Mr & Mrs R M Parkhouse

Garston Manor Nursing Home

Inspection report

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Ratings

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

Overall summary

Garston Manor Nursing Home is registered to provide nursing care and support to 26 people who have dementia, mental health needs, and /or a physical disability.

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.

This inspection took place on 14 and 20 July 2015 and was unannounced. There were 22 people living in the home at the time of the inspection. The service was last inspected on 22 October 2014. At that time, the service was rated 'inadequate'. We found the service was not meeting the regulations in relation to care and welfare, medicines management, safeguarding, respecting and involving people, consent to care and treatment, and quality assurance. We met with the provider and told

Summary of findings

them they needed to make improvements. The provider sent us an action plan telling us what they were going to do to meet the regulations. On this visit we checked and found improvements had been made.

People's relatives and representatives were pleased with the service provided. Their comments included "The staff here are excellent"; "The manager cares like she's her own Mum" and "They're incredibly patient and Mum's improving, responding better and feeding herself again. I go home with a happy heart."

People were not always supported to follow their interests and take part in social activities. During our inspection, people sat in the lounge for long periods of time, some with little interaction. There was a visual activities timetable but no one's attention was drawn to it and it did not relate to what was happening on the day. There were no distractions or stimulating activities for people to engage in independently. The deputy manager told us the service had identified this as an area that needed to be developed. During our observation staff spent a lot of their time writing records in the lounge. We discussed this with the registered manager who told us they would look at reducing the amount of records so that staff had more time to engage with people. Staff knew people's interests. For example, one person liked soft toys. Staff placed a soft toy on the person's lap and they visibly brightened and took comfort from this. Three staff were completing an activities course which included how to involve people living with dementia.

People's medicines were managed safely. People were given their medicines in a safe way, with staff asking if people needed any pain relief if prescribed. The nurse took time with people to make sure they took their medicines correctly. Records relating to medicines were completed correctly. The service could evidence that people had received their medicines as they had been prescribed by their doctor to promote good health.

Risks to people were identified and managed. Risk assessments were completed for each person. Each risk assessment gave information about the identified risk, why the person was at risk and how staff could minimise the risk. For example, one person was at high risk of falls and had fallen a number of times. The provider had monitored the falls and identified a trend. Staff knew to be available at certain times of the day to support the person safely whilst giving the person as much independence as possible. This had resulted in the person having less falls, reducing the risk of injury.

Relatives and representatives told us they felt people were safe. Staff understood the signs of abuse, and how to report concerns. Appropriate staff recruitment checks had been undertaken to ensure staff were suitable to work with vulnerable people.

Staff treated people with respect and kindness. Staff spoke with people, explained what they were doing, and reassured them when supporting them with their care needs. Staff were patient when supporting people, allowing people time without rushing them. There were enough staff to meet people's needs. There was always at least one member of staff available to people in the lounge area. Staff did not seem rushed and remained calm and attentive to people's needs.

Staff knew the people they supported. They were able to tell us about people's preferences and personal histories. Staff told us most people could make their own decisions about their day to day care, but may not be able to consent to more significant decisions. If people were not able to make decisions for themselves staff spoke with relatives and appropriate professionals to make sure people received care that met their needs and was deemed to be in their best interests. For example, when one person had a medical issue, the person's relative met with staff and the GP to discuss whether an investigation should be carried out. A decision was made in the person's best interests.

Relatives and representatives told us they had been involved in the care planning process and told us the home informed them of any concerns or changes to the care provided. Care plans were clearly written and information was easily accessible. Care plans described in detail the care and treatment people needed. For example, plans relating to people's dementia, diabetes, and pain assessment had been put in place and gave staff the information they needed to respond to people's needs.

Some staff did not have the skills to meet the needs of people with dementia. All staff were working towards the Care Certificate to ensure they received the knowledge they needed to carry out their role effectively. The deputy

Summary of findings

manager had carried out observations of staff's practice. Records showed when poor practice had been identified, this had been discussed with the individual staff member. Four staff had attended the Dementia Friends Champions course. The deputy manager was the Dementia Friends Champion lead for the service. Further dementia training was planned for all staff.

The provider had made some adaptations to the environment to support people living with dementia. For example, hand rails in corridors were painted a different colour. The dining room tables had been changed to a more suitable design and cushions had been placed on the transparent chairs to assist people with visual and perceptions problems. Aids for eating and drinking such as high contrast coloured plates and thermal cups had been purchased. Chairs in the lounge had been moved into clusters. People were sitting together and two ladies enjoyed talking together. People enjoyed the views over the town and nearby hills. Some people were able to see houses where they used to live. This provided a talking point for people and staff. The deputy manager told us there were plans to further develop the environment including looking at ways of personalising people's bedrooms and the walls in the shared areas.

