Care Quality Commission

Greenacres Nursing Home Limited

Thomas Leigh Care Home

Inspection report

Thomas Lane
Knotty Ash
Liverpool
Merseyside
L14 5NX
Tel: 01512547720
Website:

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced focussed inspection of this service on 15 September 2015 for two reasons. At the comprehensive inspection of the home which we carried out in April 2015 two breaches of legal requirements were found. This was because the provider did not have suitable arrangements in place for people to consent to their care and because systems and processes in the home did not operate effectively enough to ensure that the service provided was safe, effective, caring, or well led. We had also had concerns raised with us from external agencies regarding the management of medication at the home and the support people received with their health care.

After the comprehensive inspection in April 2015, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. As part of this focused inspection we checked to ensure they had followed their plan and to confirm that they now met legal requirements.

Summary of findings

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Thomas Leigh Care Home' on our website at www.cqc.org.uk

Thomas Leigh is located in the Knotty Ash area of Merseyside and provides accommodation for up to 54 adults living with dementia.

The service is provided in a purpose built building and is close to local public transport routes. Accommodation is over two floors and the first floor can be accessed via stairs or a passenger lift. All bedrooms are single and en-suite and people share communal lounges, dining rooms and bathrooms. There are two units within the home. Lily unit provides support for people who require nursing care; Poppy unit provides support for people who do not require nursing care.

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. At the time of this inspection the appointed manager had applied to register with CQC and was subsequently approved.

At our focused inspection on the 15 September 2015, we found that the provider had followed their plan in which they told us actions had been completed by 24 July 2015 and legal requirements had been met. They also told us that some actions would be on-going to monitor the quality of the service.

Applications for Deprivation of Liberty Safeguards had been made where appropriate; this helped to protect people's legal rights.

Action had been taken to make fire escape routes safer, improve people's experiences at mealtimes and with occupation and activities during the day, improve laundry systems and quality assurance systems.

People were receiving the support they needed with their health care and medication.

We saw that a fire escape route was partly blocked with garden furniture which could cause an obstruction for people using it as a means of escape.

Records were not always stored securely and confidentially.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the safety of the service.

Fire evacuation routes had been made safer.

People were receiving their medication as prescribed.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service effective?

We found that action had been taken to improve the effectiveness of the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Proper policies and procedures were in place to protect people's rights.

People were receiving the support they needed with their health care.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service caring?

We found that action had been taken to improve how caring the service was.

Action had been taken to improve the way people's laundry was managed.

The mealtime experience was a less rushed and more sociable for occasion for people living at the home.

We could not improve the rating for caring from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service responsive?

Care plans were up to date and contained the information staff required to monitor and support people with their health.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service well-led?

We found that action had been taken to improve how the service was managed.

Requires improvement

Summary of findings

The appointed manager had applied for registration with the Care Quality Commission. This was subsequently approved.

The home had implemented an action plan to improve issues noted at the last inspection.

Records were not always stored securely.

We could not improve the rating for well led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Thomas Leigh 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 carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 16 and 20 April 2015 had been made. We also checked whether people's medication was being managed safely and people were receiving the support they needed with their health care. This was because we had received information of concern from external agencies regarding the quality of the service provided at Thomas Leigh. The team inspected the service against the five questions we ask about services: is the service effective? Is the service caring? Is the service safe? Is the service responsive? Is the service well led?

The inspection took place on 15 September 2015 and was unannounced. The inspection was undertaken by a lead adult social care inspector, a second adult social care inspector 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.

During our inspection we spoke with four of the people living at the home and met with several other people living there. We also spoke with four of their relatives and with two health or social care professionals visiting the home. We spent time observing the care and support provided to people and toured parts of the building. In addition we spoke with eight members of staff including the appointed manager and a representative of the provider.

Prior to the inspection we looked at any information we had received about the home since our comprehensive inspection in April 2015. This included an action plan for meeting legal requirements that the provider had sent to us and information we had received from external agencies.

Requires improvement

Is the service safe?

Our findings

We spoke to a relative who told us an incident had occurred with their relative but the home had been frank and transparent with them and therefore they had no safeguarding worries about the home at all.

We had received a number of concerns from external authorities regarding the management of people's medication at the home. These had included errors with medication records and concerns that medication had not been ordered safely.

We looked at a sample of medication management for people living on Lily unit and discussed this with the nurse in charge of the unit. She explained that at the end of the current medication cycle they were changing to a new pharmacy to supply their medication and a new medication system would also be introduced at that time. She anticipated that this would improve the way medication was managed within the home.

Both Lily and Poppy units have a locked room for the storage of medication. We saw that the rooms were clean and tidy with medication appropriately stored. We noted that lighting in the medication room on Poppy Unit was dim; this could impact on the ability of staff to manage medication safely.

We looked at a sample of medication records for people living on both units. We found that people had received their medication as prescribed by their doctor. Clear records were maintained of any unused medication that had been destroyed.

Where people received their medication 'covertly' for example disguised in food or fluids, records showed that this had been discussed with their doctor and agreement reached about how this should be done safely and legally.

