records (MAR) and records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete apart from an issue related to one staff member who was not administering medicines in a safe manner. We checked the stock levels of seven boxed medicines and found anomalies with three medicines which related to this staff member's lack of recording on the MARs. Our discussion with the registered manager showed they already knew of the issue and were taking appropriate action.

We saw arrangements were in place to ensure medicines required to be given at a specific time, such as before or after food, were administered correctly. We observed staff patiently supported people to take their medicines at their own pace and showed a good understanding of people's individual preferences. We saw 'as required' medicines were supported by written instructions which described situations, frequency and presentations when these medicines could be given. Records showed people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed by the GP. Allergies or known drug reactions were clearly recorded on each person's medicine records.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely, recorded accurately and accounted for in the controlled drugs register.

All liquids, creams and eye drops in use were within date and recorded the date of opening Creams applied by care staff were recorded on a separate topical MAR sheet. At the time of our visit the medicine fridge was out of order with a new fridge due for delivery. No medicines required cold storage when we inspected.

One person had their medicines administered covertly. The person's care records showed correct procedures had been applied to ensure the medicines were administered within current guidelines. We saw meetings had occurred involving the GP, an independent mental capacity advocate (IMCA), care staff with personal knowledge of the individual and a pharmacist. Documents demonstrated a clear treatment aim of covert medication along with the required benefits to the person's health. A qualified person had made a written statement regarding the person's lack of capacity. A review process was in place. Our examination of the process to administer covert medication proved the registered manager had a good understanding of the procedures and knew how to use them for the benefit of people at the home.

Good

Is the service effective?

Our findings

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. Some staff had attained a National Vocational Qualification (NVQ) in care or were in the process of following a course of study. There was a programme to make sure staff training was kept up to date, which was confirmed by the training matrix. The registered manager invited external professionals to run additional training sessions for staff. For example, they were working with the local authority to source food hygiene training.

Staff told us they had regular checks of their competency and 'spot checks' on their care practice and told us they received feedback on this in their supervision sessions. The registered manager told us supervisions were planned four times a year. We saw letters had been sent staff informing them of forthcoming dates for appraisals

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw 17 standard authorisations had been submitted to supervisory bodies. Twelve authorisations were in place with a further four renewals and one new authorisation awaiting a response from the supervisory bodies. We saw authorisations had been submitted over several months with no response from the supervisory bodies. Throughout this time the registered manager had contacted the supervisory bodies in an attempt to secure DoLS.

We reviewed the care records of a person with a mental illness who had previously been detained in hospital under Section 3 of the Mental Health Act 1983 (MHA). The person had been discharged from hospital to the service on a Community Treatment Order (CTO). CTOs were introduced to the MHA by the Mental Health Act 2007. These orders allowed people to be discharged into a community setting whilst still being subject to mandatory conditions. Any breach of these conditions can lead to recall into hospital and detention under Section 3 of the MHA. We found the person had an appointed legal representative. We spoke with the nursing staff and the registered manager about the CTO and conditions involved. They had a thorough understanding of the conditions and the part they played in supporting the person to maintain the conditions. We saw care files contained all the necessary documents associated with people's appeals against their detention or curtailment of liberties under the MHA. This ensured the decisions of First-Tier Mental Health Tribunals and Hospital Manager reviews were known to staff which enabled them to deliver care within a prescribed legal framework.

Care plans showed inclusive consent procedures were being enacted in determining people's care needs. For example, care plan reviews showed who had been involved and people who used the service, relatives or advocates signed the review to denote their involvement. We spoke with the registered manager about the use of restraint which included the use of bed-rails. Two people had bed-rails in place and risk assessments clearly showed these were being used to keep people safe. The nurse we spoke with understood bed-rails should not be used to confine people to bed and as such would constitute illegal restraint.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of family involvement in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

Care records we reviewed showed staff worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This included GPs, hospital consultants, community nurses, specialist nurses in diabetes, speech and language therapists, dieticians and dentists. There were close working relations between the community mental health team and the service and this was an important factor in supporting effective care for people with a mental illness. We saw correspondence from a community psychiatric nurse in which they praised the staff of the home for their efforts to improve the lives of people with a mental illness.