There was an open culture in the service. Relatives and representatives spoke highly of the registered manager and confirmed they were approachable. One relative commented "The registered manager says the office is always open and I do go in and talk to them". Staff placed trust in the management and described it as supportive. The provider had systems in place to assess and monitor the quality of care. For example, The service had identified that further work was required in relation to activities. Action had been taken by enrolling staff on activities training. The management team was keen to develop and improve the service. They accessed resources to learn about research and current best practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who used the service.

Risks to people were identified. Staff had been given information telling them how to manage risks to ensure people were protected.

Relatives and representatives told us they felt people were safe. People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not yet completed training to give them the skills they needed to ensure people's individual dementia care needs were met.

People's rights were respected. Mental capacity assessments had been carried out and where a person lacked capacity to make an informed decision, staff acted in their best interests.

People had regular access to healthcare professionals. When concerns about a person's health were identified, staff monitored the situation and sought professional advice when needed.

Is the service caring?

Good

The service was caring.

People's relatives and representatives were positive about the caring attitude of staff.

People were treated with dignity and respect. Staff spoke with people, explained what they were doing, and reassured them when supporting them with their care needs.

Staff were patient when supporting people with their care needs, allowing people time without rushing them.

Is the service responsive?

Requires improvement

The service was not always responsive.

Activities of interest to each person had been identified. However, people were not always supported to follow their interests and take part in social activities. The service had identified this as an area that needed to be developed.

Summary of findings

Staff were responsive to people's individual needs and gave them support at the time they needed it.

People's needs had been assessed and care plans developed to make sure those needs were met. People's care plans were updated when needs changed.

Is the service well-led?

Good

The service was well-led.

The provider had systems in place to assess and monitor the quality of care. The system enabled them to quickly identify any issues.

The management team were keen to drive improvements in the home. They accessed resources to learn about research and current best practice.

The service had an open culture. Relatives and representatives spoke highly of the registered manager and confirmed they were approachable. Staff placed trust in the management and described it as supportive.

Garston Manor 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 was 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 14 and 20 July 2015 and was unannounced.

One adult social care inspector, a pharmacist inspector, and an expert-by-experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care for older people living with dementia.

Before the inspection we reviewed the information we held about the service and contacted the local authority to ask for their feedback about this service.

On the day of our visit there were 22 people living in the home. We used a range of different methods to help us understand people's experience. We spoke with five relatives/representatives. We spoke with the provider, registered manager, two deputy managers and five staff.

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

We looked at three care plans, medication records, two staff files, audits, policies and records relating to the management of the home.

Good

Is the service safe?

Our findings

At our last inspection on 22 October 2014, people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. At this visit in July 2015 we checked and found improvements had been made.

At lunchtime, people were given their medicines in a safe way, with staff asking if people needed any pain relief if prescribed. The nurse took time with people to make sure they took their medicines correctly. Staff said that there was nobody who currently looked after their own medicines. However people had access to lockable storage and would be able to do this if it had been assessed as safe for them.

Medicines were stored safely and securely. There was a separate refrigerator for medicines needing cold storage. Records were available to show that the refrigerator temperature was being monitored to make sure that these medicines were stored correctly and would be safe and effective for people. A new cooling unit and fan had been installed since our previous inspection, to help reduce the temperature in the medicines storage room. Records showed that medicines were now being stored in the recommended temperature range. There were suitable arrangements for the storage, recording and destruction of medicines and records showed that regular checks were undertaken by staff.

The medicine charts for 22 people were checked and they showed records were well completed. Any changes to people's medicines were clearly recorded on the charts, and checked by a second member of staff to make sure they were correct. There were separate charts for recording the use of creams or other external preparations. These included instructions for care staff on how and when to apply these preparations. People who had difficulties swallowing their medicines had been reviewed with the doctor and pharmacist, and where possible changed to liquid preparations. When it was necessary to crush tablets, or open capsules, there were clear records to show that it was safe to do this for each medicine. Records were kept of medicines received into the home, those administered and any that were sent for destruction, which provided a clear audit trail of medicines handling within the home.

There was a system for recording and dealing with any medicines issues. Regular audits were being completed by the nurses and the registered manager. The supplying pharmacy had visited to give advice on medicines management, and some recommendations were being implemented. Training had recently been updated for staff and checks had been carried out to make sure they gave medicines safely. There were policies and procedures in place to guide staff as to how to look after medicines in the home, and information on medicines was available for staff.