A small number of people were prescribed medicines to be given 'as required' Records showed that there was minimal use of this medication; however records of the use of 'as required' medication were not always clear or robust enough to provide an audit trail. For example one person was prescribed a medication twice a day and 'as required'. Records showed this had been used rarely and the time of day they had been given the medication was not clearly recorded. A second person was prescribed an 'as required' medication and although this had been rarely used the medication sheet did not record the reasons why it had been given. Recording this information would provide a clear audit trail and help to establish if it was given correctly and was benefitting the person.

We saw that hand-written medication administration records, for example for a person who had just gone to live at Thomas Leigh, were signed by two members of staff and recorded the quantities of medicines that had been brought into the home. This helped to lessen the risk of recording errors occurring.

During our comprehensive inspection of the home in April 2015 we had concerns regarding the fire evacuations routes at the home. We referred these to the local Fire Authority who visited the home.

The provider sent us an action plan in which they told us they had followed the advice of the fire officer.

We followed the fire route and found that it was no longer bolted inappropriately and the lock fitted was clearly marked. We saw that garden furniture was placed by the route people would follow; this could provide an obstruction in the event of an evacuation.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection in April 2015 we found that applications for a Deprivation of Liberty Safeguard authorisation (DoLS) had not been applied for for people living at the home who would benefit from the protection these would offer them. These laws and safeguards are a legal way to ensure people are not deprived of their liberty unduly. They also provide protection for people by ensuring decisions the person is unable to make are made in their best interests.

The provider sent us an action plan in which they stated a number of people now had a DoLS in place and applications would continue to be made as appropriate. They also stated that as part of their pre-admission assessment they would assess whether the person would benefit from a DoLS application being made when they moved into the home.

At this inspection we found that the provider had followed their action plan to meet the relevant regulation.

We discussed the use of DoLS with the appointed manager. She demonstrated knowledge of when to apply for a DoLS for someone who met the criteria for benefiting from this safeguard. This included demonstrating an awareness of the application process, ensuring an urgent application was made when needed and having systems in place to ensure that people's rights were protected.

We looked at a sample of DoLS applications that had been completed by the home and then forwarded to an 'authorising body', in this instance social services, to consider. We saw that the information had been correctly completed for both standard and urgent applications. We also saw that where a person had a DoLS in place this was recorded in their care plan, this helped to ensure that staff had access to the information they may need when supporting people.

We had received information from external bodies that people's health care was not always managed effectively at Thomas Leigh. We therefore looked at the support people received with their health as part of this focused inspection.

A relative of one of the people living at Thomas Leigh told us their relative had received excellent support with physiotherapy from the home. They also confirmed that their relative had received support to access routine health checks including the dentist and chiropodist. They told us that staff had made an appropriate decision to send their relative to hospital and had stayed with the person until their relative had arrived. They told us they had been impressed and pleased with the care staff had showed to their relative.

We spoke to a visiting health professional who told us that they had no concerns regarding the support the home provided to people with their health care and that this had improved in recent months.

We looked at care plans for five people living at Thomas Leigh. These identified people's health care needs and provided clear information for staff to follow on how to meet the person's needs. Records also showed that referrals to other health professionals had been made in a timely manner.

We spoke to staff about people's health care needs and found that they had a good understanding of the support people needed and how to provide this.

Requires improvement

Is the service caring?

Our findings

One of the people living at Thomas Leigh told us, "It is beautiful here. I love it. The food is fantastic." Another person commented, “The staff are brilliant.”

A relative told us, "I cannot fault this place. The staff are brilliant with my (relative). (Relative) Is always treated with respect and dignity even when being difficult. The staff seem able to anticipate (relative's) behaviour and keep (relative) very calm".

Another relative told us, "The staff are very caring and supportive. (My relative) is more relaxed than I have ever seen (relative) in recent years.

Our expert by experience commented, 'staff demonstrated a warm, caring rapport with residents."

At our comprehensive inspection in April 2015 we found that people's laundry was not being managed well. Clothes were going missing and there was a large stack of washed clothes undistributed in the laundry room.

We spoke to two relatives one told us that they had previously had concerns regarding the laundry but these were resolved. Another told us that they still had concerns regarding their relative's laundry.

Since the inspection in April 2015 two new staff had been appointed to work in the laundry. We spoke to one member of staff who was able to talk us through the system in place for managing laundry hygienically and ensuring it was returned to people in a timely manner.

We saw that there was a pile of unlabelled laundry remaining in the laundry room; however we noted that people's underclothes had been returned to them in a timely manner. We were advised that plans were in place to sort the unidentified laundry and ask relatives if they could identify this.

At our comprehensive inspection of the home in April 2015 we found that mealtimes were rushed, staff didn't always interact with people and the mealtime experience was not a sociable occasion people could enjoy.

At this inspection we observed mealtimes on both units. We saw that they were pleasant, unrushed occasions. Staff spent time talking with people and providing the support they needed and people had the time to sit and chat with each other.