People told us they enjoyed the food. One person said, "The food is good. I get what I like." Another person said, "The food is very good. We can have what we want, it's never a problem."

Menus were displayed in the dining room and showed a wide variety of meals were available as well as a choice of drinks and snacks. We saw people helping themselves to fresh fruit which was available in the communal areas throughout the day. We asked one person if this was usually provided and they said, "Yes", and told us there was fresh fruit around every day. Other snacks and drinks were provided throughout the day.

At mealtimes we saw people's individual preferences were catered for which included where they wanted to have their meals as well as what they wanted to eat and drink. For example, we saw some people had a roast beef dinner, while others had curry and some opted for sandwiches and fruit. Some people chose to eat in the dining room, while others preferred to be in the lounge or their own rooms. There was a relaxed atmosphere as staff were well organised and provided assistance to people in a calm and patient manner.

We spoke with the cook who told us how they fortified meals with butter and cream for people who were low weight and also provided additional snacks to boost their calorie intake. The cook knew who required fortified meals and any other special diets. We saw food and fluid charts were maintained for people who were low weight to monitor their intake. We looked at these records for one person and found the recording format needed to improve as quantities of food and drink were not always recorded and there was no evidence to show people's daily intake was being reviewed by senior staff. However, the care records showed this person's weight was being monitored by staff and their body mass index (BMI) was within the healthy range. We discussed the food and fluid charts with the registered manager who had already identified this issue and showed us new systems which were being put in place to record this information.

We found some improvements had been made to the environment to help people living with dementia find their way around the home. For example, bathroom and toilet doors as well as having pictorial signs had been painted a different colour from other doors to help people recognise them more easily. Toilet seats were blue which made them clearer for people to distinguish. Pictorial signs were on bedroom doors and

the registered manager told us they were looking to add meaningful photographs or pictures to help people identify their own rooms. The registered manager told us of ongoing plans to introduce more colour and signage to further enhance the environment for people living with dementia.

Good

Is the service caring?

Our findings

People we spoke with praised the staff and described them as kind. One person said, "It's good here. The staff are very nice. Some are new and some have been here a while but they all help me." Another person told us the staff were 'marvellous' and said the staff looked after them well. A further person said, "All the staff are good here. It's a good place to live in." A relative we spoke with confirmed their positive experiences of the staff team including the registered manager. They told us, "The staff here are wonderful and I have no hesitation in saying [name] would not be here today if it were not for the caring nature of the staff".

Positive, caring relationships had developed between people and staff. Staff took every opportunity to engage with people and we saw people laughed and smiled as they chatted with them. Interactions were warm and personal and we saw staff knew people well and adapted their approach accordingly. Staff showed consideration for people and were patient and kind. For example, when transferring one person in a wheelchair the staff member explained what they were going to do, checked the person agreed and reassured them throughout the transfer. We heard them remind the person to 'keep your elbows in' when going through the doorway. Another person said to a staff member they would like a packet of crisps, when the staff member brought these the person had changed their mind and no longer wanted them. The staff member said, "Okay no problem. I'll keep them for you in case you want them later." We saw the person smiled and said, "Yes bring them back later."

People told us staff treated them with respect and maintained their privacy and dignity. We saw staff knocked and waited for an answer before entering people's rooms and staff were discreet when asking people about their personal care needs. Staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. This showed people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment.

Staff we spoke with emphasised how important they felt it was to treat people with dignity and respect. One staff member said, "We support people to lead the lives they choose and that means treating them with respect and listening to what they want. They can get up when they want, go out or stay in, it's up to them."

We saw people had been able to make choices about the decoration and furnishings in their rooms. Many rooms contained personal treasured items, family photographs and personal televisions. At the last inspection four people's clothes were not kept in their rooms due to behaviour triggered by their mental illness and we saw this clothing had been piled up on open shelves in the laundry. At this inspection we found wardrobe space had been provided for this clothing. We saw plugs were now in place at wash hand basins and toilet and bathroom doors had locks in place. The home smelt fresher and cleaner without the pervading smell of cigarette smoke which we had noted at the last inspection.