At our last inspection, people were not protected against the risks associated with behaviour that may put themselves or others at risk. At this visit we checked and found improvements had been made. Staff knew how to manage each person's behaviour according to their individual assessment. Staff knew the triggers that may result in the behaviour, signs to look out for, and steps on how to manage the situation. The registered manager had sought and followed advice from mental health consultants to reduce the risk of further incidents.

At our last inspection, risks to people were not managed safely. At this visit we checked and found improvements had been made. Risk assessments were completed for each person. Staff had been given information telling them how to manage these risks to help ensure people were protected. Each risk assessment gave information about the identified risk, why the person was at risk and how staff could minimise the risk. For example, one person was at high risk of falls. Staff knew to be available to support the person safely whilst giving the person as much independence as possible.

Relatives and representatives told us they felt people were safe. People were protected from the risk of abuse as staff had received training in safeguarding people. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. The provider had safeguarding policies and procedures in place. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns.

Where accidents and incidents had taken place, the registered manager reviewed their practice to ensure the risk to people was minimised. For example, one person had fallen a number of times. Accident and incident reports were completed. A graph showed the times of the falls over

Good

Is the service safe?

a number of months. A trend had been identified and staff knew to monitor the person at certain times of the day. This had resulted in the person having less falls, reducing the risk of injury.

There were sufficient staff to meet people's needs. There was always at least one member of staff in the lounge area where up to 15 people were gathered before lunch. At lunchtime there were sufficient members of staff in the dining and lounge areas serving and assisting people with their food as required. Staff did not seem rushed and remained calm and attentive to people's needs. Call bells were answered in good time. At one point a fire door alarm was accidentally triggered and three staff were there within seconds.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, gas, water, and lifts. The service purchased equipment which people needed to meet their care needs.

There were arrangements in place to deal with foreseeable emergencies. For example, each person had a personal emergency evacuation plan that told staff how to safely assist them in the event of a fire.

Requires improvement

Is the service effective?

Our findings

At our last inspection, records confirmed staff had completed training. However, there was no procedure in place to ensure staff understood their training and responsibilities. At this visit we checked and found improvements had been made. All staff were working towards the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. The registered manager said this was to ensure existing staff received the knowledge they needed to carry out their role effectively. The deputy manager had carried out observations of staff's practice. Records showed when poor practice had been identified, these had been discussed with the individual staff member.

Some staff did not have the skills to meet the needs of people with dementia. For example, several people displayed signs of agitation or boredom. This included behaviours which were repetitive. Staff did not always show awareness in how to reduce these behaviours by distracting people or engaging them in some activity. People spent long periods of time sitting in a chair. Some people who were able to move were not encouraged to do so. They were passive and unresponsive. The door to an enclosed balcony area was open yet no-one was supported to go out into the fresh air. Four staff had attended the Dementia Friends Champions course. The deputy manager was the Dementia Friends Champion lead for the service. The deputy manager told us staff had started to take part in role play by experiencing care as a person would. For example, spending time sitting in the lounge. This led to discussion and feedback from staff on how it made them feel. Further dementia training was planned for all staff.

Staff had received regular supervision. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues. Staff had also received an annual appraisal to discuss their training and development.

At our last inspection, there were no suitable arrangements in place for obtaining consent or acting in people's best interests. At this visit we checked and found improvements had been made. Care plans contained mental capacity assessments. The registered manager had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Staff sought consent from people before carrying out care. For example, staff explained to a person what they were going to do. They asked the person for consent and this was given. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. Staff told us if people were not able to make decisions for themselves they spoke with relatives and appropriate professionals to make sure people received care that met their needs and was deemed to be in their best interests. For example, when one person had a medical issue, the person's relative met with staff and the GP to discuss whether an investigation should be carried out. A decision was made in the person's best interests.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so they get the care and treatment they need, where there is no less restrictive way of achieving this. The door from the lounge to the entrance hall was locked and people were unable to leave the home. The registered manager had made the appropriate DoLS applications to the local authority. One application had been authorised and there was evidence the person's best interests had been properly considered.

The provider had made some adaptations to the environment to support people living with dementia. For example, hand rails in corridors were painted a different colour. The dining room tables had been changed to a more suitable design and cushions had been placed on the transparent chairs to assist people with visual and perception problems. Aids for eating and drinking such as high contrast coloured plates and thermal cups had been purchased from a specialist organisation. After the first day of our inspection, the registered manager completed an environmental assessment. When we returned for the second day, chairs in the lounge had been moved into clusters. People were sitting together and two ladies enjoyed talking together. People enjoyed the views over the town and nearby hills. Some people were able to see houses where they used to live. This provided a talking

Requires improvement

Is the service effective?

point for people and staff. The deputy manager told us there were plans to further develop the environment including looking at ways of personalising people's bedrooms and the walls in the shared areas.