People were offered a choice of meals although we noted that the alternative was sandwiches and these were served later than the hot meal. We also noted that the lunchtime meal was shepherds / cottage pie and the evening meal was corn beef hash. We discussed how similar these meals were with the manager who explained new menus were being devised.

Requires improvement

Is the service responsive?

Our findings

Concerns had been raised with us from external bodies about the quality of care plans at Thomas Leigh, this included plans not always containing the information staff needed to support people safely and that they were not always updated as people's needs changed.

We discussed this with the appointed manager who acknowledged that this had been an issue at the home. She explained that they had briefly decided to stop admitting people to the home in order to spend time reviewing and updating care plans. She told us that this had been successful, care plans now contained the relevant information and they were now admitting people who wanted to move to the home.

A relative of one of the people living at the home told us that staff knew and understood their relative's health and social care needs well and were therefore able to meet their needs.

We looked at records for a person who had moved into the home on the previous day. Records showed that a senior member of staff had gone out to meet the person and assess their needs to ensure that the home would be able to accommodate the person safely. Their records contained comprehensive information provided by hospital staff and a full medical history from the person's GP. A brief care plan had been written so that staff had outline information about the person's needs until a full plan for their care could be written.

We looked at a further five care plans for people living at the home. The plans were lengthy and detailed and included risk assessments and plans for managing identified risks. The care files provided information to show that people had been referred to medical professionals for example physiotherapist, pharmacist, and psychiatrist.

Care plans had been reviewed regularly. This helps to ensure that any changes to the person's needs or choices are noted and can be acted upon.

At our comprehensive inspection in April 2015 we had noted that there was a lack of activities and stimulation for people living at the home. At this inspection we were informed that a part time activity coordinator had been appointed.

A visiting health professional told us that they had observed there was something going on most days and that there was increased engagement between staff and the people living at the home.

A relative of one of the people living at Thomas Leigh told us that they felt the increased activities had helped their relative to become calmer and more relaxed.

On the day of our inspection we observed that the activities coordinator spent the first hour of their shift helping support people with their lunch, rather than with activities and occupation.

In the afternoon an entertainer visited the home and set up on Poppy Unit. Our expert by experience commented, 'Real enjoyment and happiness was being displayed by staff and residents alike'. We saw that staff joined in with the singing and dancing and people living on Poppy unit really engaged with and enjoyed the activity.

People living on Lily unit were not invited to join in with this activity. We were told that there were various reasons for this, including that they may find it too noisy or may become challenging. We did see any recorded evidence that people had been invited to try attending the entertainment sessions to establish whether they benefited from this.

We spoke with the activities coordinator who explained people living on Poppy unit did receive support with activities such as games and reminiscence. We were also told other activities included art, armchair exercises and that some outings were arranged although this depended on the person having the funding and relatives providing support.

On Lily unit we noted that the television was switched on with no sound and a CD was playing music. This could be confusing for the people living there. Throughout the day we saw staff interacting and engaging with people as well as meeting their care needs. Our expert by experience commented, 'staff showed real concern over the welfare of residents, staff closely observed the safety of residents …sufficiently to allow them full autonomy but discreetly watching people so they came to no harm'.

Requires improvement

Is the service well-led?

Our findings

We spoke to a relative who told us they found the manager approachable and that they had confidence she would deal with any issues they raised.

A visiting health professional told us that the service had improved greatly over the last six months. She said the deputy manager had made a big difference and had worked alongside care staff and mentored them.

A member of staff told us, "I love working here. I feel valued and supported by the management." A second member of staff told us that they had found the manager approachable and felt they could discuss any concerns they had with her.

At our comprehensive inspection in April 2015 we found checks and audits at Thomas Leigh had failed to identify issues we had noted. This had included the lack of a registered manager, blocked fire escape route, improving the environment for people living with dementia, improving activities and the laundry service and addressing meal times to make them more sociable occasions.

The provider sent us an action plan in which they stated the action they would take to address these issues. At this inspection we found that the provider had followed their action plan to meet the relevant part of the regulation.

A deputy manager had been appointed to provide support to the manager and lead on nursing care issues. The appointed manager had applied to the Care Quality Commission to register as the manager of Thomas Leigh, since this inspection her application has been approved.

As noted elsewhere within this report issues with the laundry, blocked fire route, activities and mealtimes had been addressed.

We found that some attempt had been made regarding improving the environment to make it more suitable for people living with dementia but that further improvements would make Thomas Leigh an easier place for people to find their way around.

We saw that audits were in place and had been completed for medication, health and safety, infection control and the kitchen. We also saw that surveys had been given to relatives; the main issue these had raised regarded a lack of activities which we found had been addressed.

At this inspection we saw that care records for people living on Poppy Unit were stored in the lounge areas. This meant that they were not stored securely and could be accessed by people not authorised to do so. We also saw that information was taped to one person's wardrobe door that was confidential and inappropriate. In the dining room on Lily unit there was a large notice board which listed people's initials long with the type of diet they required. Whilst this was to help staff have ready access to people's dietary needs and prevent mistakes occurring it could also compromise their right to privacy.