Good

Is the service responsive?

Our findings

The registered manager told us they were in the process of updating all the care records which included archiving information that was not relevant to people's current needs. We looked at one of the care files which had been updated and saw improvements. The care file was well organised with separate sections for different needs which made it easy to determine the support people required. For example, the section on eating and drinking included nutritional risk assessments as well as care plans for diabetes and weight records. We saw the care plans were detailed and up to date with evidence of regular review. The other two care files we looked at had not yet been updated. We found in some of these files the care plans and risk assessments had not been signed or dated and some documentation needed archiving as it did not reflect people's current needs. We discussed with the registered manager the importance of continuing this process to ensure all the care records were updated and accurate.

Many people at the home were diagnosed with a severe mental disorder, were at risk of harm, self-neglect and had a history of having being detained under the Mental Health Act 1983. As such some people's care was coordinated under a Care Programme Approach (CPA). This approach ensured a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw written evidence that CPA meetings took place with all relevant health and social care professional in attendance.

Staff supported people to pursue activities of their choice both in the home and out in the community. In house activities included board games, baking and external entertainers such as Singing for Health. We saw, where required, people were provided with one-to-one support from staff and we were told of recent trips to the local park, the nearby Monkey Café for tea and cakes, bowling and shopping outings. Day trips were also arranged to places such as Skipton and York. One person attended a day centre once a week.

During the inspection we saw people going out for the day and others entertained themselves watching television, completing word searches and chatting with each other. The registered manager told us part of the new build included an occupational therapy room which would be staffed by an activities co-ordinator and would provide additional opportunities for people.

We found systems in place to manage complaints had improved. We saw two complaints had been received since the last inspection. Both of these were well recorded and provided detail of the investigation, any action taken in response and how the outcome had been communicated to the complainant. We saw the complaint procedure was displayed in the home. People we spoke with knew how to make a complaint and felt if they raised issues these would be dealt with. One person said, "I would go to [registered manager] if I wasn't happy with anything, she'd sort it out. She's very good."

Requires Improvement

Is the service well-led?

Our findings

We found the registered manager and provider had worked hard to secure improvements for people as shown in other sections of this report. We found quality assurance systems were in place. However, before we can conclude the service is well-led we need to be assured that the improvements made will be sustained and developed further to make sure people consistently receive high quality care.

The home has a registered manager who has been in post for over two years. People spoke highly of the registered manager and said they liked her. One person said, "She's [the registered manager] always around and listens to me." Another person said, "If I need anything I can go to [registered manager] and I know she'd sort it out."

We saw the management team were highly visible in the home throughout the day and directed and supported staff. Staff we spoke with praised the registered manager who they described as supportive and always available for advice and guidance. Staff told us they attended staff meetings which they felt were productive and said their views and suggestions were taken seriously. One staff member said, "I'm very happy here. [The registered manager] gives us a lot of support. We've got a good team and there's good communication."

We found required notifications such as serious injuries and allegations of abuse had been reported to the Care Quality Commission. This helped us to monitor events which occurred within the service.

We saw the rating for the service from the last inspection report was displayed in the home as required. The rating was also required to be displayed on the location's website, however the registered manager confirmed there was no website for the service or the provider

Following the last inspection the manager had implemented systems to assess and monitor the quality of the service. We looked at these and saw they were effective in identifying issues and making sure action had been taken to rectify any problems. For example, we saw medicine administration and management was a regular feature of the audit plan. We saw where issues were identified a clear plan to correct the shortfalls was recorded with a responsible individual identified to lead the improvements together with a date for further review. Other audits and regular checks included the quality of mattresses and the safe functionality of wheelchairs.

We found improved systems were in place to review accidents and incidents. Weekly audits were carried out by the registered manager followed by a monthly analysis of the information which identified trends and themes and look at 'lessons learnt' to prevent recurrences. The reports clearly detailed the action taken as a result of the analysis.

The registered manager had implemented a staffing tool which considered people dependencies and ensured safe staffing levels. The registered manager told us the tool also included ancillary staff hours. We saw cleaning hours had been increased since the last inspection and there was further support for night staff

provided by a 'sleep in' staff member.