People were supported to have enough to eat and drink. People were offered drinks during the morning with a choice of biscuits or fruit. Drinks with thickeners were given to the people who had been prescribed them. Staff were available to assist where necessary.

At lunchtime people ate in the one of the two dining rooms, the lounge, or their bedroom. People had a choice of chicken and mash or pasta bolognese followed by strawberry gateau, all cooked on the premises. Whilst staff made an effort to give people choice and get a response, people weren't always helped to understand the choices they were being given. Staff did not always use alternative strategies for people who were unable to understand and respond. For example, showing photographs of food or plates of food to people to assist them in making an informed choice. However, on the second day of our inspection a member of staff showed a plate of cakes to one person, explaining what each one was. The person was then enabled to make their choice and enjoyed it.

Staff knew people's food preferences including their preferred portion size. Food was brought quickly and efficiently from the kitchen and some people enjoyed their lunch independently, whilst staff encouraged others to eat. A number of people required pureed food and staff were available to assist them. People were able to ate at their own pace. The needs of people with diabetes were met by using diabetic sugar in recipes so that all meals were diabetic-friendly.

Mealtimes were flexible to meet people's needs. For example, some people chose to get up later than others. One person was eating and enjoying their cooked breakfast at 9.30am.

Records showed the food and drinks each person ate and drank each day. This helped to ensure the nurses were aware of each person's daily intake. People's weights were recorded every month. Where people were at risk of weight loss, the cook prepared enriched foods which included adding cream and butter.

Relatives confirmed people received care and treatment from outside professionals when needed. They were quickly informed of any changing needs. Records showed people had regular access to healthcare professionals such as GPs, consultants, chiropodists, opticians and dentists. For example, one person had complained of pain in their shoulder. Staff checked the person and did not find any sign of an injury. They immediately booked a GP home visit and monitored the person.

Good

Is the service caring?

Our findings

Relatives and representatives were very happy with the care provided. Comments included “The staff here are excellent”; “The manager cares like she’s her own Mum” and “They’re incredibly patient and Mum’s improving, responding better and feeding herself again. I go home with a happy heart.”

Staff demonstrated they knew the people they supported. They were able to tell us about people’s preferences and personal histories.

Staff treated people with respect and kindness. For example, staff addressed people with their preferred name and spoke with respect. People responded to this by smiling and engaging with staff in a friendly way.

Interactions showed staff were kind and compassionate when meeting people’s needs. For example, one person was being transferred from a chair to a wheelchair. Staff explained what they were doing and checked the person was alright several times during the manoeuvre. Staff sat down next to people when assisting with food and chatted to the person. Staff were patient when supporting people to mobilise, allowing people time without rushing them.

One member of staff showed patience and skill when encouraging people and distracting them to relieve distress. For example, when one person started to argue with another person, staff stepped in quickly. They reassured the person and gently led them away, walking to a different part of the lounge and not leaving the person until they were calm.

People’s privacy and dignity was respected and promoted. The registered manager had signed up to the Dignity in Care 10 point dignity challenge. When staff were observed to have shown good practice, they were given a badge and card which described values and actions that respect people’s dignity.

During our inspection, a number of care plans and documents were placed on a table for us to look at. The registered manager quickly turned the records over so they could not been seen. This meant confidential information was kept private.

People were enabled to be as independent as possible. Staff encouraged people to carry out their own personal care when they were able to. Care plans contained information for staff to follow to ensure people’s independence was promoted. Staff were seen to encourage people to do as much as they could when mobilising.

Relatives and representatives told us they were always made welcome. They had been involved in the care planning process and told us the home informed them of any concerns or changes to the care provided. One relative said “I’ve been confident enough to go on holiday. The manager encouraged me and said I was to ring them at any point, which I did from holiday”.

Requires improvement

Is the service responsive?

Our findings

At our last inspection, care plans did not give clear information to ensure people's needs were met. At this visit we checked and found improvements had been made. A new care plan format had been introduced. These were clearly written and information was easily accessible. They were reviewed every month or earlier if required to ensure people's changing needs were identified and met.

Care plans described in detail the care and treatment people needed. For example, plans relating to people's dementia, diabetes, and pain assessment had been put in place and gave staff the information they needed to respond to people's needs.

People were not always supported to follow their interests and take part in social activities. During our inspection, people sat in the lounge for long periods of time. The television was on, although people were not watching it, and music also played from a radio. There was background noise and staff raised their voices when talking with people. Two staff provided hand massage to people. People were engaged for only a few minutes on a one to one basis. Staff attempted to reminisce with one person, sharing a photograph with them but the person did not seem to recognise it and turned their head away. There was a visual activities timetable but no one's attention was drawn to it and it did not relate to what was happening on the day. People were not supported by the use of pictures to show choice of activities. There were no distractions or stimulating activities for people to engage in independently. The deputy manager told us the service had identified this as an area that needed to be developed. During our observation staff spent a lot of their time writing records in the lounge. We discussed this with the registered manager who told us they would look at reducing the amount of records so that staff had more time to engage with people.

Care plans contained detailed information about people's history and interests. Activities of interest to each person had been identified. Staff were able to tell us how one person liked to dance. Staff had danced with this person in the lounge. Another person liked soft toys. Staff placed a soft toy on the person's lap and they visibly brightened and took comfort from this. One person liked football and staff encouraged them to have a kick around with a soft ball. Some people were seen to enjoy a visit to the hairdresser. A noticeboard showed pictures with the theme of holidays and travel. The theme changed every week to give people something to look at and talk about. Staff discussed the pictures with people, identifying where they were. Three staff were completing an activities course which included how to involve people living with dementia.

During our visit, staff responded to people's requests and met their needs appropriately. On one occasion, a person triggered the alarm by opening a fire door. When staff went to assist the person to come back in, they did not wish to return through the door. The staff member responded by accompanying person on a short walk outside and round to a different door.

People were confident if they made a complaint this would be dealt with. None of the relatives we spoke with had needed to make a complaint. Relatives said "It couldn't be better" and "I've found it very, very good here and any problems are sorted straight away by the manager". For example, one person tripped a couple of times in their room. The relative said "When I spoke to the manager, they said they were about to move them in any case to a more suitable room, which they did". One person had recently raised a concern about staff bringing their meal to them in their bedroom then leaving them on their own. As a result, staff had been told to stay and chat with the person for a time after taking their meal in. The deputy manager was monitoring mealtimes to ensure this happened.

Good

Is the service well-led?

Our findings

At our previous inspection in October 2014, the provider did not have an effective system to regularly assess and monitor the quality of the service people received. At this visit we found improvements had been made.

Since our previous inspection, the Devon County Council quality improvement team has visited the home on regular basis. They provided support and guidance to the service. The team were no longer working with the home and told us the service had made good progress.

Systems had been put in place to monitor the quality of the service and enable the provider to quickly identify any issues. A new comprehensive quality assurance system had been purchased. The service had carried out audits in relation to care plans, staffing, catering, maintenance, medicines, and risk. The service had identified that further work was required in relation to activities and training. Action had been taken by enrolling staff on further training.

Two deputy managers had been recruited to support the registered manager since our previous inspection. One of the deputy managers had enrolled on the Level 5 Diploma in Leadership and Management.

The management team were keen to drive improvements in the home. They accessed resources to learn about research and current best practice. For example, they had looked up information from Skills for Care, Social Care Institute for Excellence, The National Institute for Health and Care Excellence, and Dementia Care Matters. Quality meetings were planned to discuss how to provide better quality care.

Relatives and representatives spoke highly of the registered manager and confirmed they were approachable. One relative commented “The registered manager says the office is always open and I do go in and talk to them”. There was an open culture in the home. For example, one relative told us the registered manager had been very open with them about the previous inspection and the concerns that had been identified. They said the registered manager had sat down and discussed it with them.

Staff said they placed trust in the management and described it as supportive. Staff spoke about the changes that had taken place since the previous inspection. Their comments included “I’ve seen a difference in the home, it has improved” and “Management are trying really hard, they’re involved in the home”.

Staff treated each other with respect. Most staff told us teamwork had improved since task based routines had been removed from the rota. This resulted in better outcomes for people as staff did not stick to the job they were doing.

The registered provider's vision and values for the service were written in their business plan. Their aim was to look after people in the best way possible and to regard every individual as a unique person. Staff told us how the vision had been discussed in a staff meeting. One staff member gave an example of how they are reminded of the vision. They said “The registered manager came into a staff handover to talk to staff about their job role and ask why are you here?”

Relatives, staff, and healthcare professionals were invited to give feedback. For example, service satisfaction questionnaires were sent out in November 2014. These asked people for their views of the care and support provided. A total of 23 out of 30 questionnaires were completed. All rated the care as “generally good”. New service satisfaction questionnaires had been developed and related to the five questions - safe, effective, caring, responsive, and well-led. There were plans to send out questionnaires on a regular basis to gain feedback to develop the service.